Australian Government
Department of Health

Medicare Benefits Schedule Book

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

TABLE OF CONTENTS

G.1.1. The Medicare Benefits Schedule - Introduction....19
G.1.2. Medicare - an outline....19
G.1.3. Medicare benefits and billing practices....20
G.2.1. Provider eligibility for Medicare....20
G.2.2. Provider Numbers....21
G.2.3. Locum tenens....21
G.2.4. Overseas trained doctor....21
G.2.5. Contact details for the Department of Human Services....22
G.3.1. Patient eligibility for Medicare....22
G.3.2. Medicare cards....22
G.3.3. Visitors to Australia and temporary residents....22
G.3.4. Reciprocal Health Care Agreements....22
G.4.1. General Practice....23
G.5.1. Recognition as a Specialist or Consultant Physician....24
G.5.2. Emergency Medicine....25
G.6.1. Referral Of Patients To Specialists Or Consultant Physicians....25
G.7.1. Billing procedures....28
G.8.1. Provision for review of individual health professionals....28
G.8.2. Medicare Participation Review Committee....30
G.8.3. Referral of professional issues to regulatory and other bodies....30
G.8.4. Comprehensive Management Framework for the MBS....30
G.8.5. Medical Services Advisory Committee....30
G.8.6. Pathology Services Table Committee....30
G.8.7. Medicare Claims Review Panel....30
G.9.1. Penalties and Liabilities....31
G.10.1. Schedule fees and Medicare benefits....31
G.10.2. Medicare safety nets....32
G.11.1. Services not listed in the MBS....33
G.11.2. Ministerial Determinations....33
G.12.1. Professional services....33
G.12.2. Services rendered on behalf of medical practitioners....33
G.12.3. Mass immunisation....34
G.13.1. Services which do not attract Medicare benefits....34
G.14.1. Principles of interpretation of the MBS....36
G.14.2. Services attracting benefits on an attendance basis....37
G.14.3. Consultation and procedures rendered at the one attendance....37
G.14.4. Aggregate items....37
G.14.5. Residential aged care facility....37
G.15.1. Practitioners should maintain adequate and contemporaneous records....37
A.1.. Personal Attendance by Practitioner....40
A.2.. Professional Attendances....41
A.3.. Services not Attracting Medicare Benefits....41
A.4.. Multiple Attendances on the Same Day....41
A.5.. Attendances by General Practitioners (Items 3 to 51, 193, 195, 197, 199, 597, 599, 2497-2559 and 5000-5067)....41
A.6.. Professional Attendances at an Institution (Items 4, 24, 37, 47, 58, 59, 60, 65, 5003, 5023, 5043, 5063, 5220, 5223, 5227 and 5228)....43
A.7.. Attendances at a Hospital (Items 4, 24, 37, 47, 58, 59, 60, 65)....43
A.8.. Residential Aged Care Facility Attendances (Items 20, 35, 43, 51, 92, 93, 95, 96, 5010, 5028, 5049, 5067, 5260, 5263, 5265, 5267)....43
A.9.. Attendances at Hospitals, Residential Aged Care Facility and Institutions and Home Visits....43
A.10.. After-Hours Attendances (Items 597, 598, 599, 600, 5000, 5003, 5010, 5020, 5023, 5028, 5040, 5043, 5049, 5060, 5063, 5067, 5220, 5223, 5228, 5260, 5263 and 5265)....43
A.11.. Minor Attendance by a Consultant Physician (Items 119, 131)....45
A.12.. Referred Patient Consultant Physician Treatment and Management Plan (Items 132 and 133)....45
A.13.. Referred patient assessment, diagnosis and treatment and management plan for autism or any other pervasive developmental disorder (items 135 and 289)....46
A.14.. Patient Assessment, Diagnosis and Treatment and Management Plan for a Child with Disability (Items 137 and 139)....48
A.15.. Geriatrician Referred Patient Assessment and Management Plan (Items 141-147)....49
A.16.. Prolonged Attendance in Treatment of a Critical Condition (Items 160 164)....49
A.17.. Family Group Therapy (Items 170, 171, 172)....50
A.18.. Acupuncture (Item 173, 193, 195, 197 and 199)....50

A.19.. Consultant Psychiatrist - Initial consultations for NEW PATIENTS (Items 296 to 299 and 361) Referred Patient Assessment and Management Plan (Items 291, 293 and 359) and referral to Allied Mental Health Professionals 50
A.20.. Psychiatric Attendances (Item 319) 53
A.21.. Interview of Person other than a Patient by Consultant Psychiatrist (Items 348, 350, 352) 53
A.22.. Consultant Occupational Physician Attendances (Items 385 to 388) 54
A.23.. Contact Lenses (Items 10801-10809) 54
A.24.. Refitting of Contact Lenses (Item 10816) 54
A.25.. Health Assessments (Items 701, 703, 705, 707) 54
A.26.. Health Assessment provided as a type 2 diabetes risk evaluation for people aged 40-49 years with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool 56
A.27.. Health Assessment provided for people aged 45-49 years who are at risk of developing chronic disease 57
A.28.. Health Assessment provided for people aged 75 years and older 57
A.29.. Health Assessment provided as a comprehensive medical assessment for residents of residential aged care facilities 58
A.30.. Health Assessment provided for people with an intellectual disability 58
A.31.. Health Assessment provided for refugees and other humanitarian entrants 59
A.32.. Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715) 59
A.33.. A Health Assessment for an Aboriginal and Torres Strait Islander child (less than 15 years of age) 61
A.34.. A health assessment for an Aboriginal and Torres Strait Islander adult (aged between 15 years and 54 years) 61
A.35.. A health assessment for an Aboriginal and Torres Strait Islander older person (aged 55 years and over) 62
A.36.. Chronic Disease Management Items (Items 721 to 732) 62
A.37.. Medicare Dental Items For Patients With Chronic Conditions And Complex Care Needs - Services Provided By A Dental Practitioner On Referral From A GP [Items 85011-87777] 66
A.38.. Multidisciplinary Case Conferences by Medical Practitioners (Other Than Specialist or Consultant Physician) - (Items 735 to 758) 66
A.39.. Public Health Medicine - (Items 410 to 417) 67
A.40.. Case Conferences by Consultant Physician - (Items 820 to 838) 67
A.41.. Medication Management Reviews - (Items 900 and 903) 69
A.42.. Taking a Cervical Smear from a Person who is Unscreened or Significantly Under-screened - (Items 2497 - 2509 and 2598 - 2616) 72
A.43.. Completion of the Annual Diabetes Cycle of Care for Patients with Established Diabetes Mellitus - (Items 2517 - 2526 and 2620 - 2635) 73
A.44.. Completion of the Asthma Cycle of Care - (Items 2546 - 2559 and 2664 - 2677) 74
A.45.. GP Mental Health Treatment Items - (Items 2700 to 2717) 75
A.46.. Provision of Focussed Psychological Strategies - (Items 2721 to 2727) 79
A.47.. Pain and Palliative Medicine (Items 2801 to 3093) 81
A.48.. Telepsychiatry - (Items 353 to 370) 82
A.49.. Attendances by Medical Practitioners who are Emergency Physicians - (Items 501 to 536) 83
A.50.. Prolonged Attendance by an Emergency Physician in Treatment of a Critical Condition - (Items 519 to 536) 83
A.51.. Case Conferences by Consultant Psychiatrists - (Items 855 to 866) 84
A.52.. Case Conference by Consultant Physicians in Geriatric/Rehabilitation Medicine - (Item 880) 85
A.53.. Neurosurgery Specialist Referred Consultation - (Items 6007 to 6015) 86
A.54.. Cancer Care Case Conference - (Items 871 and 872) 87
A.55.. Non-directive Pregnancy Support Counselling Service - (Item 4001) 87
A.56.. Telehealth Patient-end Support Services by Health Professionals 88
A.57.. Telehealth Specialist Services 90
A.58.. Australian Defence Force Post-discharge GP Health Assessment 91
O.1.. Benefits For Services By Participating Optometrists 92
O.2.. Participation By Optometrists 92
O.3.. Provider Numbers 93
O.4.. Patient Eligibility 94
Medicare Cards 94
Visitors to Australia and temporary residents 94
Reciprocal Health Care Agreements 94
O.5.. Benefits For Services By Participating Optometrists 95
O.6.. Schedule Fees and Medicare Benefits 96
O.7.. Billing Procedures 101
O.8.. Referrals (Read in Connection with the Relevant Paragraphs at O.6) 103
O.9.. Provision for Review of the Schedule 105
O.10.. Provision for Review of Practitioner Behaviour 105
O.11.. Visiting Optometrists Scheme (VOS) 106
O.12.. Telehealth Patient-end Support Services by Participating Optometrists 107
GROUP A1 - GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES 118
LEVEL A 118
LEVEL B 118
LEVEL C 119
LEVEL D 119
GROUP A2 - OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES 121
SUBGROUP 1 - OTHER MEDICAL PRACTITIONER ATTENDANCES 121
CONSULTATION AT CONSULTING ROOMS 121
CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS OR A RESIDENTIAL AGED CARE FACILITY 121
CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY 121

GROUP A3 - SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES 123
GROUP A4 - CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES 124
GROUP A3 - SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES 125
GROUP A4 - CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES 126
GROUP A29 - EARLY INTERVENTION SERVICES FOR CHILDREN WITH AUTISM, PERVASIVE DEVELOPMENTAL DISORDER OR DISABILITY 128
GROUP A28 - GERIATRIC MEDICINE 130
GROUP A5 - PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES 134
PROLONGED PROFESSIONAL ATTENDANCE 134
GROUP A6 - GROUP THERAPY 135
GROUP A7 - ACUPUNCTURE 136
LEVEL A 136
LEVEL B 136
LEVEL C 136
LEVEL D 137
GROUP A8 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES 138
GROUP A12 - CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES 145
GROUP A13 - PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES 146
PUBLIC HEALTH PHYSICIAN ATTENDANCES - AT CONSULTING ROOMS 146
PUBLIC HEALTH PHYSICIAN ATTENDANCES - OTHER THAN AT CONSULTING ROOMS 146
GROUP A21 - MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES 148
SUBGROUP 1 - CONSULTATIONS 148
SUBGROUP 2 - PROLONGED PROFESSIONAL ATTENDANCES TO WHICH NO OTHER GROUP APPLIES 149
GROUP A11 - URGENT ATTENDANCE AFTER HOURS 150
SUBGROUP 1 - URGENT ATTENDANCE - AFTER HOURS 150
SUBGROUP 2 - URGENT ATTENDANCE UNSOCIABLE AFTER HOURS 150
GROUP A14 - HEALTH ASSESSMENTS 151
HEALTH ASSESSMENTS 151
ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES HEALTH ASSESSMENT 152
GROUP A15 - GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS 153
SUBGROUP 1 - GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND MULTIDISCIPLINARY CARE PLANS 153
SUBGROUP 2 - CASE CONFERENCES 155
GROUP A17 - DOMICILIARY AND RESIDENTIAL MANAGEMENT REVIEWS 159
GROUP A30 - MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES 160
SUBGROUP 1 - TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS 160
SUBGROUP 2 - TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY 160
SUBGROUP 1 - TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS 161
SUBGROUP 2 - TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY 161
SUBGROUP 1 - TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS 162
SUBGROUP 2 - TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY 162
SUBGROUP 1 - TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS 163
SUBGROUP 2 - TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY 163
GROUP A18 - GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS 164
SUBGROUP 1 - TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED PERSON 164
LEVEL A 164
LEVEL B 164
LEVEL C 164
LEVEL D 165
SUBGROUP 2 - COMPLETION OF A CYCLE OF CARE FOR PATIENTS WITH ESTABLISHED DIABETES MELLITUS 166
LEVEL B 166
LEVEL C 166
LEVEL D 167
SUBGROUP 3 - COMPLETION OF THE ASTHMA CYCLE OF CARE 167
LEVEL B 167
LEVEL C 168
LEVEL D 168
GROUP A19 - OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES 169
SUBGROUP 1 - TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED PERSON 169
SUBGROUP 2 - COMPLETION OF AN ANNUAL CYCLE OF CARE FOR PATIENTS WITH ESTABLISHED DIABETES MELLITUS 170
SUBGROUP 3 - COMPLETION OF THE ASTHMA CYCLE OF CARE 171
GROUP A20 - GP MENTAL HEALTH TREATMENT 173
SUBGROUP 1 - GP MENTAL HEALTH TREATMENT PLANS 173
SUBGROUP 2 - FOCUSSED PSYCHOLOGICAL STRATEGIES 174
GROUP A24 - PAIN AND PALLIATIVE MEDICINE 175
SUBGROUP 1 - PAIN MEDICINE ATTENDANCES 175

SUBGROUP 2 - PAIN MEDICINE CASE CONFERENCES 176
SUBGROUP 3 - PALLIATIVE MEDICINE ATTENDANCES 178
SUBGROUP 4 - PALLIATIVE MEDICINE CASE CONFERENCES 179
GROUP A27 - PREGNANCY SUPPORT COUNSELLING 181
GROUP A22 - GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES 182
LEVEL A 182
LEVEL B 182
LEVEL C 183
LEVEL D 183
GROUP A23 - OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES 185
CONSULTATION AT CONSULTING ROOMS 185
CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS, HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY 185
CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY 186
GROUP A26 - NEUROSURGERY ATTENDANCES TO WHICH NO OTHER ITEM APPLIES 187
GROUP A9 - CONTACT LENSES - ATTENDANCES 189
GROUP A10 - OPTOMETRICAL SERVICES 191
INDEX 197
D.1.1. Electroencephalography (EEG), Prolonged Recording - (item 11003) 199
D.1.2. Electroencephalography (EEG), Ambulatory or Video - (Items 11004 and 11005) 200
D.1.3. Neuromuscular Diagnosis - (Item 11012) 200
D.1.4. Investigation of Central Nervous System Evoked Responses - (Items 11024 and 11027) 200
D.1.5. Electroretinography - (Items 11204, 11205, 11210 and 11211) 200
D.1.6. Computerised Perimetry Printed Results - (Items 11221 to 11225) 200
D.1.7. Computerised Perimetry - (Items 11222 and 11225) 200
D.1.8. Orbital Contents - (Items 11240, 11241, 11242 and 11243) 200
D.1.9. Brain Stem Evoked Response Audiometry - (Item 11300) 201
D.1.10. Electrocochleography - (Item 11304) 201
D.1.11. Non-determinate Audiometry - (Item 11306) 201
D.1.12. Audiology Services - (Items 11309 to 11321) 201
D.1.13. Oto-Acoustic Emission Audiometry - (Item 11332) 201
D.1.14. Respiratory Function Tests - (Item 11503) 201
D.1.15. Capsule Endoscopy - (Item 11820 and 11823) 202
D.1.16. Epicutaneous Patch Testing - (Items 12012, 12015 and 12018) 202
D.1.17. Administration of Thyrotropin Alfa-rch for the Detection of Recurrent Well-differentiated Thyroid Cancer - (Item 12201) 202
D.1.18. Investigations for Sleep Apnoea - (Items 12203, 12207, 12210, 12213, 12215, 12217 and 12250) 202
D.1.19. Bone Densitometry - (Items 12306 to 12323) 203
GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS 206
SUBGROUP 1 - NEUROLOGY 206
SUBGROUP 2 - OPHTHALMOLOGY 207
SUBGROUP 3 - OTOLARYNGOLOGY 208
SUBGROUP 4 - RESPIRATORY 209
SUBGROUP 5 - VASCULAR 210
SUBGROUP 6 - CARDIOVASCULAR 211
SUBGROUP 7 - GASTROENTEROLOGY & COLORECTAL 212
SUBGROUP 8 - GENITO/URINARY PHYSIOLOGICAL INVESTIGATIONS 213
SUBGROUP 9 - ALLERGY TESTING 214
SUBGROUP 10 - OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS 214
GROUP D2 - NUCLEAR MEDICINE (NON-IMAGING) 220
INDEX 221
T.1.1. Hyperbaric Oxygen Therapy - (Items 13015, 13020, 13025 and 13030) 224
T.1.2. Haemodialysis - (Items 13100 and 13103) 225
T.1.3. Consultant Physician Supervision of Home Dialysis - (Item 13104) 225
T.1.4. Assisted Reproductive Technology ART Services - (Items 13200 to 13221) 225
T.1.5. Intracytoplasmic Sperm Injection - (Item 13251) 226
T.1.6. Peripherally Inserted Central Catheters 226
T.1.7. Administration of Blood or Bone Marrow already Collected (Item 13706) 226
T.1.8. Collection of Blood - (Item 13709) 226
T.1.9. Intensive Care Units - (Items 13870 to 13888) 226
T.1.10. Procedures Associated with Intensive Care - (Items 13818, 13842, 13847, 13848 and 13857) 227
T.1.11. Management and Procedures in Intensive Care Unit - (Items 13870, 13873, 13876) 228
T.1.12. Cytotoxic Chemotherapy Administration - (Item 13915) 228
T.1.13. Implanted Pump or Reservoir/Drug Delivery Device - (Items 13939 and 13942) 228
T.1.14. PUVA or UVB Therapy - (Items 14050 and 14053) 228
T.1.15. Laser Photocoagulation - (Items 14106 to 14124) 228
T.1.17. Facial Injections of Poly-L-Lactic Acid - (Items 14201 and 14202) 229
T.1.18. Hormone and Living Tissue Implantation - (Items 14203 and 14206) 229
T.1.19. Implantable Drug Delivery System for the Treatment of Severe Chronic Spasticity - (Items 14227 to 14242) 229
T.1.20. Immunomodulating Agent - (Item 14245) 229
T.1.21. Therapeutic procedures may be provided by a specialist trainee (Items 13015 to 51318) 229
T.1.22. Telehealth Specialist Services 229

T.2.1. Radiation Oncology - General....231
T.2.2. Brachytherapy of the Prostate - (Item 15338)....231
T.2.3. Planning Services - (Items 15500 to 15562 and 15850)....232
T.2.4. Treatment Verification - (Items 15700 to 15705, 15710 and 15800)....232
T.3.1. Therapeutic Dose of Yttrium 90 - (Item 16003)....232
T.4.1. Antenatal Service Provided by a Nurse, Midwife or an Aboriginal and Torres Strait Islander health practitioner - (Item 16400)....233
T.4.2. Items for Initial and Subsequent Obstetric Attendances (Items 16401 and 16404)....234
T.4.3. Antenatal Care - (Item 16500)....234
T.4.4. External Cephalic Version for Breech Presentation - (Item 16501)....234
T.4.5. Labour and Delivery - (Items 16515, 16518, 16519 and 16525)....234
T.4.6. Caesarean Section - (Item 16520)....235
T.4.7. Complicated Confinement - (Item 16522)....235
T.4.8. Labour and Delivery Where Care is Transferred by a Participating Midwife - (Items 16527 to 16528)....235
T.4.9. Items for Planning and Management of a Pregnancy (Item 16590)....235
T.4.10. Post-Partum Care - (Items 16564 to 16573)....235
T.4.11. Interventional Techniques - (Items 16600 to 16636)....236
T.4.12. Telehealth Specialist Services....236
T.6.1. Pre-anaesthesia Consultations by an Anaesthetist - (Items 17610 to 17625)....238
T.6.2. Referred Anaesthesia Consultations - (Items 17640 to 17655)....239
T.6.3. Anaesthetist Consultations - Other - (Items 17680, 17690)....240
T.6.4. Telehealth Specialist Services....240
T.7.1. Regional or Field Nerve Blocks - General....242
T.7.2. Maintenance of Regional or Field Nerve Block - (Items 18222 and 18225)....242
T.7.3. Intrathecal or Epidural Injection - (Item 18232)....242
T.7.4. Intrathecal or Epidural Infusion - (Items 18226 and 18227)....242
T.7.5. Regional or Field Nerve Blocks - (Items 18234 to 18298)....242
T.8.1. Surgical Operations....243
T.8.2. Multiple Operation Rule....243
T.8.3. Procedure Performed with Local Infiltration or Digital Block....244
T.8.4. Aftercare (Post-operative Treatment)....244
T.8.5. Abandoned surgery - (Item 30001)....246
T.8.6. Repair of Wound - (Items 30023 to 30049)....246
T.8.7. Biopsy for Diagnostic Purposes - (Items 30071 to 30096)....246
T.8.8. Lipectomy - (Items 30165 to 30177)....246
T.8.9. Treatment of Keratoses, Warts etc (Items 30185, 30186, 30187, 30189, 30192 and 36815)....247
T.8.10. Cryotherapy and Serial Curettage Excision - (Items 30196 to 30203)....247
T.8.11. Telangiectases or Starburst Vessels - (Items 30213 and 30214)....247
T.8.12. Sentinel Node Biopsy for Breast Cancer - (Items 30299 to 30303)....248
T.8.13. Dissection of Axillary Lymph Nodes - (Items 30335 and 30336)....248
T.8.14. Laparotomy and Other Procedures on the Abdominal Viscera - (Items 30375 and 30622)....248
T.8.15. Diagnostic Laparoscopy - (Items 30390 and 30627)....248
T.8.16. Major Abdominal Incision - (Item 30396)....248
T.8.17. Gastrointestinal Endoscopic Procedures - (Items 30473 to 30481, 30484 to 30487, 30490 to 30494, 30680 to 32023, 32084 to 32095, 32103, 32104 and 32106)....248
T.8.18. Gastrectomy, Sub-total Radical - (Item 30523)....249
T.8.19. Anti reflux Operations - (Items 30527 to 30533, 31464 and 31466)....249
T.8.20. Radiofrequency ablation of mucosal metaplasia for the treatment of Barrett's Oesophagus (Item 30687)....249
T.8.21. Endoscopic or Endobronchial Ultrasound +/- Fine Needle Aspiration - (Items 30688 - 30710)....249
T.8.22. Removal of Skin Lesions - (Items 30611, 31200 to 31355)....249
T.8.23. Removal of Skin Lesion From Face - (Items 31235 to 31245, 31265 to 31278, 31310 to 31320)....250
T.8.24. Dissection of Lymph Nodes of Neck - (Items 30618, 31423 to 31438)....250
T.8.25. Excision of Breast Lesions, Abnormalities or Tumours - Malignant or Benign - (Items 31500 to 31515)....251
T.8.27. Fine Needle Aspiration of Breast Lesion - (Item 31533)....251
T.8.28. Diagnostic Biopsy of Breast using Advanced Breast Biopsy Instrumentation - (Items 31539 and 31545)....251
T.8.29. Preoperative Localisation of Breast Lesion Prior to the Use of Advanced Breast Biopsy Instrumentation - (Item 31542)....251
T.8.30. Bariatric Procedures - (Items 31569 to 31581, anaesthesia item 20791)....251
T.8.31. Reversal of a Bariatric Procedure - (Item 31584)....251
T.8.32. Per Anal Excision of Rectal Tumour using Rectoscopy - (Items 32103, 32104 and 32106)....252
T.8.33. Varicose veins - (Items 32500 to 32517)....252
T.8.34. Endovenous Laser Therapy (Items 32520 and 32522) and Radiofrequency Ablation (Items 32523 and 32526)....252
T.8.35. Uterine Artery Embolisation - (Item 35410)....252
T.8.36. Endovascular Coiling of Intracranial Aneurysms - (Item 35412)....253
T.8.37. Arterial and Venous Patches - (Items 33545 to 33551and 34815)....253
T.8.38. Carotid Disease - (Item 32700, 32703, 32760, 33500, 33545, 33548, 33551, 33554, 35303, 35307)....253
T.8.39. Peripheral Arterial or Venous Catheterisation - (Item 35317)....253
T.8.40. Peripheral Arterial or Venous Embolisation - (Item 35321)....253
T.8.41. Selective Internal Radiation Therapy (SIRT) using SIR-Spheres - (Items 35404, 35406 and 35408)....253
T.8.42. Percutaneous Transluminal Coronary Angioplasty - (Items 38309, 38312, 38315 and 38318)....253
T.8.43. Colposcopic Examination - (Item 35614)....253
T.8.44. Hysteroscopy - (Item 35626)....254
T.8.45. Curettage of Uterus under GA or Major Nerve Block - (Items 35639 and 35640)....254

T.8.46. Neoplastic Changes of the Cervix - (Items 35644-35648) 254
T.8.47. Sterilisation of Minors - Legal Requirements - (Items 35657, 35687, 35688, 35691, 37622 and 37623) 254
T.8.48. Debulking of Uterus - (Item 35658) 254
T.8.49. Nephrectomy - (Items 36526 and 36527) 254
T.8.50. Sacral Nerve Stimulation - (Items 36658, 36660, and 36662) 254
T.8.51. Sacral Nerve Stimulation (items 36663-36668) 254
T.8.52. Ureteroscopy - (Item 36803) 254
T.8.53. Selective Coronary Angiography - (Items 38215 to 38246) 255
T.8.54. Transurethral Needle Ablation (TUNA) of the Prostate - (Items 37201 and 37202) 255
T.8.55. Gold Fiducial Markers into the Prostate - (item 37217) 255
T.8.56. Brachytherapy of the Prostate - (Item 37220) 255
T.8.57. High Dose Rate Brachytherapy - (Item 37227) 255
T.8.58. Radical or Debulking Operation for Ovarian Tumour - (Item 35720) 256
T.8.59. Transcutaneous Sperm Retrieval - (Item 37605) 256
T.8.60. Surgical Sperm Retrieval, by Open Approach - (Item 37606) 256
T.8.61. Cardiac Pacemaker Insertion - (Items 38209, 38212, 38350, 38353 and 38356) 256
T.8.62. Implantable ECG Loop Recorder - (Item 38285) 256
T.8.63. Transluminal Insertion of Stent or Stents - (Item 38306) 256
T.8.64. Permanent Cardiac Synchronisation Device (Items 38365, 38368 and 38654) 256
T.8.65. Intravascular Extraction of Permanent Pacing Leads - (Item 38358) 257
T.8.66. Cardiac Resynchronisation Therapy - (Item 38371) 257
T.8.67. Implantable Cardioverter Defibrillator - (Items 38384 and 38387) 257
T.8.68. Cardiac and Thoracic Surgical Items - (Items 38470 to 38766) 257
T.8.69. Coronary Artery Bypass - (Items 38497 to 38504) 257
T.8.70. Re-operation via Median Sternotomy - (Item 38640) 257
T.8.71. Skull Base Surgery - (Items 39640 to 39662) 257
T.8.72. Intradiscal Injection of Chymopapain - (Item 40336) 257
T.8.73. Removal of Ventilating Tube from Ear - (Item 41500) 258
T.8.74. Meatoplasty - (Item 41515) 258
T.8.75. Reconstruction of Auditory Canal - (Item 41524) 258
T.8.76. Removal of Nasal Polyp or Polypi - (Items 41662, 41665 and 41668) 258
T.8.77. Larynx, Direct Examination - (Item 41846) 258
T.8.78. Microlaryngoscopy - (Item 41858) 258
T.8.79. Imbedded Foreign Body - (Item 42644) 258
T.8.80. Corneal Incisions - (Item 42672) 258
T.8.81. Cataract surgery (Items 42698 and 42701) 258
T.8.82. Posterior Juxtascleral Depot injection - (Item 42741) 258
T.8.83. Cyclodestructive Procedures - (Items 42770) 258
T.8.84. Insertion of drainage device for glaucoma (Item 42752) 259
T.8.85. Laser Trabeculoplasty - (Items 42782 and 42783) 259
T.8.86. Laser Iridotomy - (Items 42785 and 42786) 259
T.8.87. Laser Capsulotomy - (Items 42788 and 42789) 259
T.8.88. Laser Vitreolysis or Corticolysis of Lens Material or Fibrinolysis - (Items 42791 and 42792) 260
T.8.89. Division of Suture by Laser - (Item 42794) 260
T.8.91. Ophthalmic Sutures - (Item 42845) 260
T.8.92. Full face Chemical Peel - (Items 45019 and 45020) 260
T.8.93. Abrasive Therapy/Resurfacing - (Items 45021 to 45026) 260
T.8.94. Escharotomy - (Item 45054) 260
T.8.95. Local Skin Flap - Definition 261
T.8.96. Free Grafting to Burns - (Items 45406 to 45418) 261
T.8.97. Revision of Scar - (Items 45506 to 45518) 261
T.8.98. Augmentation Mammaplasty - (Items 45524, 45527 and 45528) 261
T.8.99. Breast Reconstruction, Myocutaneous Flap - (Item 45530) 262
T.8.100. Breast Prosthesis, Removal and Replacement of - (Items 45552 to 45555) 262
T.8.101. Breast Ptosis - (Items 45556 to 45559) 262
T.8.102. Nipple and/or Areola Reconstruction - (Items 45545 and 45546) 262
T.8.103. Liposuction - (Items 45584, 45585 and 45586) 263
T.8.104. Meloplasty for Correction of Facial Asymmetry - (Items 45587 and 45588) 263
T.8.105. Reduction of Eyelids - (Items 45617 and 45620) 263
T.8.106. Rhinoplasty - (Items 45638, 45639) 263
T.8.107. Contour Restoration - (Item 45647) 264
T.8.108. Vermilionectomy - (Item 45669) 264
T.8.109. Osteotomy of Jaw - (Items 45720 to 45752) 264
T.8.110. Genioplasty - (Item 45761) 264
T.8.111. Tumour, Cyst, Ulcer or Scar - (Items 45801 to 45813) 264
T.8.112. Fracture of Mandible or Maxilla - (Items 45975 to 45996) 264
T.8.113. Reduction of Dislocation or Fracture 264
T.8.114. Removal of Multiple Exostoses (Items 47933 and 47936) 264
T.8.115. Lumbar Discectomy - (Item 48636) 265
T.8.116. Discectomy in Relation to Anterior Interbody Spinal Fusion - (Items 48660 to 48675) 265
T.8.117. Internal Fixation - (Items 48678 to 48690) 265

T.8.118. Wrist Surgery - (Items 49200 to 49227)....265
T.8.119. Diagnostic Arthroscopy and Arthroscopic Surgery of the Knee (Items 49557 and 49563)....265
T.8.120. Paediatric Patients - (Items 50450 to 50658)....265
T.8.121. Treatment of Fractures in Paediatric Patients - (Items 50500 to 50588)....265
T.8.122. Non-resectable Hepatocellular Carcinoma Destruction of by Open or Laparoscopic Radiofrequency Ablation - (Item 50952)....265
T.8.123. Paracentesis of anterior chamber or vitreous cavity and/or intravitreal injection - (Items 42738 to 42740)....265
T.8.124. Bone Graft (Items 48200-48242 and 48642-48651)....266
T.8.125. Vulvoplasty and Labioplasty - (Items 35533 and 35534)....266
T.9.1. Assistance at Operations - (Items 51300 to 51318)....266
T.9.2. Benefits Payable under Item 51300....267
T.9.3. Benefits Payable Under Item 51303....267
T.9.4. Benefits Payable Under Item 51309....267
T.9.5. Assistance at Cataract and Intraocular Lens Surgery - (Item 51318)....267
T.10.1. Relative Value Guide For Anaesthetics - (Group T10)....267
T.10.2. Eligible Services....268
T.10.3. RVG Unit Values....268
T.10.4. Deriving the Schedule Fee under the RVG....271
T.10.5. Minimum Requirements for Claiming Benefits under Items in the RVG (including sedation)....271
T.10.6. Account Requirements....272
T.10.7. General Information....272
T.10.8. Additional Services Performed in Connection with Anaesthesia - Subgroup 19....273
T.10.9. Assistance in the Administration of Anaesthesia....273
T.10.10. Perfusion Services - (Items 22055 to 22075)....274
T.10.11. Anaesthesia as a Therapeutic Procedure - (Item 21965)....274
T.10.12. Discontinued Procedure - (Item 21990)....274
T.10.13. Anaesthesia in Connection with a Procedure not Identified as Attracting a Medicare Benefit for Anaesthesia - (Item 21997)....275
T.10.14. Anaesthesia in Connection with a Dental Service - (Items 22900 and 22905)....275
T.10.15. Anaesthesia in Connection with Cleft Lip and Cleft Palate Repair - (Items 20102 and 20172)....275
T.10.16. Anaesthesia in Connection with an Oral and MaxillofaciaI Service - (Category 4 of the Medicare Benefits Schedule)....275
T.10.17. Intra-operative Blocks for Post Operative Pain - (Items 22031 to 22050)....275
T.10.18. Anaesthesia in Connection with Extensive Surgery on Facial Bones - (Item 20192)....275
T.10.19. Intrathecal or Epidural Injection for Control of Post-operative Pain - Initial - (Item 22031)....275
T.10.20. Intrathecal or Epidural Injection for Control of Post-operative Pain - Subsequent - (Item 22036)....275
T.10.21. Regional or Field Nerve Blocks for Post-operative Pain - (Items 22040 - 22050)....276
T.10.22. Anaesthesia for Radical Procedures on the Chest Wall - (Item 20474)....276
T.10.23. Anaesthesia for Extensive Spine or Spinal Cord Procedures - (Item 20670)....276
T.10.24. Anaesthesia for Femoral Artery Embolectomy - (Item 21274)....276
T.10.25. Anaesthesia for Cardiac Catheterisation - (Item 21941)....276
T.10.26. Anaesthesia for 2 Dimensional Real Time Transoesophageal Echocardiography - (Item 21936)....276
T.10.27. Anaesthesia for Services on the Upper and Lower Abdomen - (Subgroups 6 and7)....276
T.10.28. Anaesthesia for Microvascular Free Tissue Flap Surgery - (Items 20230, 20355, 20475, 20704, 20804, 20905, 21155, 21275, 21455, 21535, 21685, 21785 and 21865)....276
T.10.29. Anaesthesia for Endoscopic Ureteric Surgery - Including Laser Procedure - (Item 20911)....276
T.11.1. Botulinum Toxin - (Items 18350 to 18379)....276
GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES....279
SUBGROUP 1 - HYPERBARIC OXYGEN THERAPY....279
SUBGROUP 2 - DIALYSIS....279
SUBGROUP 3 - ASSISTED REPRODUCTIVE SERVICES....280
SUBGROUP 4 - PAEDIATRIC & NEONATAL....281
SUBGROUP 5 - CARDIOVASCULAR....282
SUBGROUP 6 - GASTROENTEROLOGY....282
SUBGROUP 8 - HAEMATOLOGY....282
SUBGROUP 9 - PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT....283
SUBGROUP 10 - MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT....283
SUBGROUP 11 - CHEMOTHERAPEUTIC PROCEDURES....284
SUBGROUP 12 - DERMATOLOGY....285
SUBGROUP 13 - OTHER THERAPEUTIC PROCEDURES....286
GROUP T2 - RADIATION ONCOLOGY....288
SUBGROUP 1 - SUPERFICIAL....288
SUBGROUP 2 - ORTHOVOLTAGE....288
SUBGROUP 3 - MEGAVOLTAGE....288
SUBGROUP 4 - BRACHYTHERAPY....290
SUBGROUP 5 - COMPUTERISED PLANNING....292
SUBGROUP 6 - STEREOTACTIC RADIOSURGERY....294
SUBGROUP 7 - RADIATION ONCOLOGY TREATMENT VERIFICATION....294
SUBGROUP 8 - BRACHYTHERAPY PLANNING AND VERIFICATION....294
SUBGROUP 10 - TARGETTED INTRAOPERATIVE RADIOTHERAPY....295
INTRAOPERATIVE RADIOTHERAPY....295
GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE....296
GROUP T4 - OBSTETRICS....297
GROUP T6 - ANAESTHETICS....302

SUBGROUP 1 - ANAESTHESIA CONSULTATIONS....302
GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS....304
GROUP T11 - BOTULINUM TOXIN INJECTIONS....307
GROUP T10 - RELATIVE VALUE GUIDE FOR ANAESTHESIA - Medicare Benefits are only payable for anaesthesia performed in association with an eligible service....310
SUBGROUP 1 - HEAD....310
SUBGROUP 2 - NECK....311
SUBGROUP 3 - THORAX....312
SUBGROUP 4 - INTRATHORACIC....313
SUBGROUP 5 - SPINE AND SPINAL CORD....313
SUBGROUP 6 - UPPER ABDOMEN....314
SUBGROUP 7 - LOWER ABDOMEN....315
SUBGROUP 8 - PERINEUM....317
SUBGROUP 9 - PELVIS (EXCEPT HIP)....318
SUBGROUP 10 - UPPER LEG (EXCEPT KNEE)....319
SUBGROUP 11 - KNEE AND POPLITEAL AREA....320
SUBGROUP 12 - LOWER LEG (BELOW KNEE)....321
SUBGROUP 13 - SHOULDER AND AXILLA....322
SUBGROUP 14 - UPPER ARM AND ELBOW....323
SUBGROUP 15 - FOREARM WRIST AND HAND....324
SUBGROUP 16 - ANAESTHESIA FOR BURNS....325
SUBGROUP 17 - ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES....325
SUBGROUP 18 - MISCELLANEOUS....327
SUBGROUP 19 - THERAPEUTIC AND DIAGNOSTIC SERVICES....327
SUBGROUP 20 - ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE....329
SUBGROUP 21 - ANAESTHESIA/PERFUSION TIME UNITS....329
SUBGROUP 22 - ANAESTHESIA/PERFUSION MODIFYING UNITS - PHYSICAL STATUS....336
SUBGROUP 23 - ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER....337
SUBGROUP 24 - ANAESTHESIA AFTER HOURS EMERGENCY MODIFIER....337
SUBGROUP 25 - PERFUSION AFTER HOURS EMERGENCY MODIFIER....337
SUBGROUP 26 - ASSISTANCE AT ANAESTHESIA....337
GROUP T8 - SURGICAL OPERATIONS....339
SUBGROUP 1 - GENERAL....339
BARIATRIC....368
SUBGROUP 2 - COLORECTAL....369
SUBGROUP 3 - VASCULAR....376
VARICOSE VEINS....376
BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE....377
BYPASS, REPLACEMENT, LIGATION OF ANEURYSMS....378
ENDARTERECTOMY AND ARTERIAL PATCH....380
EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA....381
LIGATION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS....382
OPERATIONS FOR VASCULAR ACCESS....384
COMPLEX VENOUS OPERATIONS....385
SYMPATHECTOMY....385
DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE....386
MISCELLANEOUS VASCULAR PROCEDURES....386
ENDOVASCULAR INTERVENTIONAL PROCEDURES....386
INTERVENTIONAL RADIOLOGY PROCEDURES....388
SUBGROUP 4 - GYNAECOLOGICAL....388
SUBGROUP 5 - UROLOGICAL....395
GENERAL....395
OPERATIONS ON BLADDER....399
OPERATIONS ON PROSTATE....402
OPERATIONS ON URETHRA, PENIS OR SCROTUM....403
OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES....406
PAEDIATRIC GENITURINARY SURGERY....406
SUBGROUP 6 - CARDIO-THORACIC....408
CARDIOLOGY PROCEDURES....408
CATHETER BASED ARRHYTHMIA ABLATION....410
ENDOVASCULAR INTERVENTIONAL PROCEDURES....411
MISCELLANEOUS CARDIAC PROCEDURES....411
THORACIC SURGERY....413
CARDIAC SURGERY PROCEDURES....414
VALVULAR PROCEDURES....415
SURGERY FOR ISCHAEMIC HEART DISEASE....415
ARRHYTHMIA SURGERY....416
PROCEDURES ON THORACIC AORTA....417
TECHNIQUES FOR PRESERVATION OF ARRESTED HEART....417
CIRCULATORY SUPPORT PROCEDURES....418
RE-OPERATION....418

MISCELLANEOUS CARDIOTHORACIC SURGICAL PROCEDURES 419
CARDIAC TUMOURS 419
CONGENITAL CARDIAC SURGERY 420
MISCELLANEOUS PROCEDURES ON THE CHEST 421
SUBGROUP 7 - NEUROSURGICAL 421
GENERAL 421
PAIN RELIEF 422
PERIPHERAL NERVES 423
CRANIAL NERVES 424
CRANIO-CEREBRAL INJURIES 424
SKULL BASE SURGERY 424
INTRA-CRANIAL NEOPLASMS 425
CEREBROVASCULAR DISEASE 426
INFECTION 426
CEREBROSPINAL FLUID CIRCULATION DISORDERS 426
CONGENITAL DISORDERS 426
SPINAL DISORDERS 427
SKULL RECONSTRUCTION 428
EPILEPSY 428
STEREOTACTIC PROCEDURES 428
MISCELLANEOUS 430
SUBGROUP 8 - EAR, NOSE AND THROAT 430
SUBGROUP 9 - OPHTHALMOLOGY 437
SUBGROUP 10 - OPERATIONS FOR OSTEOMYELITIS 445
ACUTE 445
CHRONIC 446
SUBGROUP 11 - PAEDIATRIC 446
SURGERY IN NEONATE OR YOUNG CHILD 446
THORACIC SURGERY 448
ABDOMINAL SURGERY 448
MISCELLANEOUS SURGERY 450
SUBGROUP 12 - AMPUTATIONS 450
SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY 451
GENERAL 451
SKIN FLAP SURGERY 452
FREE GRAFTS 453
OTHER GRAFTS AND MISCELLANEOUS PROCEDURES 456
ORAL AND MAXILLOFACIAL SURGERY 465
SUBGROUP 14 - HAND SURGERY 468
SUBGROUP 15 - ORTHOPAEDIC 473
TREATMENT OF DISLOCATIONS 473
TREATMENT OF FRACTURES 474
GENERAL 482
BONE GRAFTS 484
OSTEOTOMY AND OSTEECTOMY 485
EPIPHYSEODESIS 485
SPINE 485
SHOULDER 488
ELBOW 489
WRIST 490
HIP 491
KNEE 492
ANKLE 494
FOOT 494
OTHER JOINTS 496
MALIGNANT DISEASE 496
LIMB LENGTHENING AND DEFORMITY CORRECTION 497
SINGLE EVEN MULTILEVEL SURGERY FOR CHILDREN WITH CEREBRAL PALSY 500
TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS 502
SPINE SURGERY FOR SCOLIOSIS AND KYPHOSIS IN PAEDIATRIC PATIENTS 504
TREATMENT OF HIP DYSPLASIA OR DISLOCATION IN PAEDIATRIC PATIENTS 505
SUBGROUP 16 - RADIOFREQUENCY ABLATION 505
GROUP T9 - ASSISTANCE AT OPERATIONS 506
INDEX 507
OM.1.1. Benefits for Medical Services Performed by Approved Dental Practitioners 541
OM.1.2. Changes to the Scheme Effective from 1 November 2004 542
OM.2.1. Definition of Oral and Maxillofacial Surgery 542
OM.2.2. Services That Can Be Provided 542
OM.3.1. Principles of Interpretation 542
OM.3.2. Multiple Operation Rule 542
OM.3.3. After Care (Post-operative Treatment) 543

OM.3.4. Administration of Anaesthetics by Medical Practitioners 543
OM.4.1. Consultations - (Items 51700 and 51703) 543
OM.4.2. Assistance at Operations - (Items 51800 and 51803) 543
OM.4.3. Repair of Wound - (Item 51900) 544
OM.4.4. Lipectomy, Wedge Excision - Two or More Excisions - (Item 51906) 544
OM.4.5. Upper Aerodigestive Tract Endoscopic Procedure - (Item 52035) 544
OM.4.6. Tumour, cyst, Ulcer or Scar - (Items 52036 to 52054) 545
OM.4.7. Aspiration of Haematoma - (Item 52056) 545
OM.4.8. Osteotomy of Jaw - (Items 52342 to 52375) 545
OM.4.9. Genioplasty - (Item 52378) 545
OM.4.10. Fracture of Mandible or Maxilla - (Items 53400 to 53439) 545
OM.4.11. Skin Sensitivity Testing - (Item 53600) 545
OM.4.12. Destruction of Nerve Branch by Neurolytic Agent - (Item 53706) 545
GROUP O1 - CONSULTATIONS 547
GROUP O2 - ASSISTANCE AT OPERATION 548
GROUP O3 - GENERAL SURGERY 549
GROUP O4 - PLASTIC & RECONSTRUCTIVE 554
GROUP O5 - PREPROSTHETIC 557
GROUP O6 - NEUROSURGICAL 558
GROUP O7 - EAR, NOSE & THROAT 559
GROUP O8 - TEMPOROMANDIBULAR JOINT 561
GROUP O9 - TREATMENT OF FRACTURES 563
GROUP O10 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS 565
GROUP O11 - REGIONAL OR FIELD NERVE BLOCKS 566
INDEX 567
DIA... Diagnostic Imaging Services - Overview 573
DIB... What Is A Diagnostic Imaging Service 575
DIC... Who May Provide A Diagnostic Imaging Service 575
DID... Requests For Diagnostic Imaging Services 576
DIE... Registration of Site Undertaking Diagnostic Imaging Procedures 580
DIF... Details Required on Accounts, Receipts and Medicare Assignment of Benefit Forms 583
DIG... Maintaining Records of Diagnostic Imaging Services 583
DIH... Contravention of State and Territory Laws and Disqualified Practitioners 584
DII... Prohibited Practices 584
DIJ... Multiple Services Rules 585
DIK... Group I1 - Ultrasound 587
DIL... Group I2 - Computed Tomography (CT) 590
DIM... Group I3 - Diagnostic Radiology 592
DIN... Group I4 - Nuclear Medicine Imaging 595
General 595
DIO... Group I5 - Magnetic Resonance Imaging 596
DIP... Management of bulk-billed services 599
DIQ... Bulk Billing Incentive 599
DIR... Capital Sensitivity Measure for Diagnostic Imaging Equipment 599
DIS... Restriction on item 55054 600
GROUP I1 - ULTRASOUND 602
SUBGROUP 1 - GENERAL 602
SUBGROUP 2 - CARDIAC 607
SUBGROUP 3 - VASCULAR 609
SUBGROUP 4 - UROLOGICAL 612
SUBGROUP 5 - OBSTETRIC AND GYNAECOLOGICAL 614
SUBGROUP 6 - MUSCULOSKELETAL 634
GROUP I2 - COMPUTED TOMOGRAPHY 641
GROUP I3 - DIAGNOSTIC RADIOLOGY 650
SUBGROUP 1 - RADIOGRAPHIC EXAMINATION OF EXTREMITIES 650
SUBGROUP 2 - RADIOGRAPHIC EXAMINATION OF SHOULDER OR PELVIS 651
SUBGROUP 3 - RADIOGRAPHIC EXAMINATION OF HEAD 651
SUBGROUP 4 - RADIOGRAPHIC EXAMINATION OF SPINE 654
SUBGROUP 5 - BONE AGE STUDY AND SKELETAL SURVEYS 655
SUBGROUP 6 - RADIOGRAPHIC EXAMINATION OF THORACIC REGION 656
SUBGROUP 7 - RADIOGRAPHIC EXAMINATION OF URINARY TRACT 657
SUBGROUP 8 - RADIOGRAPHIC EXAMINATION OF ALIMENTARY TRACT AND BILIARY SYSTEM 657
SUBGROUP 9 - RADIOGRAPHIC EXAMINATION FOR LOCALISATION OF FOREIGN BODIES 659
SUBGROUP 10 - RADIOGRAPHIC EXAMINATION OF BREASTS 659
SUBGROUP 11 - RADIOGRAPHIC EXAMINATION IN CONNECTION WITH PREGNANCY 660
SUBGROUP 12 - RADIOGRAPHIC EXAMINATION WITH OPAQUE OR CONTRAST MEDIA 661
SUBGROUP 13 - ANGIOGRAPHY 662
SUBGROUP 14 - TOMOGRAPHY 667
SUBGROUP 15 - FLUOROSCOPIC EXAMINATION 667
SUBGROUP 16 - PREPARATION FOR RADIOLOGICAL PROCEDURE 667
SUBGROUP 17 - INTERVENTIONAL TECHNIQUES 668

GROUP I4 - NUCLEAR MEDICINE IMAGING 669
GROUP I5 - MAGNETIC RESONANCE IMAGING 680
SUBGROUP 1 - SCAN OF HEAD - FOR SPECIFIED CONDITIONS 680
SUBGROUP 2 - SCAN OF HEAD - FOR SPECIFIED CONDITIONS 680
SUBGROUP 3 - SCAN OF HEAD AND NECK VESSELS - FOR SPECIFIED CONDITIONS 682
SUBGROUP 4 - SCAN OF HEAD AND CERVICAL SPINE - FOR SPECIFIED CONDITIONS 682
SUBGROUP 3 - SCAN OF HEAD AND NECK VESSELS - FOR SPECIFIED CONDITIONS 683
SUBGROUP 5 - SCAN OF HEAD AND CERVICAL SPINE - FOR SPECIFIED CONDITIONS 683
SUBGROUP 6 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS 683
SUBGROUP 7 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS 684
SUBGROUP 8 - SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS 685
SUBGROUP 9 - SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS 686
SUBGROUP 10 - SCAN OF CERVICAL SPINE AND BRACHIAL PLEXUS - FOR SPECIFIED CONDITIONS 687
SUBGROUP 11 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS 688
SUBGROUP 12 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS 688
SUBGROUP 13 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS 689
SUBGROUP 14 - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS 690
SUBGROUP 15 - MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS 690
SUBGROUP 16 - MAGNETIC RESONANCE ANGIOGRAPHY - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS 691
SUBGROUP 17 - MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS 691
SUBGROUP 18 - MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS 691
SUBGROUP 19 - SCAN OF BODY - FOR SPECIFIED CONDITIONS 692
SUBGROUP 20 - SCAN OF PELVIS AND UPPER ABDOMEN - FOR SPECIFIED CONDITIONS 694
SUBGROUP 21 - SCAN OF BODY - FOR SPECIFIED CONDITIONS 695
SUBGROUP 20 - SCAN OF PELVIS AND UPPER ABDOMEN - FOR SPECIFIED CONDITIONS 695
SUBGROUP 21 - SCAN OF BODY - FOR SPECIFIED CONDITIONS 695
SUBGROUP 22 - MODIFYING ITEMS 695
SUBGROUP 32 - MAGNETIC RESONANCE IMAGING - PIP BREAST IMPLANT 696
SUBGROUP 33 - MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16YRS 696
SUBGROUP 34 - MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS 698
SUBGROUP 20 - SCAN OF PELVIS AND UPPER ABDOMEN - FOR SPECIFIED CONDITIONS 699
GROUP I6 - MANAGEMENT OF BULK-BILLED SERVICES 700
INDEX 701
P.1.1. Pathology Services in Relation to Medicare Benefits - Outline of Arrangements 709
P.1.2. Exemptions to Basic Requirements 709
P.1.3. Circumstances Where Medicare Benefits Not Attracted 710
P.2.1. Responsibilities of Treating/Requesting Practitioners 710
P.2.2. Responsibilities of Approved Pathology Practioners 711
P.2.3. Pathology Tests not Covered by Request 715
P.3.1. Details Required on Accounts, Receipts or Assignment Forms 715
P.3.2. Approved Pathology Practitioners 715
P.3.3. Prescribed Pathology Services 716
P.4.1. Inbuilt Multiple Services Rule 716
P.4.2. Exemptions 716
P.5.1. Episode Cone 716
P.5.2. Exemptions 716
P.6.1. Bulk Billing Incentives for Episodes Consisting of a P10 Service 716
P.6.2. Patient Episode Initiation Fees (PEIs) 717
P.6.3. Patient Episode Initiation Fees for Certain Tissue Pathology and Cytology Items 717
P.6.4. Hospital, Government etc Laboratories 717
P.7.1. Assignment of Medicare Benefits - Patient Assignment 717
P.7.2. Approved Pathology Practitioner Eligibility 718
P.8.1. Accredited Pathology Laboratories - Need for Accreditation 718
P.8.2. Applying for Accreditation 718
P.8.3. Effective Period of Accreditation 718
P.8.4. Assessment of Applications for Accreditation 718
P.8.5. Refusal of Accreditation and Right of Review 718
P.8.6. National Pathology Accreditation Advisory Council (NPAAC) 718
P.8.7. Change of Address/Location 718
P.8.8. Change of Ownership of a Laboratory 719
P.8.9. Approved Collection Centres (ACC) 719
P.9.1. Approved Pathology Practitioners 719
P.9.2. Applying for Acceptance of the Approved Pathology Practitioner Undertaking 719
P.9.3. Undertakings 719

P.9.4. Obligations and Responsibilities of Approved Pathology Practitioners 720
P.10.1. Approved Pathology Authorities 720
P.10.2. Applying for Acceptance of an Approved Pathology Authority Undertaking 720
P.10.3. Undertakings 721
P.10.4. Obligations and Responsibilities of Approved Pathology Authorities 721
P.11.1. Breaches of Undertakings 721
P.11.2. Decisions by Minister 722
P.11.3. Appeals 722
P.12.1. Initiation of Excessive Pathology Services 722
P.12.2. Classes of Persons 722
P.12.3. Decisions by Minister for Health and Ageing 722
P.12.4. Appeals 722
P.13.1. Personal Supervision 722
P.13.2. Extract from Undertaking 722
P.13.3. Notes on the Above 723
P.14.1. Changes to the Pathology Services Table 723
P.15.1. Explanatory Notes - Definitions 724
P.15.2. Group of Practitioners 724
P.15.3. Initiate 724
P.15.4. Patient Episode 724
P.15.5. Episode Cone 724
P.15.6. Personal Supervision 725
P.15.7. Prescribed Pathology Service 725
P.15.8. Proprietor of a Laboratory 725
P.15.9. Specialist Pathologist 725
P.15.10. Designated Pathology Service 725
P.16.1. Interpretation of The Schedule - Items Referring to 'The Detection Of' 725
P.16.2. Blood Grouping - (Item 65096) 725
P.16.3. Glycosylated Haemoglobin - (Item 66551) 725
P.16.4. Iron Studies - (Item 66596) 726
P.16.5. Faecal Occult Blood - (Items 66764 to 66770) 726
P.16.6. Antibiotics/Antimicrobial Chemotherapeutic Agents 726
P.16.7. Human Immunodeficiency Virus (HIV) Diagnostic Tests - (Iincluded in Items 69384, 69387, 69390, 69393, 69396, 69405, 69408, 69411, 69413 and 69415) 726
P.16.8. Hepatitis - (Item 69481) 726
P.16.9. Eosinophil Cationic Protein - (Item 71095) 726
P.16.10. Tissue Pathology and Cytology - (Items 72813 to 73061) 726
P.16.11. Cervical and Vaginal Cytology - (Items 73053 to 73057) 726
P.16.12. Fragile X (A) Tests - (Items 73300 and 73305) and RET Genetic Tests - (Items 73339 and 73340) 727
P.16.13. Additional Bulk Billing Payment for Pathology Services - (Item 74990 and 74991) 727
P.16.14. Transfer of Existing Items from Group P1 (Haematology) to Group P7 Genetics Effective 1 May 2006. 727
P.16.15. RAS gene mutation status (Item 73338) 727
P.17.1. Abbreviations, Groups of Tests 727
P.17.2. Tests not Listed 728
P.17.3. Audit of Claims 728
P.17.4. Groups of Tests 728
P.18.1. Complexity Levels for Histopathology Items 729
P.19.1. Pathology Services Table 729
Precedence of items 730
Thyroid function testing 733
Antineutrophil Cytoplasmic Antibody 737
GROUP P1 - HAEMATOLOGY 741
GROUP P2 - CHEMICAL 745
GROUP P3 - MICROBIOLOGY 755
GROUP P4 - IMMUNOLOGY 761
GROUP P5 - TISSUE PATHOLOGY 766
GROUP P6 - CYTOLOGY 769
GROUP P7 - GENETICS 771
GROUP P8 - INFERTILITY AND PREGNANCY TESTS 775
GROUP P9 - SIMPLE BASIC PATHOLOGY TESTS 776
GROUP P10 - PATIENT EPISODE INITIATION 777
GROUP P11 - SPECIMEN REFERRED 779
GROUP P12 - MANAGEMENT OF BULK-BILLED SERVICES 780
GROUP P13 - BULK-BILLING INCENTIVE 781
INDEX 782
COMPLEXITY LEVELS FOR HISTOPATHOLOGY ITEMS 790
C.1.1. Introduction - Medicare Benefits 796
C.2.1. Dental Practitioner Eligibility 797
C.3.1. Patient Eligibility 797
C.3.2. Application for approval for repairs to previous reconstructive work 798
C.3.3. Visitors to Australia 799

C.3.4. Health Care Expenses Incurred Overseas 799
C.4.1. Schedule Fees and Medicare Benefits 800
C.4.2. Where Medicare Benefits are not Payable 800
C.4.3. Limiting Rule 800
C.5.1. Penalties 800
C.6.1. Billing of the Patient 801
C.6.2. Claiming of Benefits 801
C.7.1. Interpretation of the Cleft Lip and Cleft Palate Scheme 803
C.7.2. Multiple Operation Rule 803
C.7.3. Administration of Anaesthetics 804
C.7.4. Definitions 804
C.7.5. Referral of Oral and Maxillofacial Surgical Services - (Items 75150 to 75621) 804
C.7.6. General and Prosthodontic Services - (Item 75800) 804
C.7.7. Over-servicing 804
C.8.1. Cleft Lip and Cleft Palate Clinics 804
C.8.2. Commonwealth Department of Health and Ageing Addresses 806
C.8.3. The Department of Human Services Medicare Addresses 807
GROUP C1 - ORTHODONTIC SERVICES 809
GROUP C2 - ORAL AND MAXILLOFACIAL SERVICES 811
GROUP C3 - GENERAL AND PROSTHODONTIC SERVICES 813
M.1.1. Additional Bulk Billing Payment for General Medical Services - (Items 10990 and 10991) 816
M.1.2. After-hours services provided in areas eligible for the higher bulk billing payment - (Item 10992) 817
M.3.1. Individual Allied Health Services (Items 10950 to 10970) for Chronic Disease Management - Eligible Patients 818
M.3.2. Individual Allied Health Services (Items 10950 to 10970) for Chronic Disease Management - Referral Requirements 819
M.3.3. Individual Allied Health Services - (Items 10950 to 10970) for Chronic Disease Management - Eligible Providers and Services 819
M.3.4. Individual Allied Health Services - (Items 10950 to 10970) for Chronic Disease Management - Professional Eligibility 820
M.3.5. Individual Allied Health Services (10950 to 10970) for Chronic Disease Management - Further Information 822
M.6.1. Provision of Psychological Therapy Services by Clinical Psychologists - (Items 80000 TO 80020) 822
M.6.2. Psychological Therapy Services Attracting Medicare Rebates 822
Service length and type 823
M.6.3. Referral Requirements (GPs, Psychiatrists or Paediatricians to Clinical Psychologists for Psychological Therapy) 824
M.6.4. Clinical Psychologist Professional Eligibility 825
M.7.1. Provision of Focussed Psychological Strategies Services by Allied Health Providers - (Items 80100 to 80170) 826
M.8.1. Pregnancy Support Counselling - Eligible Patients - (Items 81000 to 81010) 830
M.8.2. Pregnancy Support Counselling - Eligible Services - (Items 81000 to 81010) 831
M.8.3. Pregnancy Support Counselling - Referral Requirements - (Items 81000 to 81010) 831
M.8.4. Pregnancy Support Counselling - Allied Health Professional Eligibility -(Items 81000 to 81010) 832
M.9.1. Group Allied Health Services (Items 81100 to 81125) for People with Type 2 Diabetes - Eligible Patients - 832
M.9.2. Group Allied Health Services (Items 81100 to 81125) for People with Type 2 Diabetes - GP Referral Requirements 833
M.9.3. Group Allied Health Services (Items 81100 to 81125) for People with Type 2 Diabetes - Eligible Allied Health Professionals 833
M.9.4. Assessment for Group Allied Health Services (Items 81100, 81110 and 81120) for People with Type 2 Diabetes 833
M.9.5. Group Allied Health Services (Items 81105, 81115 and 81125) for People with Type 2 Diabetes - Service Requirements and Referral Forms 834
M.9.6. Group Allied Health Services (Items 81100 to 81125) for People with Type 2 Diabetes - Additional Requirements 835
Retention of Referral Form for the Department of Human Services Audit Purposes 835
M.9.7. Group Allied Health Services (Items 81100 to 81125) for People with Type 2 Diabetes - Further Information 835
M.10.1. Provision of Autism, Pervasive Developmental Disorder or Disability Services by Allied Health Professionals - (Items 82000 to 82035) 835
M.11.1. Follow-up Allied Health Services for people of Aboriginal or Torres Strait Islander descent (Items 81300 to 81360) 838
M.12.1. Immunisation services provided by an Aboriginal and Torres Strait Islander health practitioner - (Item 10988) 842
M.12.2. Wound management services provided by an Aboriginal and Torres Strait Islander health practitioner (item 10989) 843
M.12.3. Healthy Kids check provided by a Practice Nurse or an Aboriginal and Torres Strait Islander health practitioner (Item 10986) 843
M.12.4. Follow up service provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner, on behalf of a Medical Practitioner, for an Indigenous person who has received a health assessment (Item 10987) 844
M.12.5. Provision of monitoring and support for a person with a chronic disease by a practice nurse or Aboriginal and Torres Strait Islander health practitioner (item 10997) 846
M.12.6. Telehealth Support Services by Health Professionals 847
M.13.1. Maternity Services by Participating Midwives - Overview 849
M.13.2. Participating Midwives 849
M.13.3. Eligible Midwives 849
M.13.4. Midwife Professional Indemnity Insurance 849
M.13.5. Collaborative Arrangements 849
M.13.6. Provider Numbers 851
M.13.7. Schedule Fees and Medicare Benefits 852
M.13.8. Safety Nets 852
M.13.9. Safety Net Capping for Midwifery Items 852
M.13.10. Where Medicare Benefits are not payable 852
M.13.11. Billing of Patient 853
M.13.12. Assignment of Benefits (Direct-Billing) Arrangements 853
M.13.13. Assignment of Benefit Forms 854
M.13.14. Time Limits Applicable to Lodgement of Claims for Assigned Benefits 854

M.13.15. Overview of the Maternity Items 854
M.13.16. Maternity Services Attracting Medicare Rebates 854
M.13.17. Conditions Governing the Provision and Claiming of Items 855
Service length and type 855
M.13.18. Referral Requirements 855
M.13.19. Requesting Requirements 856
M.14.1. Participating Nurse Practitioners Services - Overview 857
M.14.2. Eligible Nurse Practitioners 858
M.14.3. Provider Numbers 858
M.14.4. Participating Nurse Practitioners 858
M.14.5. Collaborative Arrangements 858
M.14.6. Schedule Fees and Medicare Benefits 859
M.14.7. Where Medicare Benefits are not payable 859
M.14.8. Billing of the Patient 859
M.14.9. Assignment of Benefits (Direct-Billing Arrangements 860
M.14.10. Assignment of Benefit Forms 860
M.14.11. Time Limits applicable to lodgement of claims for assigned benefits 860
M.14.12. Overview of the Nurse Practitioner items 860
M.14.13. Nurse Practitioner services attracting Medicare rebates 861
M.14.14. Conditions governing the provision and claiming of items 861
M.14.15. Referral requirements 861
M.14.16. Requesting requirements 861
M.15.1. Brain Stem Evoked Response Audiometry - (Item 82300) 862
M.15.2. Non-Determinate Audiometry - (Item 82306) 862
M.15.3. Conditions for Audiology Services - (Items 82309 to 82318) 862
M.15.4. Oto-Acoustic Emission Audiometry - (Item 82332) 863
M.15.5. Provision of Diagnostic Audiology Services by Audiologists - (Items 82300 to 82332) 863
GROUP M3 - ALLIED HEALTH SERVICES 866
GROUP M12 - SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER 873
SUBGROUP 1 - TELEHEALTH SUPPORT SERVICE ON BEHALF OF A MEDICAL PRACTITIONER 873
SUBGROUP 2 - TELEHEALTH SUPPORT SERVICE ON BEHALF OF A MEDICAL PRACTITIONER AT A RESIDENTIAL AGED CARE FACILITY 873
SUBGROUP 3 - SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER 873
GROUP M1 - MANAGEMENT OF BULK-BILLED SERVICES 874
GROUP M12 - SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER 876
SUBGROUP 3 - SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER 876
GROUP M6 - PSYCHOLOGICAL THERAPY SERVICES 877
GROUP M7 - FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH) 878
GROUP M8 - PREGNANCY SUPPORT COUNSELLING 881
GROUP M9 - ALLIED HEALTH GROUP SERVICES 882
GROUP M11 - ALLIED HEALTH SERVICES FOR INDIGENOUS AUSTRALIANS WHO HAVE HAD A HEALTH CHECK 885
GROUP M10 - AUTISM, PERVASIVE DEVELOPMENTAL DISORDER AND DISABILITY SERVICES 890
GROUP M13 - MIDWIFERY SERVICES 894
SUBGROUP 1 - MBS ITEMS FOR PARTICIPATING MIDWIVES 894
SUBGROUP 2 - TELEHEALTH ATTENDANCES 895
GROUP M14 - NURSE PRACTITIONERS 897
SUBGROUP 1 - NURSE PRACTITIONERS 897
SUBGROUP 2 - TELEHEALTH ATTENDANCE 898
SUBGROUP 3 - TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY 899
GROUP M15 - DIAGNOSTIC AUDIOLOGY SERVICES 901
INDEX 904

SUMMARY OF CHANGES FROM 1/1/2016

The 1/1/2016 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

New items

73342

G.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.

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

Higher rates of benefits are also provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons).

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.

G.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.

G.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.

G.2.1. 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.

G.2.2. 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.

G.2.3. 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.

G.2.4. 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.

G.2.5. 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 Human Services at Email: askmbs@humanservices.gov.au

or by phone on 132 150

G.3.1. 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.

G.3.2. 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"

G.3.3. 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.

G.3.4. 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.

G.4.1. 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:

Program Relations Officer, RACGP
Tel: (03) 8699 0494 Email at: qacpd@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.

G.5.1. 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.

G.5.2. 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.

G.6.1. 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.

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 his or her 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 <u>not</u> 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 18 months 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.

G.7.1. 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 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 on the one occasion and claims multiple Medicare items, the practitioner can choose to bulk bill some or all of those services. Where some but not all of the services are bulk billed a fee may be privately charged for the other service (or services) in excess of the Medicare rebate provided that that fee is only in relation to that service (or services).

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 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).

G.8.1. 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

G.8.2. 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).

G.8.3. 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'.

G.8.4. 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.

G.8.5. 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 6811.

G.8.6. 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.

G.8.7. MEDICARE CLAIMS REVIEW PANEL

There are MBS items which make the payment of Medicare benefits dependent on a 'demonstrated' clinical need. Services requiring prior approval are those covered by items 11222, 11225, 12207, 12215, 12217, 21965, 21997, 30214, 35534, 32501, 42783, 42786, 42789, 42792, 45019, 45020, 45051, 45528, 45557, 45558, 45559, 45585, 45586, 45588, 45639.

Claims for benefits for these services should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for approval should be addressed to:
The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

G.9.1. 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.

G.10.1. 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.

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

Schedule fees are usually adjusted on an annual basis except for Pathology, Diagnostic Imaging and certain other items.

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 '*' directly after an item number where used; or a description of the professional service, preceded by the word '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 $79.50 (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.

G.10.2. 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 2015 is $440.80. 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 2015, the threshold for singles and families that hold Commonwealth concession card, families that received Family Tax Benefit Part (A) (FTB(A)) and families that qualify for notional FTB(A) is $638.40. The threshold for all other singles and families in 2015 is $2,000.

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 is calcualted as $25 x 80% = $20. As this is less than the EMSN benefit cap, the full $20 is paid.

G.11.1. 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.

G.11.2. 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)**".

G.12.1. 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 H*ealth Insurance Regulations 1975* specify that the following medical services will attract benefits only if they have been personally performed by a medical practitioner on not more than one patient on the one occasion (i.e. two or more patients cannot be attended simultaneously, although patients may be seen consecutively), unless a group session is involved (i.e. Items 170-172). The requirement of "personal performance" is met whether or not assistance is provided, according to accepted medical standards:-

(a) All Category 1 (Professional Attendances) items (except 170-172, 342-346);
(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11212, 11304, 11500, 11600, 11627, 11701, 11712, 11724, 11921, 12000, 12003;
(c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13709, 13750-13760, 13915-13948, 14050, 14053, 14218, 14221 and 14224);
(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 – 12323 when the service is performed by a specialist or consultant physician in the practice of his or her specialty where the patient is referred by another medical practitioner.

G.12.2. SERVICES RENDERED ON BEHALF OF MEDICAL PRACTITIONERS

Medical services in Categories 2 and 3 not included in G.12.1 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. the Department of Human Services must be satisfied with the employment and supervision arrangements. While the supervising medical practitioner need not be present for the entire service, they must have a direct involvement in at least part of the service. Although the supervision requirements will vary according to the service in question, they will, as a general rule, be satisfied where the medical practitioner has:-

(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.

G.12.3. MASS IMMUNISATION

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

The location of the service, or advertising of it, or the number of patients presenting together for it, normally do not indicate a mass immunisation.

G.13.1. 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, or in connection with, an injection of blood or ablood product that is autologous.

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

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 Papanicolaou 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 on screening for the Prevention of Cervical Cancer (endorsed by the Royal Australian College of General Practitioners, the Royal Australian College of Obstetricians and Gynaecologists, the Royal College of Pathologists of Australasia, the Australian Cancer Society and the National Health and Medical Research Council) is as follows:

(a) an examination interval of two years for a person who has no symptoms or history suggestive of abnormal cervical cytology, commencing between the ages of 18 to 20 years, or one or two years after first sexual intercourse, whichever is later;
(b) cessation of cervical smears at 70 years for a person who has had two normal results within the last five years. A person over 70 who has never been examined, or who request a cervical smear, should be examined.

Note 1: As separate items exist for routine examination of cervical smears, treating practitioners are asked to clearly identify on the request form to the pathologist, if the smear has been taken as a routine examination or for the management of a previously detected abnormality (see paragraph PP.11 of Pathology Services Explanatory Notes in Category 6).

Note 2: See items 2501 to 2509, and 2600 to 2616 in Group A18 and A19 of Category 1 - Professional Attendances and 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.

G.14.1. 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.

G.14.2. 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.

G.14.3. 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.

G.14.4. 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.

G.14.5. 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.

G.15.1. 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.

PROFESSIONAL ATTENDANCES

CATEGORY 1

SUMMARY OF CHANGES FROM 1/1/2016

The 1/1/2016 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

There are no changes to this Category for 1 January 2016.

A.1.. PERSONAL ATTENDANCE BY PRACTITIONER

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

A.2.. PROFESSIONAL ATTENDANCES

Professional attendances by medical practitioners cover consultations during which the practitioner: evaluates the patient's health-related issue or issues, using certain health screening services if applicable; formulates a management plan in relation to one or more health-related issues for the patient; provides advice to the patient and/or relatives (if authorised by the patient); provides appropriate preventive health care; and records the clinical detail of the service(s) provided to the patient. (See the General Explanatory Notes for more information on health screening services.)

A.3.. SERVICES NOT ATTRACTING MEDICARE BENEFITS

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

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

A.4.. MULTIPLE ATTENDANCES ON THE SAME DAY

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

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

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

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

A.5.. ATTENDANCES BY GENERAL PRACTITIONERS (ITEMS 3 TO 51, 193, 195, 197, 199, 597, 599, 2497-2559 AND 5000-5067)

Items 3 to 51 and 193, 195, 197, 199, 597, 599, 2497-2559 and 5000-5067 relate specifically to attendances rendered by medical practitioners who are either:

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

Only general practitioners are eligible to itemise the *Group A1, items 597and 599 of Group A11 and Group A22* content-based items. (See the General Explanatory Notes for further details of eligibility and registration.)

To assist general practitioners in selecting the appropriate item number for Medicare benefit purposes the following notes in respect of the various levels are given.

LEVEL A
A Level A item will be used for obvious and straightforward cases and this should be reflected in the practitioner's records. In this context, the practitioner should undertake the necessary examination of the affected part if required, and note the action taken.

LEVEL B
A Level B item will be used for a consultation lasting less than 20 minutes for cases that are not obvious or straightforward in relation to one or more health related issues. The medical practitioner may undertake all or some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

LEVEL C
A Level C item will be used for a consultation lasting at least 20 minutes for cases in relation to one or more health related issues. The medical practitioner may undertake all or some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

LEVEL D
A Level D item will be used for a consultation lasting at least 40 minutes for cases in relation to one or more health related issues. The medical practitioner may undertake all or some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

Creating and Updating a Personally Controlled Electronic Health Record (PCEHR)
The time spent by a medical practitioner on the following activities may be counted towards the total consultation time:

- Reviewing a patient's clinical history, in the patient's file and/or the PCEHR, and preparing or updating a Shared Health Summary where it involves the exercise of clinical judgement about what aspects of the clinical history are relevant to inform ongoing management of the patient's care by other providers; or
- Preparing an Event Summary for the episode of care.

Preparing or updating a Shared Health Summary and preparing an Event Summary are clinically relevant activities. When either of these activities are undertaken with any form of patient history taking and/or the other clinically relevant activities that can form part of a consultation, the item that can be billed is the one with the time period that matches the total consultation time.

MBS rebates are not available for creating or updating a Shared Health Summary as a stand alone service.

Counselling or Advice to Patients or Relatives
For items 23 to 51 and 5020 to 5067 'implementation of a management plan' includes counselling services.

Items 3 to 51 and 5000 to 5067 include advice to patients and/or relatives during the course of an attendance. The advising of relatives at a later time does not extend the time of attendance.

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

Other Services at the Time of Attendance
Where, during the course of a single attendance by a general practitioner, both a consultation and another medical service are rendered, Medicare benefits are generally payable for both the consultation and the other service. Exceptions are in respect of medical services which form part of the normal consultative process, or services which include a component for the associated consultation (see the General Explanatory Notes for further information on the interpretation of the Schedule).

The Department of Human Services (DHS) has developed an Health Practitioner Guideline for responding to a request to substantiate that a patient attended a service which is located on the DHS website.

A.6.. PROFESSIONAL ATTENDANCES AT AN INSTITUTION (ITEMS 4, 24, 37, 47, 58, 59, 60, 65, 5003, 5023, 5043, 5063, 5220, 5223, 5227 AND 5228)

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

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

A.7.. ATTENDANCES AT A HOSPITAL (ITEMS 4, 24, 37, 47, 58, 59, 60, 65)

These items refer to attendances on patients admitted to a hospital. Where medical practitioners have made arrangements with a local hospital to routinely use out-patient facilities to see their private patients, items for services provided in consulting rooms would apply.

A.8.. RESIDENTIAL AGED CARE FACILITY ATTENDANCES (ITEMS 20, 35, 43, 51, 92, 93, 95, 96, 5010, 5028, 5049, 5067, 5260, 5263, 5265, 5267)

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

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

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

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

A.9.. ATTENDANCES AT HOSPITALS, RESIDENTIAL AGED CARE FACILITY AND INSTITUTIONS AND HOME VISITS

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

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

A.10.. AFTER-HOURS ATTENDANCES (ITEMS 597, 598, 599, 600, 5000, 5003, 5010, 5020, 5023, 5028, 5040, 5043, 5049, 5060, 5063, 5067, 5220, 5223, 5228, 5260, 5263 AND 5265)

After-Hours Attendances (items 597, 598, 599, 600, 5000, 5003, 5010, 5020, 5023, 5028, 5040, 5043, 5049, 5060, 5063, 5067, 5220, 5223, 5228, 5260, 5263 and 5265)

Guidelines for the After Hours Other Medical Practitioners (AHOMPs) Programme are available on the Department of Health's website.

GuidelinesAfter hours attendance items may be claimed as follows:
Items 597, 598, 599, 600 apply only to a professional attendance that is provided:
on a public holiday;
on a Sunday;
before 8am, or after 12 noon on a Saturday;
before 8am, or after 6pm on any day other than a Saturday, Sunday or public holiday.

Items 5000, 5020, 5040, 5060, 5200, 5203, 5207 and 5208 apply only to a professional attendance that is provided:
on a public holiday;

on a Sunday;
before 8am, or after 1 pm on a Saturday;
before 8am, or after 8pm on any day other than a Saturday, Sunday or public holiday.

Items 5003, 5010, 5023, 5028, 5043, 5049, 5063, 5067, 5220, 5223, 5227, 5228, 5260, 5263, 5265 and 5267 apply to a professional attendance that is provided:

on a public holiday;
on a Sunday;
before 8am, or after 12 noon on a Saturday;
before 8am, or after 6pm on any day other than a Saturday, Sunday or public holiday.

Urgent After Hours Attendances (Items 597- 600)
Items 597, 598, 599 and 600 can be used for urgent services provided in consulting rooms, or at a place other than consulting rooms, in an after hours period.

Urgent After Hours Attendances (Items 597 and 598) allow for urgent attendances (other than an attendance between 11pm and 7am) in an after hours period.

Urgent After Hours Attendances during Unsociable Hours (Items 599 and 600) allow for urgent attendances between 11pm and 7am in an after hours period.

The attendance for all these items must be requested by the patient or a responsible person in, or not more than 2 hours before the start of the same unbroken urgent after hours period. The patient's condition must require urgent medical treatment and if the attendance is undertaken at consulting rooms, it is necessary for the practitioner to return to, and specially open the consulting rooms for the attendance.

If more than one patient is seen on the one occasion, the standard after-hours attendance items should be used in respect of the second and subsequent patients attended on the same occasion.

Medical practitioners who routinely provide services to patients in the after-hours periods at consulting rooms, or who provide the services (as a contractor, employee, member or otherwise) for a general practice or clinic that routinely provides services to patients in after-hours periods at consulting rooms will not be able to bill urgent after hours items 597, 598, 599 and 600.

A routine service means a regular or habitual provision of services to patients. This does not include ad hoc services provided after-hours in consulting rooms by a medical practitioner (excluding consultant physicians and specialists) working in a general practice or a clinic while participating in an on-call roster

Non-Urgent After Hours Attendances (5000 – 5063 and 5220 - 5267)
Non-Urgent After Hours Attendances in Consulting Rooms (Items 5000, 5020, 5040, 5060, 5200, 5203, 5207 and 5208) are to be used for non-urgent consultations at consulting rooms initiated either on a public holiday, on a Sunday, or before 8am and after 1pm on a Saturday, or before 8am and after 8pm on any other day.

Non-Urgent After Hours Attendances at a Place Other than Consulting Rooms (Other than a Hospital or Residential Aged Care Facility) (items 5003, 5023, 5043, 5063, 5220, 5223, 5227 and 5228) and Non-Urgent After Hours Attendances in a Residential Aged Care Facility (Items 5010, 5028, 5049, 5067, 5260, 5263, 5265 and 5267) are to be used for non-urgent attendances on 1 or more patients on 1 occasion on a public holiday, on a Sunday, or before 8am and after 12 noon on a Saturday, or before 8am and after 6pm on any other day.

Attendance Period	**Applicable Time**			**Items**
	Monday to Friday*	**Saturday***	**Sunday and/or public holiday**	
Urgent after-hours attendance	Between 7am - 8am and 6pm - 11pm	Between 7am - 8am and 12 noon - 11pm	Between 7am - 11pm	597, 598
Urgent after-hours in unsociable hours	Between 11pm - 7am	Between 11pm - 7am	Between 11pm - 7am	599, 600
Non-urgent After hours In consulting rooms	Before 8am or after 8pm	Before 8am or after 1pm	24 hours	5000, 5020 5040, 5060 5200, 5203, 5207, 5208

Non-urgent After hours at a place other than consulting rooms	Before 8am or after 6pm	Before 8am or after 12 noon	24 hours	5003, 5010, 5023, 5028 5043, 5049, 5063, 5067 5220 - 5267

with the exception of public holidays which fall on a Saturday

A.11.. MINOR ATTENDANCE BY A CONSULTANT PHYSICIAN (ITEMS 119, 131)

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

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

A.12.. REFERRED PATIENT CONSULTANT PHYSICIAN TREATMENT AND MANAGEMENT PLAN (ITEMS 132 AND 133)

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

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

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

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

Preparation of the consultant physician treatment and management plan should be in consultation with the patient. If appropriate, a written copy of the consultant physician treatment and management plan should be provided to the patient. A written copy of the consultant physician treatment and management plan should be provided to the referring medical practitioner, usually within two weeks of the consultant physician consultation. In more serious cases, more prompt provision of the plan and verbal communication with the referring medical practitioner may be appropriate. A guide to the content of such consultant physician treatment and management plans which are to be provided under this item is included within this Schedule.
(Note: This information is provided as a guide only and each case should be addressed according to a patient's individual needs.)

REFERRED PATIENT CONSULTANT PHYSICIAN TREATMENT AND MANAGEMENT PLAN

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

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

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

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

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

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

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

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

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

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

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.

A.13.. REFERRED PATIENT ASSESSMENT, DIAGNOSIS AND TREATMENT AND MANAGEMENT PLAN FOR AUTISM OR ANY OTHER PERVASIVE DEVELOPMENTAL DISORDER (ITEMS 135 AND 289)

These items are for consultant paediatricians (item 135) or psychiatrists (item 289), on referral from a medical practitioner, to provide early diagnosis and treatment of autism or any other pervasive development disorder (PDD) for children aged under 13 years. The items are for assessment, diagnosis and the creation of a treatment and management plan, and are claimable only once per patient per lifetime.

When item 135 or item 289 is in place, a consultant paediatrician or psychiatrist can refer a child with autism or other PDD to eligible allied health professionals for treatment services.

A child can access either the allied health services for autism/other PDD (using item 135 or 289) or for disability (using item 137 or 139), but not both.

If a child sees a consultant paediatrician or psychiatrist other than the one who put the treatment and management plan in place, the consultant paediatrician or psychiatrist who is seen subsequently can refer the child for any remaining allied health treatment services that are available to the child.

Children with an existing treatment and management plan created under item 135 or 289 can be reviewed under attendance items for consultant psychiatrists and paediatricians.

Where the patient presents with another morbidity in addition to autism or other PDD, item 132 can also be used for development of a treatment and management plan. However, the use of this item will not provide access to Medicare rebateable allied health services for treatment of autism or any other PDD.

Items 135 or 289 also provide a referral pathway for access to services provided through Childhood Autism Advisors by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). For further information

on assistance available through FaHCSIA, phone 1800 778 581 or email ASD.Support@fahcsia.gov.au. TTY users - phone 1800 555 677 then ask for the 1800 toll-free number you wish to contact.

Referral requirements
Items 135 (paediatrician) or 289 (psychiatrist) are for diagnosis and treatment of autism or any other PDD where clinically appropriate, including referral to allied health treatment services.

A course of treatment for the allied health treatment services consists of the number of allied health services stated on the child's referral, up to a maximum of 10 services. This enables the referring practitioner to consider a report from the allied health professional(s) about the services provided to the child, and the need for further treatment.

Within the maximum service allocation of twenty treatment services, the allied health professional(s) can provide one or more courses of treatment. Patients will require a separate referral for each allied health professional they are referred to and they will also need new referrals for each new course of treatment.

In addition to referrals to allied health treatment services, a consultant paediatrician or psychiatrist can refer a child to an eligible allied health provider to assist with diagnosis of the child or for the purpose of contributing to the child's pervasive developmental disorder (PDD). Referrals for these allied health assessment services can be made by a consultant paediatrician or psychiatrist as an outcome of the service provided under one of items 110-131 or 296-370 inclusive.

Referrals are only valid when prerequisite MBS services have been provided. If the referring service has not yet been claimed, the Department of Human Services (DHS) will not be aware of the child's eligibility and Medicare benefits cannot be paid. Providers can call DHS on 132 150 to confirm whether a relevant MBS service has been claimed and/or the number of allied health services already claimed by the child.

Referring medical practitioners are not required to use a specific form to refer patients for the allied health services that are available through the *Helping Children with Autism* program. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring practitioner.

Allied health assistance with diagnosis/assessment and treatment

Helping Children with Autism Program – Allied Health Items

MBS items for allied health assessment and treatment of autism/PDD	***Allied health provider***
*Assistance with diagnosis / contribution to a treatment plan**	
82000	Psychologist
82005	Speech pathologist
82010	Occupational therapist
82030	Audiologist, optometrist, orthoptist, physiotherapist
*Treatment services***	
82015	Psychologist
82020	Speech pathologist
82025	Occupational therapist
82035	Audiologist, optometrist, orthoptist, physiotherapist

* Prerequisite MBS items: 110-131 (paediatrician) or items 296-370 (psychiatrist).
** Prerequisite MBS items: 135 (paediatrician) or 289 (psychiatrist).

Assessment services
Assessment services are available for an allied health provider to assist the referring practitioner with diagnosis or for contributing to a child's treatment and management plan. These services can be accessed by children aged under 13 years.

Medicare rebates are available for up to four allied health services in total per eligible child.

An allied health professional can provide these services when:

- the child has previously been provided with any MBS service covering items 110-131 inclusive by a consultant paediatrician; or
- the child has previously been provided with any MBS service covering items 296-370 (excluding item 359) inclusive by a consultant psychiatrist.

The four allied health assessment services may consist of any combination of items 82000, 82005, 82010 and 82030.

It is the responsibility of the referring practitioner to allocate these services in keeping with the child's individual treatment needs and to refer the child to appropriate allied health professional(s) accordingly.

Treatment services
Treatment services can be accessed when a child with autism or other PDD is aged under 15 years and has had a treatment and management plan put in place for them before their 13th birthday.

Medicare rebates are available for up to twenty allied health treatment services in total per eligible child.

An eligible allied health professional can provide these services when:

- the child has previously been provided with a treatment plan (item 135) by a consultant paediatrician; or
- the child has previously been provided with a treatment plan (item 289) by a consultant psychiatrist.

The twenty treatment services may consist of any combination of items 82015, 82020, 82025 or 82035.

It is the responsibility of the referring practitioner to allocate these services in keeping with the child's individual treatment needs and to refer the child to appropriate allied health professional(s) accordingly.

Existing patients or patients with an existing diagnosis
Where a specific plan has not been created previously for the treatment and management of autism or any other PDD, a new plan can be developed by the treating practitioner under item 135 or 289 where it is clinically appropriate to treat the patient under such a plan.

Children with an existing treatment and management plan created under item 135 or 289 can be reviewed under attendance items for consultant psychiatrists and paediatricians.

A.14.. PATIENT ASSESSMENT, DIAGNOSIS AND TREATMENT AND MANAGEMENT PLAN FOR A CHILD WITH DISABILITY (ITEMS 137 AND 139)

Items 137 and 139 are for specialists and consultant physicians (137) or for general practitioners (139) to provide early diagnosis and treatment of children with any of the following conditions:

(a) sight impairment that results in vision of less than or equal to 6/18 vision or equivalent field loss in the better eye, with correction.
(b) hearing impairment that results in:
(i) a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or
(ii) permanent conductive hearing loss and auditory neuropathy.
(c) deafblindness
(d) cerebral palsy
(e) Down syndrome
(f) Fragile X syndrome
(g) Prader-Willi syndrome
(h) Williams syndrome
(i) Angelman syndrome
(j) Kabuki syndrome
(k) Smith-Magenis syndrome
(l) CHARGE syndrome
(m) Cri du Chat syndrome
(n) Cornelia de Lange syndrome
(o) microcephaly if a child has:
  (i) a head circumference less than the third percentile for age and sex; and
  (ii) a functional level at or below 2 standard deviations below the mean for age on a standard developmental test, or an IQ score of less than 70 on a standardised test of intelligence.
(p) Rett's disorder

"Standard developmental test" refers to the Bayley Scales of Infant Development or the Griffiths Mental Development Scales; "standardised test of intelligence" refers to the Wechsler Intelligence Scale for Children (WISC) or the Wechsler Preschool and Primary Scale of Intelligence (WPPSI). It is up to the clinical judgement of the diagnosing practitioner if other tests are appropriate to be used.

Items 137 and 139 are for assessment, diagnosis and the creation of a treatment and management plan, and are claimable only once per patient per lifetime.

A.15.. GERIATRICIAN REFERRED PATIENT ASSESSMENT AND MANAGEMENT PLAN (ITEMS 141-147)

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

Referral for Items 141-147 should be through the general practitioner for the comprehensive assessment and management of frail older patients, older than 65, with complex, often interacting medical, physical and psychosocial problems who are at significant risk of poor health outcomes. In the event that a specialist of another discipline wishes to refer a patient for this item, the referral should take place through the GP.

A comprehensive assessment of an older person should as a minimum cover:

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

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

Some of the information collection component of the assessment may be rendered by a nurse or other assistant in accordance with accepted medical practice, acting under the supervision of the geriatrician. The remaining components of the assessment and development of the management plan must include a personal attendance by the geriatrician.

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

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

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

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

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

A.16.. PROLONGED ATTENDANCE IN TREATMENT OF A CRITICAL CONDITION (ITEMS 160 164)

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

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

(ii) if the personal attendance is not continuous, the occasion on which the service is provided is taken to be the total time of the attendance; and

(iii) if personal attendance on a single patient is provided by 1 or more medical practitioners concurrently, each practitioner may claim an attendance fee.

A.17.. FAMILY GROUP THERAPY (ITEMS 170, 171, 172)

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

A.18.. ACUPUNCTURE (ITEM 173, 193, 195, 197 AND 199)

The service of "acupuncture" must be performed by a medical practitioner and itemised under item 173, 193, 195, 197 or 199 to attract benefits. These items cover not only the performance of the acupuncture but include any consultation on the same occasion and any other attendance on the same day for the condition for which acupuncture was given.

Items 193, 195, 197 and 199 may only be performed by a general practitioner, (see Note 4 of 'Medicare Benefit Arrangements' for a definition) if the Medicare Australia CEO has received a written notice from the Royal Australian College of General Practitioners (RACGP) stating that the person meets the skills requirements for providing services to which the items apply.

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

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

For more information on the content-based item structure used in this Group, see A.5 in the explanatory notes.

A.19.. CONSULTANT PSYCHIATRIST - INITIAL CONSULTATIONS FOR NEW PATIENTS (ITEMS 296 TO 299 AND 361) REFERRED PATIENT ASSESSMENT AND MANAGEMENT PLAN (ITEMS 291, 293 AND 359) AND REFERRAL TO ALLIED MENTAL HEALTH PROFESSIONALS

Referral for items 291, 293 and 359 should be through the general practitioner or participating nurse practitioner for the management of patients with mental illness. In the event that a specialist of another discipline wishes to refer a patient for this item the referral should take place through the GP or participating nurse practitioner.

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

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

Preparation of the management plan should be in consultation with the patient. If appropriate, a written copy of the management plan should be provided to the patient. A written copy of the management plan should be provided to the general practitioner within a maximum of two weeks of the assessment. It should be noted that two weeks is the outer limit and in more serious cases more prompt provision of the plan and verbal communication with the GP or participating nurse practitioner may be appropriate. A guide to the content of the report which should be provided to the GP or participating nurse practitioner under this item is included within this Schedule.

It is expected that item 291 will be a single attendance. However, there may be particular circumstances where a patient has been referred by a GP or participating nurse practitioner for an assessment and management plan, but it is not possible for the consultant psychiatrist to determine in the initial consultation whether the patient is suitable for management under such a plan. In these cases, where clinically appropriate, items 296, 297, 299 or 361 (for a new patient) or 300-308 (for continuing patients) may be used, and item 291 may be used subsequently, in those circumstances where the consultant psychiatrist undertakes a consultation (in accordance with the item requirements) prior to the consultation for providing the referring practitioner with an assessment and management plan. It is not intended that items 296, 297, 299, 361 or 300-308 will generally or routinely be used in conjunction with, or prior to, item 291.

Items 293 and 359 are available in instances where the GP or participating nurse practitioner initiates a review of the plan provided under item 291, usually where the current plan is not achieving the anticipated outcome. It is expected that when a plan is reviewed, any modifications necessary will be made.

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

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

REFERRED PATIENT ASSESSMENT AND MANAGEMENT PLAN

Preliminary

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

History and Examination

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

Diagnosis

A diagnosis should be made either using ICD 10 or DSM IV classification. In some cases the diagnosis may differ from that stated by the GP or participating nurse practitioner, and an explanation of why the diagnosis differs should be included.

Psychiatric formulation

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

Management plan

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

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

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

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

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

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

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

Initial Consultation for a NEW PATIENT (item 296 in rooms, item 297 at hospital, item 299 for home visits and 361 for telepsychiatry)

The rationale for items 296 - 299 and 361 is to improve access to psychiatric services by encouraging an increase in the number of new patients seen by each psychiatrist, while acknowledging that ongoing care of patients with severe mental

illness is integral to the role of the psychiatrist. Referral for items 296 - 299 and 361 may be from a participating nurse practitioner, medical practitioner practising in general practice, a specialist or another consultant physician.

It is intended that either item 296, 297, 299 or 361 will apply once only for each new patient on the first occasion that the patient is seen by a consultant psychiatrist, **unless** the patient is referred by a medical practitioner practising in general practice or participating nurse practitioner for an assessment and management plan, in which case the consultant psychiatrist, if he or she agrees that the patient is suitable for management in a general practice setting, will use item 291 where an assessment and management plan is provided to the referring practitioner.

There may be particular circumstances where a patient has been referred by a GP or participating nurse practitioner to a consultant psychiatrist for an assessment and management plan, but it is not possible for the consultant psychiatrist to determine in the initial consultation whether the patient is suitable for management under such a plan. In these cases, where clinically appropriate, item 296, 297, 299 or 361(for a new patient) or 300-308 (for continuing patients) may be used and item 291 may be used subsequently, in those circumstances where the consultant psychiatrist undertakes a consultation (in accordance with the item requirements) and provides the referring practitioner with an assessment and management plan. It is not generally intended that item 296, 297, 299 or 361 will be used in conjunction with, or prior to, item 291.

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

Items 300 - 308 are available for consultations in consulting rooms other than those provided under item 296, and items 291, 293 and 359. Similarly time tiered items remain available for hospital, home visits and telepsychiatry. These would cover a new course of treatment for patients who have already been seen by the consultant psychiatrist in the preceding 24 months as well as subsequent consultations for all patients.

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

Referrals from psychiatrists and paediatricians to an allied mental health professional must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

Within the maximum service allocation of ten services, the allied mental health professional can provide one or more courses of treatment. For the purposes of these services, a course of treatment will consist of the number of services stated in the patient's referral (up to a maximum of six in any one referral). These services should be provided, as required, for an initial course of treatment (a maximum of six services but may be less depending on the referral and patient need) to a maximum of ten services per calendar year.

While such referrals are likely to occur for new patients seen under items 296 - 299 and 361, they are also available for patients at any point in treatment (from items 293 to 370), as clinically required, under the same arrangements and limitations as outlined above. The referral may be in the form of a letter or note to an eligible allied health professional signed and dated by the referring practitioner.

There is provision for a further referral for up to an additional six individual services to be provided in exceptional circumstances (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012).

Exceptional circumstances apply where there has been a significant change in the patient's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services. In such cases, the patient's referral should be annotated to briefly indicate the reason why the additional allied mental health services were required in excess of the ten individual services permitted within a calendar year. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring practitioner.

Note: Patients will be able to receive an additional six individual allied mental health services under exceptional circumstances from 1 March 2012 to 31 December 2012. From 1 January 2013 the number of individual allied mental health services for which a person can receive a Medicare rebate will be ten services per calendar year.

Patients will also be eligible to claim up to ten services within a calendar year for group therapy services involving 6-10 patients to which items 80020 (psychological therapy - clinical psychologist), 80120 (focussed psychological strategies - psychologist), 80145 (focussed psychological strategies - occupational therapist) and 80170 (focussed psychological strategies - social worker) apply. These group services are separate from the individual services and do not count towards the ten individual services per calendar year maximum associated with those items.

A.20.. PSYCHIATRIC ATTENDANCES (ITEM 319)

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

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

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

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

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

It is the responsibility of the psychiatrist to ensure that the patient meets these criteria. the Department of Human Services will be closely monitoring the use of item 319.

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

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

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

A.21.. INTERVIEW OF PERSON OTHER THAN A PATIENT BY CONSULTANT PSYCHIATRIST (ITEMS 348, 350, 352)

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

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

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

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

A.22.. CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES (ITEMS 385 TO 388)

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

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

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

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

A.23.. CONTACT LENSES (ITEMS 10801-10809)

Benefits are paid for consultations concerned with the prescription and fitting of contact lenses only if patients fall into specified categories (ie patients with certain conditions). The classes of patients eligible for benefits for contact lens consultations are described in items 10801 to 10809.

Benefits are not payable for item 10809 in circumstances where patients want contact lenses only for:

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

(b) sporting purposes;

(c) work purposes; or

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

Benefits are payable for an initial referred consultation rendered in association with the fitting and prescribing of the lenses. Subsequent follow-up attendances attract benefits on a consultation basis.

A.24.. REFITTING OF CONTACT LENSES (ITEM 10816)

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

A.25.. HEALTH ASSESSMENTS (ITEMS 701, 703, 705, 707)

There are four time-based health assessment items, consisting of brief, standard, long and prolonged consultations.

Brief Health Assessment (MBS Item 701)
A brief health assessment is used to undertake simple health assessments. The health assessment should take no more than 30 minutes to complete.

Standard Health Assessment (MBS Item 703)
A standard health assessment is used for straightforward assessments where the patient does not present with complex health issues but may require more attention than can be provided in a brief assessment. The assessment lasts more than 30 minutes but takes less than 45 minutes.

Long Health Assessment (MBS Item 705)
A long health assessment is used for an extensive assessment, where the patient has a range of health issues that require more in-depth consideration, and longer-term strategies for managing the patient's health may be necessary. The assessment lasts at least 45 minutes but less than 60 minutes.

Prolonged Health Assessment (MBS Item 707)
A prolonged health assessment is used for a complex assessment of a patient with significant, long-term health needs that need to be managed through a comprehensive preventive health care plan. The assessment takes 60 minutes or more to complete.

Medical practitioners may select one of the MBS health assessment items to provide a health assessment service to a member of any of the target groups listed in the table below. The health assessment item that is selected will depend on

the time taken to complete the health assessment service. This is determined by the complexity of the patient's presentation and the specific requirements that have been established for each target group eligible for health assessments.

MBS Items 701, 703, 705 and 707 may be used to undertake a health assessment for the following target groups:

Target Group	**Frequency of Service**
A type 2 diabetes risk evaluation for people aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool	Once every three years to an eligible patient
A health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease	Once only to an eligible patient
A health assessment for people aged 75 years and older	Provided annually to an eligible patient
A comprehensive medical assessment for permanent residents of residential aged care facilities	Provided annually to an eligible patient
A health assessment for people with an intellectual disability	Provided annually to an eligible patient
A health assessment for refugees and other humanitarian entrants	Once only to an eligible patient
A health assessment for former serving members of the Australian Defence Force	Once only to an eligible patient

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

Health assessments are not available to people who are in-patients of a hospital or care recipients in a residential aged care facility (with the exception of a comprehensive medical assessment provided to a permanent resident of a residential aged care facility).

Before a health assessment is commenced, the patient (and/or his or her parent(s), carer or representative, as appropriate) must be given an explanation of the health assessment process and its likely benefits. The patient must be asked whether he or she consents to the health assessment being performed. In cases where the patient is not capable of giving consent, consent must be given by his or her parent(s), carer or representative. Consent to the health assessment must be noted in the patient's records.

A health assessment must include the following elements:

(a) information collection, including taking a patient history and undertaking or arranging examinations and investigations as required;

(b) making an overall assessment of the patient;

(c) recommending appropriate interventions;

(d) providing advice and information to the patient;

(e) keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and

(f) offering the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

A health assessment may only be claimed by a medical practitioner (including a general practitioner but not including a specialist or consultant physician).

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the health assessment items, 'usual doctor' means the medical practitioner, or a medical practitioner working in the medical practice, which has provided the majority of primary health care to the patient over the previous twelve months and/or will be providing the majority of care to the patient over the next twelve months.

A health assessment should not take the form of a health screening service.

MBS health assessment items 701, 703, 705, 707 must be provided by a medical practitioner personally attending upon a patient. Suitably qualified health professionals, such as practice nurses or Aboriginal and Torres Strait Islander health

practitioners, employed and/or otherwise engaged by a general practice or health service, may assist medical practitioners in performing health assessments. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the medical practitioner. This may include activities associated with:

- information collection; and
- providing patients with information about recommended interventions at the direction of the medical practitioner.

The medical practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

Medical practitioners should not conduct a separate consultation for another health-related issue in conjunction with a health assessment unless it is clinically necessary (ie. the patient has an acute problem that needs to be managed separately from the assessment). The only exception is the comprehensive medical assessment, where, if this health assessment is undertaken during the course of a consultation for another purpose, the health assessment item and the relevant item for the other consultation may both be claimed.

Items 701, 703, 705 and 707 do not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, items 701, 703, 705 and 707 can be claimed for services provided by medical practitioners salaried by or contracted to, the Service or health clinic. All other requirements of the items must be met.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment, provided the conditions of item 10990 and 10991 are satisfied.

A.26.. HEALTH ASSESSMENT PROVIDED AS A TYPE 2 DIABETES RISK EVALUATION FOR PEOPLE AGED 40-49 YEARS WITH A HIGH RISK OF DEVELOPING TYPE 2 DIABETES AS DETERMINED BY THE AUSTRALIAN TYPE 2 DIABETES RISK ASSESSMENT TOOL

Items 701, 703, 705 and 707 may be used to undertake a type 2 diabetes risk evaluation for people aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes, as determined by the Australian Type 2 Diabetes Risk Assessment Tool.

The aim of this health assessment is to review the factors underlying the 'high risk' score identified by the Australian Type 2 Diabetes Risk Assessment Tool to instigate early interventions, such as lifestyle modification programs, to assist with the prevention of type 2 diabetes.

The Australian Type 2 Diabetes Risk Assessment Tool has been developed to provide a basis for both health professionals and health consumers to assess the risk of type 2 diabetes. It consists of a short list of questions which, when completed, provides a guide to a patient's current level of risk of developing type 2 diabetes. The item scores and risk rating calculations in the tool have been developed using demographic, lifestyle, anthropometric and biomedical data from the 2000 Australian Diabetes, Obesity and Lifestyle baseline survey and the AusDiab 2005 follow-up study.

The Australian Type 2 Diabetes Risk Assessment Tool can be obtained from the Department's prevention of diabetes web page.

Clinical risk factors that the medical practitioner must consider when providing this health assessment include:

(a) lifestyle, such as smoking, physical inactivity and poor nutrition;

(b) biomedical risk factors, such as high blood pressure, impaired glucose metabolism and excess weight;

(c) any relevant recent diagnostic test results; and

(d) a family history of chronic disease.

The health assessment must include the following:

(a) evaluating a patient's high risk score, as determined by the Australian Type 2 Diabetes Risk Assessment Tool which has been completed by the patient within a period of 3 months prior to undertaking the health assessment;

(b) updating the patient's history and undertaking physical examinations and clinical investigations in accordance with relevant guidelines;

(c) making an overall assessment of the patient's risk factors and of the results of relevant examinations and investigations;

(d) initiating interventions, if appropriate, including referral to a lifestyle modification program and follow-up relating to the management of any risk factors identified (further information is available at the Department's prevention of diabetes web page.); and

(e) providing the patient with advice and information (such as the Lifescript resources produced by the Department of Health), including strategies to achieve lifestyle and behaviour changes if appropriate (further information is available at the Department's Lifescript web page).

The completion of the Australian Type 2 Diabetes Risk Assessment Tool is mandatory for patient access to this health assessment. The tool can be completed either by the patient or with the assistance of a health professional or practice staff. Patients with a 'high' score result are eligible for the health assessment, and subsequent referral to the subsidised lifestyle modification programs if appropriate (further information is available at the Department's prevention of diabetes web page).

A health assessment for a type 2 diabetes risk evaluation for people aged 40-49 years with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool may only be claimed once every three years by an eligible patient.

A.27.. HEALTH ASSESSMENT PROVIDED FOR PEOPLE AGED 45-49 YEARS WHO ARE AT RISK OF DEVELOPING CHRONIC DISEASE

Items 701, 703, 705 and 707 may be used to undertake a health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease.

For the purposes of this health assessment, a patient is at risk of developing a chronic disease if, in the clinical judgement of the attending medical practitioner, a specific risk factor for chronic disease is identified.

Risk factors that the medical practitioner can consider include, but are not limited to:

(a) lifestyle risk factors, such as smoking, physical inactivity, poor nutrition or alcohol use;

(b) biomedical risk factors, such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight; or

(c) family history of a chronic disease.

A chronic disease or condition is one that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions.

If, after receiving this health assessment, a patient is identifed as having a high risk of type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool, the medical practitioner may refer that person to a subsidised lifestyle modification program, along with other possible strategies to improve the health status of the patient (further information is available at http://www.health.gov.au/preventionoftype2diabetes).

The Australian Type 2 Diabetes Risk Assessment Tool can be obtained from http://www.health.gov.au/preventionoftype2diabetes

A health assessment for people aged 45-49 years who are at risk of developing chronic disease may only be claimed once by an eligible patient.

A.28.. HEALTH ASSESSMENT PROVIDED FOR PEOPLE AGED 75 YEARS AND OLDER

Items 701, 703, 705 and 707 may be used to undertake a health assessment for people aged 75 years and older.

A health assessment for people aged 75 years and older is an assessment of a patient's health and physical, psychological and social function for the purpose of initiating preventive health care and/or medical interventions as appropriate.

This health assessment must include:

(a) measurement of the patient's blood pressure, pulse rate and rhythm;
(b) an assessment of the patient's medication;
(c) an assessment of the patient's continence;
(d) an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus;
(e) an assessment of the patient's physical function, including the patient's activities of daily living, and whether or not the patient has had a fall in the last 3 months;
(f) an assessment of the patient's psychological function, including the patient's cognition and mood; and
(g) an assessment of the patient's social function, including the availability and adequacy of paid and unpaid help, and whether the patient is responsible for caring for another person.
(h) A health assessment for people aged 75 years and older may be claimed once every twelve months by an eligible patient.

A.29.. HEALTH ASSESSMENT PROVIDED AS A COMPREHENSIVE MEDICAL ASSESSMENT FOR RESIDENTS OF RESIDENTIAL AGED CARE FACILITIES

Items 701, 703, 705 and 707 may be used to undertake a comprehensive medical assessment of a resident of a residential aged care facility
This health assessment requires assessment of the resident's health and physical and psychological function, and must include:

(a) making a written summary of the comprehensive medical assessment;
(b) developing a list of diagnoses and medical problems based on the medical history and examination;
(c) providing a copy of the summary to the residential aged care facility; and
(d) offering the resident a copy of the summary.

A residential aged care facility is a facility in which residential care services, as defined in the *Aged Care Act 199*7, are provided. This includes facilities that were formerly known as nursing homes and hostels. A person is a resident of a residential aged care facility if the person has been admitted as a permanent resident of that facility.

This health assessment is available to new residents on admission into a residential aged care facility. It is recommended that new residents should receive the health assessment as soon as possible after admission, preferably within six weeks following admission into a residential aged care facility.

A health assessment for the purpose of a comprehensive medical assessment of a resident of a residential aged care facility may be claimed by an eligible patient:

(a) on admission to a residential aged care facility, provided that a comprehensive medical assessment has not already been provided in another residential aged care facility within the previous 12 months; and
(b) at 12 month intervals thereafter.

A.30.. HEALTH ASSESSMENT PROVIDED FOR PEOPLE WITH AN INTELLECTUAL DISABILITY

Items 701, 703, 705 and 707 may be used to undertake a health assessment for people with an intellectual disability.

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

The health assessment provides a structured clinical framework for medical practitioners to comprehensively assess the physical, psychological and social function of patients with an intellectual disability and to identify any medical intervention and preventive health care required. The health assessment must include the following items as relevant to the patient or his or her representative:

(a) Check dental health (including dentition);
(b) Conduct aural examination (arrange formal audiometry if audiometry has not been conducted within 5 years);
(c) Assess ocular health (arrange review by an ophthalmologist or optometrist if a comprehensive eye examination has not been conducted within 5 years);
(d) Assess nutritional status (including weight and height measurements) and a review of growth and development;
(e) Assess bowel and bladder function (particularly for incontinence or chronic constipation);
(f) Assess medications (including non-prescription medicines taken by the patient, prescriptions from other doctors, medications prescribed but not taken, interactions, side effects and review of indications);
    - Advise carers of the common side effects and interactions.
    - Consider the need for a formal medication review.
(g) Check immunisation status, including influenza, tetanus, hepatitis A and B, Measles, Mumps and Rubella (MMR) and pneumococcal vaccinations;
(h) Check exercise opportunities (with the aim of moderate exercise for at least 30 minutes per day);
(i) Check whether the support provided for activities of daily living adequately and appropriately meets the patient's needs, and consider formal review if required;
(j) Consider the need for breast examination, mammography, Papanicolaou smears, testicular examination, lipid measurement and prostate assessment as for the general population;
(k) Check for dysphagia and gastro-oesophageal disease (especially for patients with cerebral palsy), and arrange for investigation or treatment as required;
(l) Assess risk factors for osteoporosis (including diet, exercise, Vitamin D deficiency, hormonal status, family history, medication fracture history) and arrange for investigation or treatment as required;

(m) For patients diagnosed with epilepsy, review of seizure control (including anticonvulsant drugs) and consider referral to a neurologist at appropriate intervals;

(n) Check for thyroid disease at least every two years (or yearly for patients with Down syndrome);

(o) For patients without a definitive aetiological diagnosis, consider referral to a genetic clinic every 5 years;

(p) Assess or review treatment for co-morbid mental health issues;

(q) Consider timing of puberty and management of sexual development, sexual activity and reproductive health; and

(r) Consider whether there are any signs of physical, psychological or sexual abuse.

A health assessment for people with an intellectual disability may be claimed once every twelve months by an eligible patient.

A.31.. HEALTH ASSESSMENT PROVIDED FOR REFUGEES AND OTHER HUMANITARIAN ENTRANTS

Items 701, 703, 705 and 707 may be used to undertake a health assessment for refugees and other humanitarian entrants.

The purpose of this health assessment is to introduce new refugees and other humanitarian entrants to the Australian primary health care system, as soon as possible after their arrival in Australia (within twelve months of arrival).

The health assessment applies to humanitarian entrants who are resident in Australia with access to Medicare services. This includes Refugees, Special Humanitarian Program and Protection Program entrants with the following visas:

Offshore Refugee Category including:

(a) 200 Refugee
(b) 201 In Country Special Humanitarian
(c) 203 Emergency rescue
(d) 204 Women at Risk
(e) Offshore – Special Humanitarian Program
(f) 202 Global Special Humanitarian

Offshore – Temporary Humanitarian Visas (THV) including:

(g) Subclass 695 (Return Pending)
(h) Subclass 070 (Removal Pending Bridging)

Onshore Protection Program including:

(i) 866 Permanent Protection Visa (PPV)
(j) 785 Temporary Protection Visa (TPV)

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

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

A health assessment for refugees and other humanitarian entrants may only be claimed once by an eligible patient.

A.32.. HEALTH ASSESSMENT FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE (MBS ITEM 715)

This health assessment is available to all people of Aboriginal and Torres Strait Islander descent and should be used for health assessments for the following age categories:

- An Aboriginal or Torres Strait Islander child who is less than 15 years.
- An Aboriginal or Torres Strait Islander person who is aged between 15 years and 54 years.
- An Aboriginal or Torres Strait Islander older person who is aged 55 years and over.

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

MBS item 715 must include the following elements:

(a) information collection, including taking a patient history and undertaking examinations and investigations as required;

(b) making an overall assessment of the patient;

(c) recommending appropriate interventions;

(d) providing advice and information to the patient; and

(e) keeping a record of the health assessment, and offering the patient, and/or patient's carer, a written report about the health assessment with recommendations about matters covered by the health assessment; and

(f) offering the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

If, after receiving this health assessment, a patient who is aged fifteen years and over but under the age of 55 years, is identified as having a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool, the medical practitioner may refer that person to a subsidised lifestyle modification program, along with other possible strategies to improve the health status of the patient.

The Australian Type 2 Diabetes Risk Assessment Tool can be obtained from
http://www.health.gov.au/preventionoftype2diabetes

A health assessment may only be claimed by a medical practitioner (including a general practitioner but not including a specialist or consultant physician).

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the health assessment, "usual doctor" means the medical practitioner, or a medical practitioner working in the medical practice, which has provided the majority of primary health care to the patient over the previous twelve months and/or will be providing the majority of care to the patient over the next twelve months.

The Health Assessment for Aboriginal and Torres Strait Islander People is not available to people who are in-patients of a hospital or care recipients in a residential aged care facility.

A health assessment should not take the form of a health screening service (see General Explanatory Notes G.13.1).

MBS health assessment item 715 must be provided by a medical practitioner personally attending upon a patient. Suitably qualified health professionals, such as practice nurses, Aboriginal health workers or Aboriginal and Torres Strait Islander health practitioners employed and/or otherwise engaged by a general practice or health service, may assist medical practitioners in performing this health assessment. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the medical practitioner. This may include activities associated with:

- information collection; and
- providing patients with information about recommended interventions at the direction of the medical practitioner.

The medical practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

Medical practitioners should not conduct a separate consultation in conjunction with a health assessment unless it is clinically necessary (ie. the patient has an acute problem that needs to be managed separately from the assessment).

Item 715 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, item 715 can be claimed for services provided by medical practitioners salaried by or contracted to, the Service or health clinic. All requirements of the item must be met.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment provided to an Aboriginal and Torres Strait Islander person, provided the conditions of item 10990 and 10991 are satisfied.

The Health Assessment for Aboriginal and Torres Strait Islander People may be provided once every 9 months.

A.33.. A HEALTH ASSESSMENT FOR AN ABORIGINAL AND TORRES STRAIT ISLANDER CHILD (LESS THAN 15 YEARS OF AGE)

An Aboriginal and Torres Strait Islander child health assessment must include:

(a) a personal attendance by a medical practitioner;

(b) taking the patient's medical history, including the following:
  i. mother's pregnancy history;
  ii. birth and neo-natal history;
  iii. breastfeeding history;
  iv. weaning, food access and dietary history;
  v. physical activity;
  vi. previous presentations, hospital admissions and medication usage;
  vii. relevant family medical history;
  viii. immunisation status;
  ix. vision and hearing (including neonatal hearing screening);
  x. development (including achievement of age appropriate milestones);
  xi. family relationships, social circumstances and whether the person is cared for by another person;
  xii. exposure to environmental factors (including tobacco smoke);
  xiii. environmental and living conditions;
  xiv. educational progress;
  xv. stressful life events;
  xvi. mood (including incidence of depression and risk of self-harm);
  xvii. substance use;
  xviii. sexual and reproductive health; and
  xix. dental hygiene (including access to dental services).

(c) examination of the patient, including the following:
  i. measurement of height and weight to calculate body mass index and position on the growth curve;
  ii. newborn baby check (if not previously completed);
  iii. vision (including red reflex in a newborn);
  iv. ear examination (including otoscopy);
  v. oral examination (including gums and dentition);
  vi. trachoma check, if indicated;
  vii. skin examination, if indicated;
  viii. respiratory examination, if indicated;
  ix. cardiac auscultation, if indicated;
  x. development assessment, if indicated, to determine whether age appropriate milestones have been achieved;
  xi. assessment of parent and child interaction, if indicated; and
  xii. other examinations in accordance with national or regional guidelines or specific regional needs, or as indicated by a previous child health assessment.

(d) undertaking or arranging any required investigation, considering the need for the following tests, in particular:
  i. haemoglobin testing for those at a high risk of anaemia; and
  ii. audiometry, if required, especially for those of school age

(e) assessing the patient using the information gained in the child health check; and

(f) making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

A.34.. A HEALTH ASSESSMENT FOR AN ABORIGINAL AND TORRES STRAIT ISLANDER ADULT (AGED BETWEEN 15 YEARS AND 54 YEARS)

An Aboriginal and Torres Strait Islander adult health assessment must include:

(a) a personal attendance by a medical practitioner;

(b) taking the patient's medical history, including the following:
  i. current health problems and risk factors;
  ii. relevant family medical history;
  iii. medication usage (including medication obtained without prescription or from other doctors);
  iv. immunisation status, by reference to the appropriate current age and sex immunisation schedule;
  v. sexual and reproductive health;
  vi. physical activity, nutrition and alcohol, tobacco or other substance use;

vii. hearing loss;
viii. mood (including incidence of depression and risk of self-harm); and
ix. family relationships and whether the patient is a carer, or is cared for by another person;
x. vision

(c) examination of the patient, including the following:
i. measurement of the patient's blood pressure, pulse rate and rhythm;
ii. measurement of height and weight to calculate body mass index and, if indicated, measurement of waist circumference for central obesity;
iii. oral examination (including gums and dentition);
iv. ear and hearing examination (including otoscopy and, if indicated, a whisper test); and
v. urinalysis (by dipstick) for proteinurea;
vi. eye examination; and

(d) undertaking or arranging any required investigation, considering the need for the following tests, in particular, (in accordance with national or regional guidelines or specific regional needs):
i. fasting blood sugar and lipids (by laboratory based test on venous sample) or, if necessary, random blood glucose levels;
ii. pap smear;
iii. examination for sexually transmitted infection (by urine or endocervical swab for chlamydia and gonorrhoea, especially for those aged from 15 to 35 years); and
iv. mammography, if eligible (by scheduling appointments with visiting services or facilitating direct referral).

(e) assessing the patient using the information gained in the adult health assessment; and

(f) making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

An Aboriginal and Torres Strait Islander Older Person's health assessment must also include:
(a) keeping a record of the health assessment; and
(b) offering the patient a written report on the health assessment, with recommendations on matters covered by the health assessment;

A.35.. A HEALTH ASSESSMENT FOR AN ABORIGINAL AND TORRES STRAIT ISLANDER OLDER PERSON (AGED 55 YEARS AND OVER)

An Aboriginal and Torres Strait Islander Older Person's health assessment must include:

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

An Aboriginal and Torres Strait Islander Older Person's health assessment must also include:
(c) keeping a record of the health assessment; and
(d) offering the patient a written report on the health assessment, with recommendations on matters covered by the health assessment; and
(e) offering the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

A.36.. CHRONIC DISEASE MANAGEMENT ITEMS (ITEMS 721 TO 732)

Description	*Item No*	*Minimum claiming period**
Preparation of a GP Management Plan (GPMP)	721	12 months
Coordination of Team Care Arrangements (TCAs)	723	12 months
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care	729	3 months

Plan, for a patient who is not a care recipient in a residential aged care facility		
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	731	3 months
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	732	3 months

- CDM services may be provided more frequently in the exceptional circumstances defined below.

Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitates the performance of the service for the patient.

REGULATORY REQUIREMENTS
Items 721, 723, 729, 731 and 732 provide rebates for GPs to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to chronic disease management (CDM) plans. They apply for a patient who suffers from at least one medical condition that has been present (or is likely to be present) for at least six months or is terminal.

Restriction of Co-claiming of Chronic Disease and General Consultation Items
Co-claiming of GP consultation items 3, 4, 23, 24, 36, 37, 44, 47, 52, 63, 54, 57, 58, 59, 60, 65, 597, 598, 599, 600, 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5200, 5203, 5207, 5208, 5220, 5223, 5227 and 5228 with chronic disease management items 721, 723, or 732 is not permitted for the same patient, on the same day.

Patient eligibility
In addition to the eligibility requirements listed in the individual CDM item descriptors, the General Medical Services Table (GMST) mandates the following eligibility criteria:

CDM items 721, 723 and 732
These are:
- available to:
  i. patients in the community; and
  ii. private in-patients of a hospital (including private in-patients who are residents of aged care facilities) being discharged from hospital.
- not available to:
  i. public in-patients of a hospital; or
  ii. care recipients in a residential aged care facility.

CDM item 729
This is:
- available to:
  i. patients in the community;
  ii. both private and public in-patients being discharged from hospital.
- not available to care recipients in a residential aged care facility.

CDM item 731
This item is available to care recipients in a residential aged care facility only.

Item 721
A comprehensive written plan must be prepared describing:
(a) the patient's health care needs, health problems and relevant conditions;
(b) management goals with which the patient agrees;
(c) actions to be taken by the patient;
(d) treatment and services the patient is likely to need;
(e) arrangements for providing this treatment and these services; and
(f) arrangements to review the plan by a date specified in the plan.

In preparing the plan, the provider must:
(a) explain to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan; and
(b) record the plan; and
(c) record the patient's agreement to the preparation of the plan; and
(d) offer a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
(e) add a copy of the plan to the patient's medical records.

Item 723
When coordinating the development of Team Care Arrangements (TCAs), the medical practitioner must:
(a) consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another medical practitioner, when making arrangements for the multidisciplinary care of the patient; and
(b) prepare a document that describes:
    i. treatment and service goals for the patient;
    ii. treatment and services that collaborating providers will provide to the patient; and
    iii. actions to be taken by the patient;
    iv. arrangements to review (i), (ii) and (iii) by a date specified in the document; and
(c) explain the steps involved in the development of the arrangements to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);
(d) discuss with the patient the collaborating providers who will contribute to the development of the TCAs and provide treatment and services to the patient under those arrangements; and
(e) record the patient's agreement to the development of TCAs;
(f) give copies of the relevant parts of the document to the collaborating providers;
(g) offer a copy of the document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
(h) add a copy of the document to the patient's medical records.

One of the minimum two service providers collaborating with the GP can be another medical practitioner. The patient's informal or family carer can be included in the collaborative process but does not count towards the minimum of three collaborating providers.

Item 729
A multidisciplinary care plan means a written plan that:
(a) is prepared for a patient by:
    i. a medical practitioner in consultation with two other collaborating providers, each of whom provides a different kind of treatment or service to the patient, and one of whom may be another medical practitioner; or
    ii. a collaborating provider (other than a medical practitioner) in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and
(b) describes, at least, treatment and services to be provided to the patient by the collaborating providers.

When contributing to a multidisciplinary care plan or to a review of the care plan, the medical practitioner must:
(a) prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or
(b) give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

Item 731
A multidisciplinary care plan in a Residential Aged Care Facility (RACF) means a written plan that:
(a) is prepared for a patient by a collaborating provider (other than a medical practitioner, e.g. a RACF), in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and
(b) describes, at least, treatment and services to be provided to the patient by the collaborating providers.

When contributing to a multidisciplinary care plan or to a review of the care plan, the medical practitioner must:
(a) prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or
(b) give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

Item 731 can also be used for contribution to A MULTIDISCIPLINARY CARE PLAN PREPARED FOR A RESIDENT BY ANOTHER PROVIDER BEFORE THE RESIDENT IS DISCHARGED from a hospital or an approved day-hospital facility, OR TO A REVIEW OF SUCH A PLAN prepared by another provider (not being a service associated with a service to which items 735 to 758 apply).

Item 732
An "associated medical practitioner" is a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) who, if not engaged in the same general practice as the medical practitioner mentioned in that item, performs the service mentioned in the item at the request of the patient (or the patient's guardian).

When reviewing a GP Management Plan, the medical practitioner must:
(a) explain to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in the review;
(b) record the patient's agreement to the review of the plan;

(c) review all the matters set out in the relevant plan;
(d) make any required amendments to the patient's plan;
(e) offer a copy of the amended document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);
(f) add a copy of the amended document to the patient's records; and
(g) provide for further review of the amended plan by a date specified in the plan.

When coordinating a review of Team Care Arrangements, a multidisciplinary community care plan or a multidisciplinary discharge care plan, the practitioner must:
(a) explain the steps involved in the review to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);
(b) record the patient's agreement to the review of the TCAs or plan;
(c) consult with at least two health or care providers (each of whom provides a service or treatment to the patient that is different from each other and different from the service or treatment provided by the medical practitioner who is coordinating the TCAs or plan) to review all the matters set out in the relevant plan;
(d) make any required amendments to the patient's plan;
(e) offer a copy of the amended document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);
(f) provide for further review of the amended plan by a date specified in the plan;
(g) give copies of the relevant parts of the amended plan to the collaborating providers; and
(h) add a copy of the amended document to the patient's records.

Item 732 can also be used to COORDINATE A REVIEW OF A MULTIDISCIPLINARY COMMUNITY CARE PLAN (former item 720) or to COORDINATE REVIEW OF A DISCHARGE CARE PLAN (former item 722), where these services were coordinated or prepared by that medical practitioner (or an associated medical practitioner), and not being a service associated with a service to which items 735-758 apply.

Claiming of benefits
Each service to which item 732 applies (i.e. Review of a GP Management Plan and Review of Team Care Arrangements) may be claimed once in a three-month period, except where there are exceptional circumstances arising from a significant change in the patient's clinical condition or care circumstances that necessitates earlier performance of the service for the patient.
Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher should be annotated to indicate the reason why the service was required earlier than the minimum time interval for the relevant item. Payment can then be made.
Item 732 can be claimed twice on the same day providing an item 732 for reviewing a GP Management Plan and another 732 for reviewing Team Care Arrangements (TCAs) are both delivered on the same day as per the MBS item descriptors and explanatory notes.

Medicare requirements when item 732 is claimed twice on the same day
If a GPMP and TCAs are both reviewed on the same date and item 732 is to be claimed twice on the same day, both electronic claims and manual claims need to indicate they were rendered at different times:

- **Non electronic Medicare claiming of items 732 on the same date**
  The time that each item 732 commenced should be indicated next to each item

- **Electronic Medicare claiming of item 732 on the same date**
  Medicare Easyclaim*:* use the 'ItemOverrideCde" set to 'AP', which flags the item as *not duplicate services*
  Medicare Online/ECLIPSE: set the 'DuplicateServiceOverrideIND' to 'Y', which flags the item as *not duplicate*

Items 721, 723 and 732
The GP Management Plan items (721 and 732) and the Team Care Arrangement items (723 and 732) can not be claimed by general practitioners when they are a recognised specialist in the specialty of palliative medicine and treating a referred palliative care patient under items 3005-3093. The referring practitioner is able to provide the CDM services.

ADDITIONAL INFORMATION
Advice on the items and further guidance are available at: www.health.gov.au/mbsprimarycareitems
Items 721-732 should generally be undertaken by the patient's **usual medical practitioner**. The patient's "usual GP" means the GP, or a GP working in the medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of GP services to the patient over the next twelve months. The term "usual GP" would not generally apply to a practice that provides only one specific CDM service.

A **practice nurse, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker or other health professional** may assist a GP with items 721, 723, and 732 (e.g. in patient assessment, identification of patient

needs and making arrangements for services). However, the GP must meet all regulatory requirements, review and confirm all assessments and see the patient.

Patients being managed under the chronic disease management items may be eligible for:
- individual allied health services (items 10950 to 10970); and/or
- group allied health services (items 81100 to 81125.

More information on eligibility requirements can be found in the explanatory note for individual allied health services and group allied health services.

Further information is also available for providers from the Department of Human Services provider inquiry line on 132 150.

The Department of Human Services (DHS) has developed two guidelines, the Health Practitioner Guideline to substantiate the preparation of a valid GP Management Plan (for medical practitioners) and the Health Practitioner Guideline to substantiate the coordination of the development of Team Care Arrangements (for medical practitioners) which are both located on the DHS website.

A.37.. MEDICARE DENTAL ITEMS FOR PATIENTS WITH CHRONIC CONDITIONS AND COMPLEX CARE NEEDS - SERVICES PROVIDED BY A DENTAL PRACTITIONER ON REFERRAL FROM A GP [ITEMS 85011-87777]

Closure of Medicare Dental Items 85011-87777

The Medicare Chronic Disease Dental Scheme closed on 30 November 2012. No Medicare benefits will be payable for any dental services provided under Medicare dental items 85011-87777 provided after this date. The cost of any future dental services will need to be met by the patient.

Further details regarding the closure are available at www.health.gov.au/dental.

A.38.. MULTIDISCIPLINARY CASE CONFERENCES BY MEDICAL PRACTITIONERS (OTHER THAN SPECIALIST OR CONSULTANT PHYSICIAN) - (ITEMS 735 TO 758)

Items 735 to 758 provide rebates for medical practitioners (not including a specialist or consultant physician) to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities.

REGULATORY REQUIREMENTS

To organise and coordinate case conference items **735, 739 and 743**, the provider must:
(a) explain to the patient the nature of a multidisciplinary case conference, and ask the patient for their agreement to the conference taking place; and
(b) record the patient's agreement to the conference; and
(c) record the day on which the conference was held, and the times at which the conference started and ended; and
(d) record the names of the participants; and
(e) offer the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a summary of the conference and provide this summary to other team members; and
(f) discuss the outcomes of the conference with the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
(g) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

To participate in multidisciplinary case conference items **747, 750 and 758**, the provider must:
(a) explain to the patient the nature of a multidisciplinary case conference, and ask the patient whether they agree to the medical practitioner's participation in the conference; and
(b) record the patient's agreement to the medical practitioner's participation; and
(c) record the day on which the conference was held, and the times at which the conference started and ended; and
(d) record the names of the participants; and
(e) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

ADDITIONAL INFORMATION

Usual medical practitioner

Items 735-758 should generally be undertaken by the patient's usual medical practitioner. This is a medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

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

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.

The patient's informal or family carer may be included as a formal member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.

Discharge case conference
Organisation and coordination of a multidisciplinary discharge case conference (items 735, 739 and 743) may be provided for private in-patients being discharged into the community from hospital.

Further sources of information
Advice on the items and further guidance are available at: www.health.gov.au/mbsprimarycareitems

Further information is also available for providers from the Department of Human Services provider inquiry line on 132 150.

A.39.. PUBLIC HEALTH MEDICINE - (ITEMS 410 TO 417)

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

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

For more information on the content-based item structure used in this Group, see A.5 in the explanatory notes.

A.40.. CASE CONFERENCES BY CONSULTANT PHYSICIAN - (ITEMS 820 TO 838)

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

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

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

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

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

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

For the purposes of A.37.5 and A25.6, "formal care providers" includes:
- the patient's usual General Practitioner;
- allied health professionals, being: registered nurse, physiotherapist, occupational therapist, podiatrist, speech pathologist, pharmacist; dietician; psychologist; orthoptist; orthotist and prosthetist, optometrist; audiologist, social worker, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker, mental health worker, asthma educator, diabetes educator, dental therapist, dentist; and
- community service providers being: personal care worker, home and community care service provider, meals on wheels provider, education provider and probation officer.

Organisation of a case conference
For items 820, 822, 823, 830, 832 and 834, organise and coordinate a community case conference means undertaking the following activities in relation to a case conference:
(a) explaining to the patient or the patient's agent the nature of a case conference, and asking the patient or the patient's agent whether he or she agrees to the case conference taking place; and
(b) recording the patient's or agent's agreement to the case conference; and
(c) recording the day on which the conference was held, and the times at which the conference started and ended; and
(d) recording the names of the participants; and
(e) recording the matters mentioned in A.37.4 and putting a copy of that record in the patient's medical records; and
(f) giving the patient or the patient's agent, and each other member of the team a summary of the conference; and
(h) giving a copy of the summary of the conference to the patient's usual general practitioner; and
(i) discussing the outcomes of the patient or the patient's agent.

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

Participation in a case conference
For items 825, 826, 828, 835, 837 and 838, participation in a case conference must be at the request of the person who organises and coordinates the case conference and includes undertaking the following activities when participating in a case conference:
(a) recording the day on which the conference was held, and the times at which the conference started and ended; and
(b) recording the matters mentioned in A.37.4 in so far as they relate to the medical practitioner's participation in the case conference, and putting a copy of that record in the patient's medical records.

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

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

Prior informed consent must be obtained from the patient, or the patient's agent. In obtaining informed consent the consultant physician should:
- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other case conference participants;
- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to, or withheld from, the other care providers;
- Inform the patient that he or she will incur a charge for the service for which a Medicare rebate will be payable.

Medicare benefits are only payable in respect of the service provided by the coordinating consultant physician or the participating consultant physician. Benefits are not payable for another medical practitioner organising a case conference

or for participation by other medical practitioners at a case conference, except where a medical practitioner organises or participates in a case conference in accordance with Items 734 to 779.

The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. See point G.7.1 of the General Explanatory Notes for further details on billing procedures.

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

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

A.41.. MEDICATION MANAGEMENT REVIEWS - (ITEMS 900 AND 903)

Item 900 - Domiciliary Medication Management Review
A Domiciliary Medication Management Review (DMMR) (Item 900), also known as Home Medicines Review, is intended to maximise an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, involving the patient's GP and preferred community pharmacy or accredited pharmacist.

Patient eligibility
The item is available to people living in the community who meet the criteria for a DMMR.

The item is not available for in-patients of a hospital, or care recipients in residential aged care facilities.

DMMRs are targeted at patients who are likely to benefit from such a review: patients for whom quality use of medicines may be an issue or; patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a lack of knowledge and skills to use medicines to their best effect.

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

REGULATORY REQUIREMENTS
In conducting a DMMR, a medical practitioner must:
(a) assess a patient's medication management needs; and
(b) following that assessment, refer the patient to a community pharmacy or an accredited pharmacist for a DMMR; and
(c) with the patient's consent, provide relevant clinical information required for the review; and
(d) discuss with the reviewing pharmacist the results of that review, including suggested medication management strategies; and
(e) develop a written medication management plan following discussion with the patient.

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

The benefit is not claimable until all the components of the item have been rendered.

Benefits for a DMMR service under item 900 are payable only once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (e.g. diagnosis of a new condition or recent discharge from hospital involving significant changes in medication). In such cases the patient's invoice or Medicare voucher should be annotated to indicate that the DMMR service was required to be provided within 12 months of another DMMR service.

If the DMMR is initiated during the course of a consultation undertaken for another purpose, this consultation may also be claimed separately.

If the consultation at which the medication management review is initiated is only for the purposes of initiating the review only item 900 may be claimed.

If the medical practitioner determines that a DMMR is not necessary, item 900 does not apply. In this case, normal consultation items should be used.

Where a DMMR cannot be completed due to circumstances beyond the control of the medical practitioner (e.g. because the patient decides to not proceed further with the DMMR, or because of a change in the circumstances of the patient), the relevant MBS attendance items should be used.

FURTHER GUIDANCE
A DMMR should generally be undertaken by the patients usual medical practitioner. This is the medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

The potential need for a DMMR may be identified either by the medical practitioner in the process of a consultation or by receipt of advice from the patient, a carer or another health professional including a pharmacist.

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

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

Development of ***a written medication management plan following discussion with the patient*** includes:
- Developing a draft medication management plan and discussing this with the patient; and
- Once agreed, offering a copy of the written medication management plan to the patient and providing a copy to the community pharmacy or accredited pharmacist.

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

Item 903 - Residential Medication Management Review
A Residential Medication Management Review (RMMR) is a collaborative service available to permanent residents of a Residential Aged Care facility (RACF) who are likely to benefit from such a review. This includes residents for whom quality use of medicines may be an issue or residents who are at risk of medication misadventure because of a significant change in their condition or medication regimen.

Patient eligibility
RMMRs are available to:
new residents on admission into a RACF; and
existing residents on an 'as required' basis, where in the opinion of the resident's medical practitioner, it is required because of a significant change in medical condition or medication regimen.

RMMRs are not available to people receiving respite care in a RACF. Domiciliary Medicines Reviews are available to these people when they are living in the community setting.

REGULATORY REQUIREMENTS

When conducting a RMMR, a GP must:

(a) discuss the proposed review with the resident and seek the resident's consent to the review; and
(b) collaborate with the reviewing pharmacist about the pharmacist's involvement in the review; and
(c) provide input from the resident's most recent comprehensive medical assessment or, if such an assessment has not been undertaken, provide relevant clinical information for the review and for the resident's records; and
(d) If recommended changes to the resident's medication management arise out of the review, participate in a post-review discussion (either face-to-face or by telephone) with the pharmacist to discuss the outcomes of the review including:
    (i) the findings; and
    (ii) medication management strategies; and
    (iii) means to ensure that the strategies are implemented and reviewed, including any issues for implementation and follow-up; and
    (iv) develop or revise the resident's medication management plan after discussion with the reviewing pharmacist; and
    (v) finalise the plan after discussion with the resident.

A medical practitioner's involvement in a residential medication management review also includes:

(a) offering a copy of the medication management plan to the resident (or the resident's carer or representative if appropriate); and
(b) providing copies of the plan for the resident's records and for the nursing staff of the residential aged care facility; and
(c) discussing the plan with nursing staff if necessary.

A post-review discussion is not required if:

(a) there are no recommended changes to the resident's medication management arising out of the review; or
(b) any changes are minor in nature and do not require immediate discussion; or
(c) the pharmacist and medical practitioner agree that issues arising out of the review should be considered in a case conference.

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

Claiming

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

Benefits are payable when all the activities of a RMMR have been completed. A RMMR service covers the consultation at which the results of the medication management review are discussed and the medication management plan agreed with the resident:

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

In some cases a RMMR may not be able to be completed due to circumstances beyond the control of the medical practitioner (e.g. because the resident decides not to proceed with the RMMR or because of a change in the circumstances of the resident). In these cases the relevant MBS attendance item should be used in relation to any consultation undertaken with the resident.

If the consultation at which the RMMR is initiated, including discussion with resident and obtaining consent for the RMMR, is only for the purposes of initiating the review, only the RMMR item should be claimed.

If the RMMR is initiated during the course of a consultation undertaken for another purpose, the other consultation may be claimed as a separate service and the RMMR service would also apply.

If the medical practitioner determines that an RMMR is not necessary, the RMMR item does not apply. In this case, relevant consultation items should be used.

FURTHER GUIDANCE
A RMMR should generally be undertaken by the resident's 'usual GP'. This is the medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of care to the resident over the previous 12 months and/or will be providing the majority of care to the resident over the next 12 months.

GPs who provide services on a facility-wide contract basis, and/or who are registered to provide services to RACFs as part of aged care panel arrangements, may also undertake RMMRs for residents as part of their services.

Generally, new residents should receive an RMMR as soon as possible after admission. Where a resident has a Comprehensive Medical Assessment (CMA), the RMMR should be undertaken preferably after the results of the CMA are available to inform the RMMR.

A RMMR service should be completed within a reasonable timeframe. As a general guide, it is expected that most RMMR services would be completed within four weeks of being initiated.

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

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

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

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

RMMRs do not count for the purposes of derived fee arrangements that apply to other consultations in a Residential Aged Care Facility.

A.42.. TAKING A CERVICAL SMEAR FROM A PERSON WHO IS UNSCREENED OR SIGNIFICANTLY UNDER-SCREENED - (ITEMS 2497 - 2509 AND 2598 - 2616)

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

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

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

(a) asking the person if they can remember having a cervical screen in the last four years; and
(b) checking their own practice's medical records.

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

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

Vault smears are not eligible for items 2497 - 2509 and 2598 - 2616.

In addition to attracting a Medicare rebate, the use of these items will initiate a Cervical Screening SIP through the PIP.

A PIP Cervical Screening SIP is available for taking a cervical screen from a person who has not been screened in the last for four years. The SIP will be paid to the medical practitioner who provided the service if the service was provided in a general practice participating in the PIP Cervical Screening Incentive. A further PIP Cervical Screening Incentive payment is paid to practices which reach target levels of cervical screening for their patients aged 20-69 years inclusive. More

detailed information on the PIP Cervical Screening Incentive is available from the Department of Human Services PIP enquiry line on 1800 222 032 or from the Department of Human Services website.

A.43.. Completion of the Annual Diabetes Cycle of Care for Patients with Established Diabetes Mellitus - (Items 2517 - 2526 and 2620 - 2635)

The item numbers 2517, 2518, 2521, 2522, 2525, 2526, and 2620, 2622, 2624, 2631, 2633, 2635, should be used in place of the usual attendance item when a consultation completes the minimum requirements of the annual Diabetes Cycle of Care for a patient with established diabetes mellitus.

The annual Diabetes Cycle of Care must be completed over a period of 11 months and up to 13 months, and at a minimum must include:

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

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

These requirements are generally based on the current general practice guidelines produced by Diabetes Australia and the Royal Australian College of General Practitioners (Diabetes Management in General Practice). Doctors using these items should familiarise themselves with these guidelines and with subsequent editions of these guidelines as they become available.

Use of these items certifies that the minimum requirements of the Diabetes Cycle of Care have been completed for a patient with established diabetes mellitus in accordance with the guidelines above.

These items should only be used once per cycle per patient of either A18 Subgroup 2 or A19 Subgroup 2. For example, if item 2517 is claimed for a patient then no other diabetes item in groups A18 or A19 can be used for this patient in the same cycle.

The requirements for claiming these items are the minimum needed to provide good care for a patient with diabetes. Additional levels of care will be needed by insulin-dependent patients and those with abnormal review findings, complications and/or co-morbidities.

In addition to attracting a Medicare rebate, recording a completion of a Diabetes Cycle of Care through the use of these items will initiate a Diabetes Service Incentive Payment (SIP) through the Practice Incentives Program (PIP).

All visits should be billed under the normal attendance items with the exception of the visit that completes all of the minimum requirements of the Diabetes Cycle of Care.

A PIP Diabetes SIP is available for completing the minimum requirements of the Diabetes Cycle of Care for individual patients as specified above. The Diabetes SIP is only paid once every 11-13 month period per patient. The SIP will be paid to the medical practitioner who provided the service if the service was provided in a general practice participating in the PIP Diabetes Incentive. A further PIP Diabetes Incentive payment is paid to practices which reach target levels of care for

their patients with diabetes mellitus. More detailed information on the PIP Diabetes Incentive is available from the Department of Human Services PIP enquiry line on 1800 222 032 or the Department of Human Services website.

A.44.. COMPLETION OF THE ASTHMA CYCLE OF CARE - (ITEMS 2546 - 2559 AND 2664 - 2677)

The item numbers 2546, 2547, 2552, 2553, 2558, 2559 and 2664, 2666, 2668, 2673, 2675 and 2677 should be used in place of the usual attendance item when a consultation completes the minimum requirements of the Asthma Cycle of Care. The Practice Incentives Program (PIP) Asthma Incentive is for patients with moderate to severe asthma who in the opinion of the doctor could benefit from review, eg those whose asthma management could be improved.

At a minimum the Asthma Cycle of Care must include:

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

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

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

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

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

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

The visit that completes the Asthma Cycle of Care should be billed using the appropriate item listed in Group A18 Subgroup 3 and Group A19 Subgroup 3.

In addition to attracting a Medicare rebate, recording a completion of an Asthma Cycle of Care through the use of these items, will initiate an Asthma Service Incentive Payment (SIP) through the PIP.

All visits should be billed under the normal attendance items with the exception of the visit that completes all of the minimum requirements of the Asthma Cycle of Care.

A PIP Asthma SIP is available for completing the minimum requirements of the Asthma Cycle of Care for individual patients as specified above. The SIP will be paid to the medical practitioner who provided the service if the service was provided in a general practice participating in the PIP Asthma Incentive. More detailed information on the PIP Asthma Incentive is available from the Department of Human Services PIP enquiry line on 1800 222 032 or from the Department of Human Services website.

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

Assessment of Severity

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

- Symptoms on most days, OR
- Use of preventer medication, OR

- Bronchodilator use at least 3 times per week, OR
- Hospital attendance or admission following an acute exacerbation of asthma.

Where the general rule does not apply to a particular patient, the classification of severity described by the current edition of the National Asthma Council's *Asthma Management Handbook* can be used. Visit the National Asthma Council's website for more details.

A.45.. GP MENTAL HEALTH TREATMENT ITEMS - (ITEMS 2700 TO 2717)

This note provides information on the GP Mental Health Treatment items 2700, 2701, 2712, 2713, 2715 and 2717. It includes an overview of the items, patient and provider eligibility, what activities are involved in providing services rebated by these items, links to other Medicare items and additional claiming information.

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

The GP Mental Health Treatment items incorporate a model for best practice primary health treatment of patients with mental disorders, including patients with both chronic or non-chronic disorders, that comprises:

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

Who can provide
The GP Mental Health Treatment Plan, Review and Consultation items are available for use in general practice by medical practitioners, including general practitioners but excluding specialists or consultant physicians. The term 'GP' is used in these notes as a generic reference to medical practitioners able to claim these items.

Training Requirements (item 2715 and 2717)
GPs providing Mental Health Treatment Plans, and who have undertaken mental health skills training recognised through the General Practice Mental Health Standards Collaboration, have access to items 2715 and 2717. For GPs who have not undertaken training, items 2700 and 2701 are available. Items 2715 provides for a Mental Health Treatment Plan lasting at least 20 minutes and item 2717 provides for a Mental Health Treatment Plan lasting at least 40 minutes. It is strongly recommended that GPs providing mental health treatment have appropriate mental health training. GP organisations support the value of appropriate mental health training for GPs using these items.

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

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

PREPARING A GP MENTAL HEALTH TREATMENT PLAN – (Item 2700, 2701, 2715 or 2717)
What is involved - Assess and Plan
A rebate can be claimed once the GP has undertaken an assessment and prepared a GP Mental Health Treatment Plan by completing the steps from Assessment to the point where patients do not require a new plan after their initial plan has been prepared, and meeting the relevant requirements listed under 'Additional Claiming Information'. This item covers both the assessment and preparation of the GP Mental Health Treatment Plan. Where the patient has a carer, the practitioner may find it useful to consider having the carer present for the assessment and preparation of the GP Mental Health Treatment Plan or components thereof (subject to patient agreement).

Assessment
An assessment of a patient must include:

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

The assessment can be part of the same consultation in which the GP Mental Health Treatment Plan is developed, or can be undertaken in different visits. Where separate visits are undertaken for the purpose of assessing the patient and developing the GP Mental Health Treatment Plan, they are part of the GP Mental Health Treatment Plan service and are included in item 2700, 2701, 2715 or 2717.

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

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

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

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

Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare either through item 2700, 2701, 2715 or 2717 a patient is eligible to be referred for up to ten (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) Medicare rebateable allied mental health services per calendar year for psychological therapy or focussed psychological strategy services. Patients will also be eligible to claim up to ten separate services for the provision of group therapy (either as part of psychological therapy or focussed psychological strategies).

When referring patients GPs should provide similar information as per normal GP referral arrangements. This could include providing a copy of the patient's GP Mental Health Treatment Plan, where appropriate and with the patient's agreement. The necessary referrals should be made after the steps above have been addressed and the patient's GP Mental Health Treatment Plan has been completed. It should be noted that the patient's mental health treatment plan should be treated as a living document for updating as required. In particular, the plan can be updated at any time to incorporate relevant information, such as feedback or advice from other health professionals on the diagnosis or treatment of the patient.

On completion of a course of treatment provided through Medicare rebateable services, the service provider must provide a written report on the course of treatment to the GP. For the purposes of the Medicare rebateable allied mental health items, a course of treatment will consist of the number of services stated on the patient's referral (up to a maximum of six in any one referral). There may be two or more courses of treatment within a patient's entitlement of up to ten services per calendar year (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply). The number of services that the patient is being referred for is at the discretion of the referring practitioner (eg. GP).

Many patients will not require a new plan after their initial plan has been prepared. A new plan should not be prepared unless clinically required, and generally not within 12 months of a previous plan. Ongoing management can be provided through the GP Mental Health Treatment Consultation and standard consultation items, as required, and reviews of progress through the GP Mental Health Treatment Plan Review item. A rebate for preparation of a GP Mental Health

Treatment Plan will not be paid within 12 months of a previous claim for the patient for the same or another Mental Health Treatment Plan item or within three months following a claim for a GP Mental Health Treatment Review (item 2712 or former item 2719), other than in exceptional circumstances.

REVIEWING A GP MENTAL HEALTH TREATMENT PLAN – (Item 2712)
The review item is a key component for assessing and managing the patient's progress once a GP Mental Health Treatment Plan has been prepared, along with ongoing management through the GP Mental Health Treatment Consultation item and/or standard consultation items. A patient's GP Mental Health Treatment Plan should be reviewed at least once.

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

The review must include:

- recording the patient's agreement for this service;
- a review of the patient's progress against the goals outlined in the GP Mental Health Treatment Plan;
- modification of the documented GP Mental Health Treatment Plan if required;
- checking, reinforcing and expanding education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided; and
- re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate.

Note: This review is a formal review point only and it is expected that in most cases there will be other consultations between the patient and the GP as part of ongoing management.

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

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

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

A rebate will not be paid within three months of a previous claim for the same item/s or within four weeks following a claim for a GP Mental Health Treatment Plan item other than in exceptional circumstances.

GP MENTAL HEALTH TREATMENT CONSULTATION – (Item 2713)
The GP Mental Health Treatment Consultation item is for an extended consultation with a patient where the primary treating problem is related to a mental disorder, including for a patient being managed under a GP Mental Health Treatment Plan. This item may be used for ongoing management of a patient with a mental disorder. This item should not be used for the development of a GP Mental Health Treatment Plan.

A GP Mental Health Treatment Consultation must include:

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

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

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

REFERRAL
Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare, or a GP is managing a patient under a referred psychiatrist assessment and management plan (item 291), a patient is eligible for up to ten (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) Medicare rebateable allied mental health services per calendar year for services by:

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

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

When referring patients, GPs should provide similar information as per normal GP referral arrangements, and specifically consider including both a statement identifying that a GP Mental Health Treatment Plan has been completed for the patient (including, where appropriate and with the patient's agreement, attaching a copy of the patient's GP Mental Health Treatment Plan) and clearly identifying the specific number of sessions the patient is being referred for. Referrals for patients with either a GP Mental Health Treatment Plan or referred psychiatrist assessment and management plan (item 291) should be provided, as required, for an initial course of treatment (a maximum of six services in any one referral but may be less depending on the referral and the patient's clinical need). There may be two or more courses of treatment within a patient's entitlement of up to ten services per calendar year (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply). The GP should consider the patient's clinical need for further sessions after the initial referral. This can be done using a GP Mental Health Treatment Plan Review, a GP Mental Health Treatment Consultation or a standard consultation item.

Provisions exist which allow a further referral for up to an additional six services in a calendar year to be made in exceptional circumstances (to a maximum total of 16 individual allied mental health services per patient from 1 March 2012 to 31 December 2012).

Note: Patients will be able to receive an additional six individual allied mental health services under exceptional circumstances from 1 March 2012 to 31 December 2012. From 1 January 2013 the number of individual allied mental health services for which a person can receive a Medicare rebate will be ten services per calendar year.

Exceptional circumstances are defined as a significant change in the patient's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services. It is up to the referring practitioner (e.g. GP) to determine that the patient meets these requirements.

Where referrals are provided in exceptional circumstances, both the patient's mental health treatment plan and referral should be annotated to briefly indicate the reason why the allied mental health service involved was required in excess of the 10 services permitted within a calendar year.

Services provided under the Access to Allied Psychological Services (ATAPS) should not be used in addition to the ten (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) psychological therapy services (items 80000 to 80020), focussed psychological services-allied mental health services (items 80100 to 80170) or GP focussed psychological strategies services (items 2721 to 2727) available under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative per calendar year. GPs referring patients for services under the ATAPS program should refer to the ATAPS Operational Guidelines.

ADDITIONAL CLAIMING INFORMATION

Before proceeding with any GP Mental Health Treatment Plan or Review service the GP must ensure that:

(a) the steps involved in providing the service are explained to the patient and (if appropriate and with the patient's permission) to the patient's carer; and

(b) the patient's agreement to proceed is recorded.

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

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

- if a GP Mental Health Treatment item is undertaken or initiated during the course of a consultation for another purpose, the GP Mental Health Treatment Plan, Review or Consultation item and the relevant item for the other consultation may both be claimed;
- if a GP Mental Health Treatment Plan is developed over more than one consultation, and those consultations are for the purposes of developing the plan, only the GP Mental Health Treatment Plan item should be claimed; and

- if a consultation is for the purpose of a GP Mental Health Treatment Plan, Review or Consultation item, a separate and additional consultation should not be undertaken in conjunction with the mental health consultation, unless it is clinically indicated that a separate problem must be treated immediately.

Where separate consultations are undertaken in conjunction with mental health consultations, the patient's invoice or Medicare voucher (assignment of benefit form) for the separate consultation should be annotated (e.g. separate consultation clinically required/indicated).

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

All consultations conducted as part of the GP Mental Health Treatment items must be rendered by the GP and include a personal attendance with the patient. A specialist mental health nurse, other allied health practitioner, Aboriginal and Torres Strait Islander health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to GPs in provision of mental health care.

Exceptional circumstances
There are minimum time intervals for payment of rebates for GP Mental Health Treatment items (as detailed above), with provision for claims to be made earlier than these minimum intervals in exceptional circumstances. In addition, eligible patients may be referred for up to 10 individual and 10 group therapy Medicare rebateable allied mental health services per calendar year, with provision for referral for up to an additional 6 individual services in exceptional circumstances from 1 March 2012 to 31 December 2012.

Note: Patients will be able to receive an additional six individual allied mental health services under exceptional circumstances from 1 March 2012 to 31 December 2012. From 1 January 2013 the number of individual allied mental health services for which a person can receive a Medicare rebate will be ten services per calendar year.

Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that requires, for example a new GP Mental Health Treatment Plan or a new Review, rather than amending the existing GP Mental Health Treatment Plan.

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

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

The Chronic Disease Management (CDM) care plan items (items 721, 723, 729, 731 and 732) continue to be available for patients with chronic medical conditions, including patients with complex needs.

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

The Department of Human Services (DHS) has developed a Health Practitioner Guideline to substantiate the preparation of a valid GP Mental Health treatment Plan which is located on the DHS website.

A.46.. PROVISION OF FOCUSSED PSYCHOLOGICAL STRATEGIES - (ITEMS 2721 TO 2727)

Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies that have been shown to integrate the best research evidence of clinical effectiveness with general practice clinical expertise. The decision to recommend Focussed Psychological Strategies to a patient must be made either in the context of a GP Mental Health Treatment Plan or a Psychiatrist Assessment and Management Plan.

Minimum Requirements
All consultations providing Focussed Psychological Strategies must be rendered by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician).

To ensure appropriate standards for the provision of Focussed Psychological Strategies, payment of Medicare rebates for these items will be limited to medical practitioners who are registered with the Department of Human Services as having satisfied the requirements for higher level mental health skills for provision of the service, as determined by the General Practice Mental Health Standards Collaboration.

Continued access to item numbers 2721 - 2727 will be dependent on the practitioner meeting the ongoing mental health education requirements as determined by the General Practice Mental Health Standards Collaboration.

Patients will be permitted to claim Medicare rebates for up to ten allied mental health services under these item numbers per calendar year. The ten services may consist of: GP focussed psychological strategies services (items 2721 to 2727); and/or psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165).

The referring practitioner may consider that in exceptional circumstances the patient may require an additional 6 services above those already provided (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012).

Note: Patients will be able to receive an additional six individual allied mental health services under exceptional circumstances from 1 March 2012 to 31 December 2012. From 1 January 2013 the number of individual allied mental health services for which a person can receive a Medicare rebate will be ten services per calendar year.

After the patient has received 10 focussed psychological strategies services, the practitioner managing the patient under either the GP Mental Health Treatment Plan or Psychiatrist Assessment and Management Plan must conduct a review, and the conclusion of the review be noted in the patient's record, before a further 6 services may be provided in the case of exceptional circumstances.

'Exceptional circumstances' are defined as a significant change in the patient's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services. It is up to the referring practitioner (e.g GP) to determine that that patient meets these requirements.

Where referrals are provided in exceptional circumstances, both the patient's mental health treatment plan and referral should be annotated to briefly indicate the reason why the allied mental health service involved was required in excess of the 10 services permitted within a calendar year.

Invoices for services provided under exceptional circumstances must state that exceptional circumstances apply.

Out-of-Surgery Consultation
It is expected that this service would be provided only for patients who are unable to attend the practice.

Specific Focussed Psychological Strategies
A range of acceptable strategies has been approved for use by medical practitioners in this context. These are:

1. Psycho-education
(including motivational interviewing)

2. Cognitive-behavioural Therapy including:

- **Behavioural interventions**
  - Behaviour modification
  - Exposure techniques
  - Activity scheduling
- **Cognitive interventions**
  - Cognitive therapy

3. Relaxation strategies
- Progressive muscle relaxation
- Controlled breathing

4. Skills training

- Problem solving skills and training
- Anger management
- Social skills training
- Communication training
- Stress management
- Parent management training

5. Interpersonal Therapy

Mental Disorder

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

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

A.47.. PAIN AND PALLIATIVE MEDICINE (ITEMS 2801 TO 3093)

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

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

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

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

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

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

General Practitioners who are recognised specialist in the specialty of palliative medicine and are treating a referred palliative patient and claiming items 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093 cannot access the GP Management Plan items (721 and 732) or Team Care Arrangement items (723 and 732) for that patient. The referring practitioner is able to provide these services.

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

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

A.48.. TELEPSYCHIATRY - (ITEMS 353 TO 370)

Telepsychiatry is defined as electronic transmission of psychiatric consultations, advice or services in digital form from one location to another using a data communication link provided by a third party carrier, or carriers. It requires the providers to comply with the International Telecommunications Union Standards which cover all types of videoconferencing from massive bandwidth to internet use. If X-rays are required for a psychiatric consultation then the consultant psychiatrist must comply with the DICOM Standards.

Support and Resourcing

The Royal Australian and New Zealand College of Psychiatrists encourages best practice in telepsychiatry and to this end has developed a Telepsychiatry Position Statement. To obtain a copy of this document and/or further information, assistance and support, practitioners are able to contact the College by email cpd@ranzcp.org or by visiting www.ranzcp.org.

Duration of Telepsychiatry Consultation

For items 353 to 358 the **time** provides a range of options equal to those provided in items 300 to 308 to allow for the appropriate treatment depending on the requirements of the treatment plan.

Number of Consultations in a Calendar Year

Items 353 to 358 may only be claimed for up to a maximum of 12 consultations in aggregate for each patient in a calendar year. Items 364 to 370 are to be claimed where face-to-face consultations are clinically indicated. Items 364 to 370 must be used to ensure that Medicare payments continue for further telepsychiatry consultations.

If the number of attendances in aggregate to which items 296 to 299, 300 to 308, 353 to 358 and 361 to 370 apply exceeds 50 for a single patient in any calendar year, any further attendances on that patient in that calendar year would be covered by items 310 to 318.

Documenting the Telepsychiatry Session

For items 353 to 370 the psychiatrist must keep a record of the treatment provided during an episode of care via telepsychiatry sessions or face-to-face consultations and must convey this in writing to the referring practitioner after the first session and then, at a minimum, after every six consultations.

Geographical

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

Referred Patient Assessment and Management Plan review (Item 359)

Referral for item 359 should be through the GP or participating nurse practitioner for the management of patients with mental illness. In the event that a specialist of another discipline wishes to refer a patient for this item the referral should take place through the GP or participating nurse practitioner. Item 359 is available in instances where the GP or participating nurse practitioner initiates a review of the management plan provided under item 291, usually where the current plan is not achieving the anticipated outcome. It is expected that when a plan is reviewed, any modifications necessary will be made.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Referred Patient Assessment and Management Plan Guidelines` (Note: An electronic version of the Guidelines is available on the RANZCP website at www.ranzcp.org)

Initial Consultations for NEW PATIENTS (Item 361)

The rationale for item 361 is to improve access to psychiatric services by encouraging an increase in the number of new patients seen by each psychiatrist, while acknowledging that ongoing care of patients with severe mental illness is integral to the role of the psychiatrist. Referral for item 361 may be from a participating nurse practitioner, medical practitioner practising in general practice, a specialist or another consultant physician. It is intended that item 361 will apply once only for each new patient on the first occasion that the patient is seen by a consultant psychiatrist. It is not generally intended that item 361 will be used in conjunction with, or prior to, item 291.

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

A.49.. ATTENDANCES BY MEDICAL PRACTITIONERS WHO ARE EMERGENCY PHYSICIANS - (ITEMS 501 TO 536)

Items 501 to 536 relate specifically to attendances rendered by medical practitioners who are holders of the Fellowship of the Australasian College for Emergency Medicine (FACEM) and who participate in, and meet the requirements for, quality assurance and maintenance of professional standards by the ACEM.

Items 501 to 511 cover five categories of attendance based largely on the tasks undertaken in a recognised emergency medicine department of a private hospital by the practitioner during the attendance on the patient rather than simply on the time spent with the patient. The emergency department must be part of a hospital and this department must be licensed as an "emergency department" by the appropriate State government authority.

The attendances for items 501 to 515 are divided into five categories relating to the level of complexity, namely:
(i) Level 1
(ii) Level 2
(iii) Level 3
(iv) Level 4
(v) Level 5

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

LEVEL 1
This item is for the obvious and straightforward cases and the practitioner's records would reflect this. In this context "limited examination", means examination of the affected part if required, and management of the action taken.

LEVEL 2
The description of this item introduces the words "expanded problem focussed history" and "formulation and documentation of a diagnosis and management plan in relation to one or more problems". In this context an "expanded problem focussed history" means a history relating to a specific problem or condition; and "formulation and documentation of a management plan" includes formulation of the decision or plan of management and any immediate action necessary such as advising or counselling the patient, ordering tests, or referring the patient to a specialist medical practitioner or other allied health professional. The essential difference between Levels 1 and 2 relate not to time but to complexity.

LEVEL 3
Further levels of complexity are implied in these terms by the introduction of "medical decision making of moderate complexity".

LEVEL 4
This item covers more difficult problems requiring the taking of a "detailed history" and "detailed examination of one or more systems", with or without liaison with other health care professionals and subsequent discussion with the patient, his or her agent and/or relatives.

LEVEL 5
This item covers the difficult problems where the diagnosis is elusive and highly complex, requiring consideration of several possible differential diagnoses, and the making of decisions about the most appropriate investigations and the order in which they are performed. These items also cover cases which need prolonged discussion. It involves the taking of a comprehensive history, comprehensive examination and involving medical decision making of high complexity.

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

A.50.. PROLONGED ATTENDANCE BY AN EMERGENCY PHYSICIAN IN TREATMENT OF A CRITICAL CONDITION - (ITEMS 519 TO 536)

The conditions to be met before services covered by items 519 to 536 attract benefits are:
(i) the patient must be in imminent danger of death ;
(ii) the times relate to the total time spent with a single patient, even if the time spent by the physician is not continuous.

A.51.. CASE CONFERENCES BY CONSULTANT PSYCHIATRISTS - (ITEMS 855 TO 866)

A range of new items has been introduced for case conferences by consultant psychiatrists in community settings and for discharge planning for hospital in-patients. These items are introduced to improve the effectiveness of psychiatric case conferences and make it easier for psychiatrists to work with general practitioners and allied health professionals, thereby ensuring better coordinated care for patients. Three new items (855, 857 and 858) cover the organisation of a community case conference and a further three (861, 864 and 866) cover the organisation of a discharge case conference. Where a consultant psychiatrist organises a case conference a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines. The consultant psychiatrist and one other medical practitioner (other than a specialist or a consultant physician) are counted towards the minimum of three.

Items 855, 857, and 858 apply to a community case conference (including a case conference conducted in a residential aged care facility) organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal. Items 855, 857, and 858 do not apply to an in-patient of a hospital.

For items 861, 864 and 866 a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital. Items 861, 864 or 866 are payable not more than once for each hospital admission.

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

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

For the purposes of items 855 to 866, a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines, each of whom provides a different kind of care or service to the patient, and one of whom must be the patient's usual medical practitioner. The consultant psychiatrist and the medical practitioner are counted toward the minimum of three.
The patient's carer may be included as a member of the team (See A.49.8 below), in addition to the minimum of three health or care providers but do not count towards the minimum of three for Medicare purposes.

For the purposes of items 855 to 866 a consultant psychiatrist should generally be the consultant psychiatrist that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

For the purposes of A.49.5, "formal care provider" includes in addition to the consultant psychiatrist and a medical practitioner (other than a specialist or consultant physician):
- allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dieticians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.
- home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.

The involvement of a patient's carer, such as a friend or family member, in a multidisciplinary case conference team can provide significant benefits in terms of coordination of care for the patient. Where the patient has a carer, the consultant psychiatrist should consider inviting the carer to be an additional member of the multidisciplinary case conference team, with the patient's agreement and where the carer's input is likely to be relevant to the subject matter of the case conference. The involvement of the patient's carer is not counted towards the minimum of three members.

Where the patient's carer is not a member of the multidisciplinary team, the practitioner should involve the carer and provide information to the carer where appropriate and with the patient's agreement. However, the practitioner should take account of the impact of the tasks identified in the case conference on the capacity of the carer to provide support to the patient. Additional responsibilities should not be assigned to the patient's carer without the carer's agreement.

Organisation of a case conference
Organise and coordinate a case conference means undertaking the following activities in relation to a case conference:
- explaining to the patient the nature of a case conference, and asking the patient whether the patient agrees to the case conference taking place; and
- recording the patient's agreement to the case conference; and

- recording the day on which the conference was held, and the times at which the conference started and ended; and
- recording the names of the participants; and
- recording the matters mentioned in A.49.4 and putting a copy of that record in the patient's medical records; and
- offering the patient (and the patient's carer, if appropriate and with the patient's agreement), and giving each other member of the team a summary of the conference; and
- discussing the outcomes of the case conference with the patient.

General requirements
In circumstances where the patient's usual medical practitioner, is not available to be a member of the case conference team, another medical practitioner known to the patient may be substituted.

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

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

In explaining to the patient the nature of a case conference and asking the patient whether he or she agrees to the case conference taking place, the medical practitioner should:
- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers;
- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to or withheld from the other case conference team members; and
- Inform the patient that he or she will incur a charge for the service provided by the practitioner for which a Medicare rebate will be payable.
- Inform the patient of any additional costs he or she will incur. The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. (See General Notes 7.6)

A.52.. CASE CONFERENCE BY CONSULTANT PHYSICIANS IN GERIATRIC/REHABILITATION MEDICINE - (ITEM 880)

Item 880 applies only to a service provided by a consultant physician or a specialist in the specialty of Geriatric or Rehabilitation Medicine who has completed the additional requirements of the Royal Australasian College of Physicians for recognition in the subspecialty of geriatric medicine or rehabilitation medicine. The service must be in relation to an admitted patient in a hospital (not including a patient in a residential aged care facility) who is receiving one of the following types of specialist care:
- geriatric evaluation and management (GEM), in which the clinical intent is to maximise health status and/or optimise the living arrangements for a patient with multidimensional medical conditions with disabilities and psychosocial problems, who is usually (but not always) an older patient; or
- rehabilitation care, in which the clinical intent is to improve the functional status of a patient with an impairment or disability.

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

The specific responsibilities of the coordinating consultant physician or specialist are defined as:
- coordinating and facilitating the multidisciplinary team meeting;
- resolving any disagreement or conflict so that management consensus can be achieved;
- clarifying responsibilities; and
- ensuring that the input of participants and the outcome of the case conference is appropriately recorded.

The multidisciplinary team participating in the case conference must include a minimum of three formal inpatient care providers from different disciplines, including at least two providers from different allied health disciplines (listed at dot point 2 of A24.7). The consultant physician or specialist is counted toward the minimum of three. Although they may attend the case conference, neither the patient nor his or her informal carer, or any other medical practitioner can be counted toward the minimum of three.

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

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

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

A.53.. NEUROSURGERY SPECIALIST REFERRED CONSULTATION - (ITEMS 6007 TO 6015)

Referred consultations provided by specialist neurosurgeons will be covered under items 6007 to 6015. These new items replace the use of specialist items 104 and 105 for referred consultations by neurosurgeons.

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

(i) Level 1 - 6009
(ii) Level 2 - 6011
(iii) Level 3 - 6013
(iv) Level 4 - 6015

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

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

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

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

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

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

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

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

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

- managing adverse neurological outcomes;
- detailed discussion when multiple modalities are available for treatment (e.g. clipping versus coiling for management of a cerebral aneurysm, surgical resection versus radiosurgery for cerebral tumour); or

- discussion where surgical intervention is likely to result in a neurological deficit but surgery is critical to patient's life or to stop progressive neurologic decline (e.g. cranial nerve dysfunction, motor dysfunction secondary to a cerebral or spinal cord lesion).

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

Complex neurosurgical problems referred to in items 6013 and 6015 include:

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

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

A.54.. CANCER CARE CASE CONFERENCE - (ITEMS 871 AND 872)

For the purposes of these items:

- private patients in public or private hospitals or the community with a malignancy of a solid organ or tissue or a systemic cancer such as a leukaemia or lymphoma are covered, with the exception of patients whose only cancer is a non-melanoma skin cancer;
- the billing medical practitioner may be from any area of medical practice and must be a treating doctor of the patient discussed at the case conference. A treating doctor should generally have treated or provided a formal diagnosis of the patient's cancer in the past 12 months or expect to do so within the next 12 months. Attending non-treating clinicians, allied health providers or support staff are not eligible to bill the item.
- only one practitioner is eligible to claim item 871 for each patient case conference. This should be the doctor who assumes responsibility for leading and coordinating the case conference, ensures that records are kept and that the patient is informed of the outcome of the case conference. In most cases this will be the lead treating doctor.
- each billing practitioner must ensure that his or her patient is informed that a charge will be incurred for the case conference for which a Medicare rebate will be payable;
- participants must be in communication with each other throughout the case conference, either face-to-face, or by telephone or video link;
- suitable allied health practitioners would generally be from one of the following disciplines: aboriginal health care worker; asthma educator; audiologist; dental therapist; dentist; diabetes educator; dietician; mental health worker; occupational therapist; optometrist; orthoptist; orthotist or prosthetist; pharmacist; physiotherapist; podiatrist; psychologist; registered nurse; social worker; or, speech pathologist;
- in general, it is expected that no more than two case conferences per patient per year will be billed by a practitioner; and
- cancer care case conferences are for the purpose of developing a cancer treatment plan in a multidisciplinary team meeting and should not be billed against case conference items for other purposes eg community or discharge case conferences.

A.55.. NON-DIRECTIVE PREGNANCY SUPPORT COUNSELLING SERVICE - (ITEM 4001)

Overview

The Pregnancy Support Counselling initiative provides for Medicare benefits to be paid for non-directive pregnancy support counselling services provided to a person who is pregnant or who has been pregnant in the 12 months preceding the first service to which this item or item 81000, 81005 or 81010 applies in relation to that pregnancy, by an eligible medical practitioner (including a general practitioner, but not including a specialist or consultant physician) or allied health professional on referral from a medical practitioner. The term 'GP' is used hereafter as a generic reference to medical practitioners (including a general practitioner, but not including a specialist or consultant physician) able to provide these services.

There are four MBS items for the provision of non-directive pregnancy support counselling services:
Item 4001 – services provided by an eligible GP;
Item 81000 – services provided by an eligible psychologist;
Item 81005 – services provided by an eligible social worker; and
Item 81010 – services provided by an eligible mental health nurse.

This notes relate to provision of a non-directive pregnancy support counselling service by an eligible GP.

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

what the person reveals to them, the counsellor helps them to explore and understand their feelings. With this understanding, the person is able to make the decision which is best for them.

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

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

Patient eligibility
Medicare rebates for non-directive pregnancy support counselling services provided using item 4001 are available to a person who is pregnant or who has been pregnant in the 12 months preceding the first service to which this item or item 81000, 81005 or 81010 applies in relation to that pregnancy.

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

Medicare benefits
Medicare benefits are payable for up to three non-directive pregnancy support counselling services per patient, per pregnancy, from any of the following items - 4001, 81000, 81005 and 81010.

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

Item 10990 or item 10991 can also be claimed in conjunction with item 4001 provided the conditions of the relevant item, 10990 or 10991, are satisfied.

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

A.56.. TELEHEALTH PATIENT-END SUPPORT SERVICES BY HEALTH PROFESSIONALS

These notes provide information on the telehealth MBS attendance items for medical practitioners to provide clinical support to their patients, when clinically relevant, during video consultations with specialists or consultant physicians under items 2100, 2122, 2125, 2126, 2137, 2138, 2143, 2147, 2179, 2195, 2199 and 2220 in Group A30.

Telehealth patient-end support services can only be claimed where:
- a Medicare eligible specialist service is claimed;
- the service is rendered in Australia; and
- where this is necessary for the provision of the specialist service.

A video consultation will involve a single specialist or consultant physician attending to the patient, with the possible participation of another medical practitioner, a participating optometrist, a participating nurse practitioner, a participating midwife, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker at the patient end. The above time-tiered items provide for patient-end support services in various settings including, consulting rooms, other than consulting rooms, eligible residential aged care services and Aboriginal Medical Services.

Clinical indications
The specialist or consultant physician must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist or physician.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Collaborative Consultation
The practitioner, who provides assistance to the patient where this is necessary for the provision of the specialist service, may seek assistance from a health professional (e.g. a practice nurse, Aboriginal or Torres Strait Islander health practitioner or Aboriginal health worker) but only one item is billable for the patient-end support service. The practitioner must be present during part or all of the consultation in order to bill an appropriate time-tiered MBS item. Any time spent by another health professional called to assist with the consultation may not be counted against the overall time taken to complete the video consultation.

Restrictions
The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes Hospital in the Home patients). Benefits are not payable for telephone or email consultations. In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Eligible Geographical Areas
Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are those areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in an eligible residential care service; or at an eligible Aboriginal Medical Service or Aboriginal Community Controlled Health Service for which a direction, made under subsection 19(2) of the Health Insurance Act 1973, as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/ telehealth eligible areas

Record Keeping
Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Multiple attendances on the same day
In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Extended Medicare Safety Net (EMSN)
Items which provide for telehealth patient-end support services are subject to EMSN caps equal to 300% of the schedule fee (to a maximum of $500). This is consistent with Government policy relating to capping EMSN for MBS consultation services.

Aftercare Rule
Video consultations are subject to the same aftercare rules as face to face consultations.

Referrals
The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements
In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a specialist video consultation is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

Bulk billing
Bulk bill incentive items 10990 or 10991 may be billed in conjunction with the telehealth items 2100, 2122, 2125, 2126, 2137, 2138, 2143, 2147, 2179, 2195, 2199 and 2220.

Duration of attendance
The practitioner attending at the patient end of the video consultation does not need to be present for the entire consultation, only as long as is clinically relevant - this can be established in consultation with the specialist. The MBS fee payable for the supporting practitioner will be determined by the total time spent assisting the patient. This time does not need to be continuous.

A.57.. TELEHEALTH SPECIALIST SERVICES

These notes provide information on the telehealth MBS video consultation items by specialists, consultant physicians and psychiatrists. A video consultation involves a single specialist, consultant physician or psychiatrist attending a patient, with the possible support of another medical practitioner, a participating optometrist, a participating nurse practitioner, a participating midwife, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker at the patient end of the video conference. The decision as to whether the patient requires clinical support at the patient end of the specialist service is based on whether the support is necessary for the provision of the specialist service. Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

MBS items numbers 99, 112, 149, 288, 389, 2820, 3015, 6016, 13210, 16399 and 17609 allow a range of existing MBS attendance items to be provided via video conferencing. These items have a derived fee which is equal to 50% of the schedule fee for the consultation item claimed (e.g. 50% of the schedule fee for item 104) when billed with one of the associated consultation items (such as 104). A patient rebate of 85% for the derived fee is payable.

Six MBS item numbers (113, 114, 384, 2799, 3003 and 6004) provide for an initial attendance via videoconferencing by a specialist, consultant physician, consultant occupational physician, pain medicine specialist/consultant physician, palliative medicine specialist/consultant physician or neurosurgeon where the service is 10 minutes or less. The items are stand-alone items and do not have a derived fee.

Where an attendance is more than 10 minutes, practitioners should use the existing item numbers consistent with the current arrangements. Normal restrictions which apply for initial consultations will also apply for these items. For example, if a patient has an initial consultation via telehealth, they cannot also claim an initial face-to-face consultation as part of the same course of treatment.

Clinical indications
The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist, consultant physician or psychiatrist.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Restrictions
The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations. In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Billing Requirements
All video consultations provided by specialists, consultant physicians or psychiatrists must be **separately billed**. That is, only the relevant telehealth MBS consultation item and the associated derived item are to be itemised on the account/bill/voucher. Any other service/item billed should be itemised on a separate account/bill/voucher. This will ensure the claim is accurately assessed as being a video consultation and paid accordingly.

Practitioners should not use the notation ‘telehealth’, ‘verbal consent’ or ‘Patient unable to sign’ to overcome administrative difficulties to obtaining a patient signature for bulk billed claims (for further information see mbsonline.gov.au/telehealth).

Eligible Geographical Areas
Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are those areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in a residential care service; or at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the *Health Insurance Act 1973* as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/ telehealth eligible areas

Record Keeping
Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Extended Medicare Safety Net (EMSN)
All telehealth consultations (with the exception of the participating optometrist telehealth items) are subject to EMSN caps. The EMSN caps for ART and Obstetric telehealth items 13210 and 16399 were set in reference to the EMSN caps applying to the base ART and Obstetric consultation items.

The EMSN caps for all other telehealth consultation items are equal to 300% of the schedule fee (to a maximum of $500). The maximum EMSN benefit for a telehealth consultation is equal to the sum of the EMSN cap for the base item and the EMSN cap for the telehealth items.

Aftercare Rule
Video consultations are subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple attendances on the same day
In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Referrals
The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements
In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

A.58.. AUSTRALIAN DEFENCE FORCE POST-DISCHARGE GP HEALTH ASSESSMENT

Items 701, 703, 705 and 707 may be used to undertake a health assessment for a former serving member of the Australian Defence Force, including a former member of permanent and reserve forces.

A health assessment for a former serving member of the Australian Defence Force is an assessment of:
(a) a patient's physical and psychological health and social function; and
(b) whether health care, education and other assistance should be offered to the patient to improve their physical, psychological health or social function.

This health assessment must include:
(a) a personal attendance by a medical practitioner; and
(b) taking the patient's history, including the following:
    i. the patient's service with the Australian Defence Force, including service type, years of service, field of work, number of deployments and reason for discharge;
    ii. the patient's social history, including relationship status, number of children (if any) and current occupation;
    iii. the patient's current medical conditions;

iv. whether the patient suffers from hearing loss or tinnitus;
v. the patient's use of medication, including medication prescribed by another doctor and medication obtained without a prescription;
vi. the patient's smoking, if applicable;
vii. the patient's alcohol use, if applicable;
viii. the patient's substance use, if applicable;
ix. the patient's level of physical activity;
x. whether the patient has bodily pain;
xi. whether the patient has difficulty getting to sleep or staying asleep;
xii. whether the patient has psychological distress;
xiii. whether the patient has posttraumatic stress disorder;
xiv. whether the patient is at risk of harm to self or others;
xv. whether the patient has anger problems;
xvi. the patient's sexual health;
xvii. any other health concerns the patient has.

The assessment must also include the following:

i. measuring the patient's height;
ii. weighing the patient and ascertaining, or asking the patient, whether the patient's weight has changed in the last 12 months;
iii. measuring the patient's waist circumference;
iv. taking the patient's blood pressure;
v. using information gained in the course of taking the patient's history to assess whether any further assessment of the patient's health is necessary;
vi. either making the further assessment or referring the patient to another medical practitioner who can make the further assessment;
vii. documenting a strategy for improving the patient's health;
viii. offering to give the patient a written report of the assessment that makes recommendations for treating the patient including preventive health measures;
ix. keeping a record of the assessment.

A medical practitioner may use the 'ADF Post-discharge GP Health Assessment Tool' as a screening tool for the health assessment. This assessment tool can be viewed on the At Ease portal of the Department of Veterans' Affairs' website at: http://at-ease.dva.gov.au. Other assessment tools mentioned in the Department of Veteran's Affairs Mental Health Advice Book may be relevant and can also be viewed on the At Ease portal.

This health assessment may only be claimed once by an eligible patient.

The health assessment must not be performed in conjunction with a separate consultation in relation to the patient unless the consultation is clinically necessary.

The health assessment must be performed by the patient's usual doctor.

O.1.. BENEFITS FOR SERVICES BY PARTICIPATING OPTOMETRISTS

All Australian residents and certain categories of visitors to Australia can claim Medicare benefits for services by participating optometrists. The *Health Insurance Act 1973* contains legislation covering the major elements of the Medicare program.

Responsibility for regulating the Medicare program lies with the Australian Government through the Department of Health. The Department of Human Services is responsible for consideration of applications for the acceptance of the Common Form of Undertaking for Participating Optometrists and for the day to day operation of Medicare and the payment of benefits.

O.2.. PARTICIPATION BY OPTOMETRISTS

Medicare pays benefits for services provided by optometrists who have signed an agreement to participate in arrangements with the Commonwealth Government. This agreement is formally known as the "Common Form of Undertaking for Participating Optometrists" and is often referred to as the 'Participating Agreement' or the 'Undertaking'.

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

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

The Undertaking sets out the obligations to be met under the arrangements. Copies of the Undertaking may be obtained from the Department of Health website at http://www.health.gov.au/internet/main/publishing.nsf/Content/optometry, or the Department of Human Services website www.humanservices.gov.au or by calling 132 150 (charges may apply).

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

When completed, the Undertaking should be returned to the Department of Human Services at:

Manager
Provider Eligibility and Accreditation Section
Medicare and Veterans Branch
The Department of Human Services
PO Box 1001
Tuggeranong ACT 2901.

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

After acceptance by the Minister, or his delegate, of the completed Undertaking, a letter of acceptance of the Undertaking will be forwarded to the optometrist.

The Manager (Provider Eligibility and Accreditation Section) must be notified in writing of any changes to the details furnished by an optometrist in schedule 2 and schedule 3 of the Undertaking.

Participating optometrists may at any time terminate Undertakings either wholly or as they relate to particular premises, by notifying:

Manager
Provider Eligibility and Accreditation Section
Medicare and Veterans Branch
The Department of Human Services
PO Box 1001
Tuggeranong ACT 2901.

The date of termination may not be earlier than 30 days after the day on which the notice is served.

O.3.. PROVIDER NUMBERS

To ensure that benefits are paid only for services provided by optometrists registered with the Optometry Board of Australia, each optometrist providing services for which a Medicare benefit is payable requires an individual provider number.

Provider numbers will be issued only to registered optometrists. Corporations, other business entities and individuals who are not registered optometrists will not be issued with provider numbers.

Provider numbers are allocated to enable claims for Medicare benefits to be processed. The number may be up to eight characters. The second last character identifies the practice location, the last being a check character.

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

Locum Tenens
An optometrist who has signed an Undertaking and is to provide services at a practice location as a locum for more than two weeks or will return to the practice on a regular basis for short periods should apply for a provider number for that location.

If the locum is to provide services at a practice for less than two weeks, the locum can use their own provider number or can obtain an additional provider number for that location.

Normally, Medicare benefits are payable for services rendered by an optometrist only when the optometrist has completed an Undertaking. However, benefits may be claimed for services provided by an optometrist who has not signed the Undertaking if the optometrist has provided them on behalf of an optometrist who has signed the Undertaking.

To ensure benefits are payable when a locum practises in these circumstances, the locum optometrist should:

- Check that they will be providing optometry services on behalf of a participating optometrist i.e. their employer has a current Undertaking.
- Complete the Schedule which is available on the Department of Human Services' website http://www.humanservices.gov.au/, before commencing the locum arrangement of the name and address of the participating optometrist on whose behalf they will be providing services.

Locums can direct Medicare payments to a third party, for example the principal of the practice, by either arranging a pay group link and/or by nominating the principal as the payee provider on bulk-bill stationery.

O.4.. PATIENT ELIGIBILITY

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.

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 (RHCA) receive a card bearing the words "RECIPROCAL HEALTH CARE".

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

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

Visitors from these countries are entitled to medical treatment while they are in Australia, comprising public hospital care (as public patients), Medicare benefits for out of hospital services and drugs under the Pharmaceutical Benefits Scheme (PBS). Visitors must enrol 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 only, 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. Visitors from New Zealand and the Republic of Ireland are NOT entitled to optometric treatment under a RHCA.

O.5.. BENEFITS FOR SERVICES BY PARTICIPATING OPTOMETRISTS

What services are covered?

The *Health Insurance Act 1973* stipulates that Medicare benefits are payable for professional services .The professional services coming within the scope of the optometric benefit arrangements are those clinically relevant services ordinarily rendered by the optometrist in relation to a consultation on ocular or vision problems or related procedures. *The Health Insurance Act 1973* defines a 'clinically relevant service' as a service rendered by an optometrist that is generally accepted in the optometrical profession as being necessary for the appropriate treatment of the patient to whom it is rendered.

From 1 January 2015, optometrists will be free to set their own 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. 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. Where it is necessary for the optometrist to seek patient information from the Department of Human Services in order to determine appropriate itemisation of accounts, receipts or bulk-billed claims, the optometrist must ensure that:

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

Benefits may only be claimed when:

(a) a service has been performed and a clinical record of the service has been made;
(b) a significant consultation or examination procedure has been carried out;
(c) the service has been performed at premises to which the Undertaking relates;
(d) the service has involved the personal attendance of both the patient and the optometrist; and
(e) the service is "clinically relevant" (as defined in the *Health Insurance Act 1973*).

Where Medicare benefits are not payable

Medicare benefits may not be claimed for attendances for:

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

Benefits are not payable for optometric services associated with:

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

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

(a) where the expenses for the service are paid or payable to a recognised (public) hospital;
(b) an attendance on behalf of teaching institutions on patients of supervised students of optometry;
(c) where the service is not "clinically relevant" (as defined in the *Health Insurance Act 1973).*

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

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

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

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

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

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.

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.

O.6.. SCHEDULE FEES AND MEDICARE BENEFITS

Medicare benefits are based on fees determined for each optometrical service. The services provided by participating optometrists which attract benefits are set out in the *Health Insurance (General Medical Services Table) Regulations* (as amended).

If the fee is greater than the Medicare benefit, optometrists participating in the scheme are to inform the patient of the Medicare benefit payable for the item, at the time of the consultation and that the additional fee will not attract benefits.

Medicare benefits are payable at 85% of the Schedule fee for services rendered.

Medicare Safety Nets
The Medicare safety net provides 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 (EMSN).

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.

Under the 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 at www.mbsonline.gov.au.

The thresholds for the Medicare safety nets are 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 of 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 at www.humanservices.gov.au. If you have already registered it is important to ensure your details are up to date.

Further information on the Medicare safety nets is available at
http://www.humanservices.gov.au/customer/services/medicare/medicare-safety-net..

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

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

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

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

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

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

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

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

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

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

Single Course of Attention
A reference to a single course of attention means:
(a) In the case of items 10905 to 10918, and old item 10900 - a course of attention by one or more optometrists in relation to a specific episode of optometric care.
(b) In relation to items 10921 to 10930 - a course of attention, including all associated attendances, by one or more optometrists for the purpose of prescribing and fitting of contact lenses. This includes those after-care visits necessary to ensure the satisfactory performance of the lenses.

Referred comprehensive initial consultations (item 10905) - Read in conjunction with 08 Referrals
For the purposes of item 10905, the referring optometrist, having considered the patient's need for the referred consultation, is required to provide a written referral, dated and signed, and setting out the patient's condition and the reason for the referral.

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

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

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

Second comprehensive initial consultation, within 36 months for a patient who is less than 65 years of age and once every 12 months for a patient who is at least 65 years of age, of a previous comprehensive consultation (item 10907)
A patient can receive a comprehensive initial consultation by another optometrist within 36 months if the patient is less than 65 years of age, and once every 12 months if the patient is at least 65 years of age, if the patient has attended another optometrist for an attendance to which item 10905, 10907, 10910, 10911, 10912, 10913, 10914 or 10915 applies, or old item 10900 applied.

Comprehensive initial consultations (items 10910 and 10911)
There are two new MBS items for comprehensive initial consultation that have been introduced. Item 10910 has been introduced for a professional attendance of more than 15 minutes for a patient who is less than 65 years of age. This item is payable once only within a 36 month period, and if the patient has not received a service in this timeframe to which item 10905, 10907, 10910, 10912, 10913, 10914 or 10915 applies, or old item 10900 applied.

Item 10911 has been introduced for a professional attendance of more than 15 minutes for a patient who is at least 65 years of age. This item is payable once only within a 12 month period, and if the patient has not received a service in this timeframe to which item 10905, 10907, 10910, 10911, 10912, 10913, 10914 or 10915 applies, or old item 10900 applied.

However, a benefit is payable under item 10912, 10913, 10914 or 10915 where the patient has an ocular condition which necessitates a further course of attention being started within 36 months for a patient who is less than 65 years of age (item 10910) and within 12 months for a patient who is at least 65 years of age (item 10911) of the previous initial consultation. The conditions which qualify for a further course of attention are contained in the descriptions of these items.

Where an attendance would have been covered by item 10905, 10907, 10910, 10911, 10912, 10913, 10914, or 10915 but is of 15 minutes duration or less, item 10916 (Short consultation) applies.

Significant change in visual function requiring comprehensive re-evaluation (item 10912)
Significant changes in visual function which justify the charging of item 10912 could include documented changes of:

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

New signs or symptoms requiring comprehensive re-evaluation (item 10913)
When charging item 10913 the optometrist should document the new signs or symptoms suffered by the patient on the patient's record card.

Progressive disorder requiring comprehensive re-evaluation (item 10914)
When charging item 10914, the optometrist should document the nature of the progressive disorder suffered by the patient on the patient's record card. Progressive disorders may include conditions such as maculopathy (including age related maculopathy) cataract, corneal dystrophies, glaucoma etc.

Examination of the eyes of a patient with diabetes mellitus (item 10915)
Where an examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus is being conducted, where possible this item should be billed rather than item 10914 to assist in identifying whether such patients are receiving appropriate eye care.

Second or subsequent consultations (item 10918)
Each consultation, apart from the initial consultation, in a single course of attention, other than a course of attention involving the fitting and prescription of contact lenses, is covered by item 10918.

Contact lens consultations (items 10921 to 10930)
In the case of contact lens consultations, benefit is payable only where the patient is one of the prescribed classes of patient entitled to benefit for contact lens consultations as described in items 10921 to 10929.

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

Medicare benefits are not payable for item 10929 in circumstances where a patient wants contact lenses for:
(a) reasons of appearance (because they do not want to wear spectacles);
(b) sporting purposes;
(c) work purposes; or
(d) psychological reasons (because they cannot cope with spectacles).

All attendances subsequent to the initial consultation in a course of attention involving the prescription and fitting of contact lenses are collectively regarded as a single service under items 10921 to 10930, as appropriate. The date of service is deemed to be the date on which the contact lenses are delivered to the patient. In some cases, where the patient decides not to proceed with contact lenses, no Medicare fee is payable because the patient has not taken delivery of the lenses. In such instances, the patient may be charged a non-rebatable (private) fee for a 'part' service. Any visits related to the prescribing and fitting of lenses are regarded to be covered by the relevant item in the range 10921 to 10930. The bulk

item includes those aftercare visits necessary to ensure the satisfactory performance of the lenses. This interpretation is unaltered by the frequency of aftercare visits associated with various lens types including extended wear lenses.

Consultations during the aftercare period that are unrelated to the prescription and fitting of contact lenses or that are not part of normal aftercare may be billed under other appropriate items (not items 10921 to 10930).

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

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

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

Benefit under items 10921 to 10929 is payable once only in any period of 36 consecutive months except where circumstances are met under item 10930 within a 36 month period.

Domiciliary visits (items 10931 – 10933)
Where patients are unable to travel to an optometrist's practice for treatment, and where the request for treatment is initiated by the patient, a domiciliary visit may be conducted, which involves the optometrist travelling to the patient's place of residence, and transporting the necessary equipment. Where possible, it is preferable that the patient travel to the practice so that the full range of equipment is available for the examination of the patient.

Benefits are payable under items 10931 – 10933 to provide some financial assistance in the form of a loading to the optometrist, in recompense for travel costs and packing and unpacking of equipment. The loading is in addition to the consultation item. For the purposes of the loading, acceptable places of residence for domiciliary visits are:

- the patient's home;
- a residential aged care facility as defined by the *Aged Care Act 1997;* or
- an institution which means a place (other than a residential aged care facility or hospital) at which residential accommodation and/or day care is made available to any of the following categories: disadvantaged children, juvenile offenders, aged persons, chronically ill psychiatric patients, homeless persons, unemployed persons, persons suffering from alcoholism, persons addicted to drugs, or physically or intellectually disabled persons.

Visits to a hospital at the patient's request are not covered by the loading and instead, an extra fee in addition to the Schedule fee can be charged, providing the service is not bulk-billed. Medicare benefits are not payable in respect of the private charge.

Items 10931 – 10933 may be used whether or not the optometrist chooses to bulk-bill but it is important that if the consultation is bulk-billed the loading is also, and no private charge can then be levied. If the consultation is not bulk-billed, the loading should also not be bulk-billed and a private charge may be levied. The usual requirement that the patient must have requested the domiciliary visit applies.

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

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

Where a private charge is levied for a domiciliary visit, bulk-billing is precluded. Medicare benefits are not payable in respect of the private charge and the patient should be informed of this. Private charges should be shown separately on

accounts issued by optometrists and must not be included in the fees for the service. Domiciliary visit loading items cannot be claimed in conjunction with brief initial consultation item 10916, or with computerised perimetry items 10940 or 10941.

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

These items can be billed either in association with comprehensive consultation items 10905, 10907, 10910, 10911, 10912, 10913, 10914, or 10915, or independently, but they cannot be billed with items 10916, 10918, 10931, 10932 or 10933. An assessment and report is required and, where referral to an ophthalmologist for further treatment is required, the printed results of the perimetry should be provided to the ophthalmologist to discourage repetition of perimetry unless clinically necessary. If Medicare benefits are to be claimed, a maximum of two perimetry services in any twelve month period may be provided.

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

Item 10942 may be claimed on the same day as either a comprehensive initial consultation (items 10905 – 10915) or a subsequent consultation (item 10918), but only where the additional low vision testing has been carried out on an eligible patient. Item 10942 is not intended to be claimed with a brief initial consultation (item 10916), or with any of the contact lens items (items 10921-10930).

Children's vision assessment (item 10943)
Children aged 0 to 2 years, and 15 years and over, are not eligible for item 10943 and may be treated under appropriate attendance items.

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

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

Item 10943 may be claimed on the same day as either a comprehensive consultation (items 10905 – 10915) or a subsequent consultation (item 10918), but only where the additional assessment/testing has been carried out on an eligible child. Item 10943 is not intended to be claimed with a brief initial consultation (item 10916), or with any of the contact lens items (items 10921-10930).

Removal of an embedded corneal foreign body (item 10944)
Item 10944 has been introduced for the complete removal of an embedded corneal foreign body that is sub-epithelial or intra-epithelial and the removal of rust rings from the cornea.

The removal of an embedded foreign body should be performed using a hypodermic needle, foreign body gouge or similar surgical instrument, with magnification provided by a slit lamp biomicroscope, loupe or similar device.

The optometrist should document the nature of the embedded foreign body (sub-epithelial or intra-epithelial), method of removal and the magnification. Similarly, with rust ring removal, the optometrist should document the method of removal and the magnification.

Where complexity of the procedure is beyond the skill of the optometrist, or if other complications are present (e.g. globe perforation, penetration >25%, or patient unable to hold still due to pathological anxiety, nystagmus, or tremor etc, without some form of systemic medication), the patient should be referred to an ophthalmologist.

This item cannot be billed on the same occasion as items 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915, 10916 or 10918. If the embedded foreign body or rust ring has not been completely removed, benefits are only payable under item 10916.

O.7.. BILLING PROCEDURES

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

(a) the claimant may pay the optometrist's account in full and then claim benefits from the Department of Human Services office by submitting the account and the receipt;

(b) the claimant may submit the unpaid account to the Department of Human Services who will then send a cheque in favour of the optometrist, to the claimant; or

(c) the optometrist may bill Medicare instead of the patient for the consultation. This is known as bulk billing. If an optometrist direct-bills, they undertake to accept the relevant Medicare benefit as full payment for the consultation. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient.

Claiming of benefits

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

Paid accounts

If the account has been paid in full a claimant can claim Medicare benefits in a number of ways:

- Electronically if the claimant's doctor offers this service and the claimant has completed and lodged a Bank account details collection form with Medicare.
- Online through Medicare Online Services.
- At the claimant's local Department of Human Services Service Centre.
- By mail by sending a completed Medicare claim form with the original accounts and/or receipts to:

  Department of Human Services
  GPO Box 9822
  In the claimant's capital city

- Over the phone by calling 132 011 and giving the claim details and then sending the accounts and/or receipts to:

  Telephone Claiming
  Department of Human Services
  GPO Box 9847
  In the claimant's capital city

Practitioners seeking information regarding registration to allow EFT payments and other E-Business transactions, can do so by viewing the Health Professionals section at the Department of Human Services at www.humanservices.gov.au.

Unpaid accounts

Where the patient has not paid the account in full, the unpaid account may be presented to the Department of Human Services with a completed Medicare claim form. In this case the Department of Human Services will forward to the claimant a benefit cheque made payable to the optometrist.

It is the patient's responsibility to forward the cheque to the optometrist and make arrangements for payment of the balance of the account, if any. "Pay optometrist" cheques involving Medicare benefits must (by law), not be sent direct to optometrists, or to the claimant at an optometrist's address (even if requested by the claimant to do so). "Pay optometrist" cheques are required to be forwarded to the claimant's last known address as recorded with the Department of Human Services.

When issuing a receipt to a patient for an account that is being paid wholly or in part by a Medicare "pay optometrist" cheque the optometrist should indicate on the receipt that a "Medicare cheque for $..... was involved in the payment of the account". The receipt should also include any money paid by the claimant or patient.

Itemised accounts

When an optometrist bills a patient for a service, the patient should be issued with a correctly itemised account and receipt to enable the patient to claim Medicare benefits. Where both a consultation and another service, for example computerised perimetry occur, these may be itemised on the same account.

Medicare benefits are only payable in respect of optometric services where it is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of each service to each patient, the following information:

(a) patient's name;

(b) date on which the service(s) was rendered;

(c) a description of the service(s) (e.g. "initial consultation," "subsequent consultation" or "contact lens consultation"and/or "computerised perimetry" in those cases where it is performed);

(d) Medicare Benefits Schedule item number(s);

(e) the name and practice address or name and provider number of the optometrist who actually rendered the service(s). Where the optometrist has more than one practice location, the provider number used should be that which is applicable to the practice location where the service(s) was given;
(f) the fee charged for the service(s); and
(g) the time each service began if the optometrist attended the patient on more than one occasion on the same day and on each occasion rendered a professional service relating to an optometric item, except where a perimetry item is performed in association with a consultation item, where times do not need to be specified.

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

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

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

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

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

Assignment of benefit (bulk billed) arrangements
Under the *Health Insurance Act 1973* an Assignment of Benefit (bulk-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need.

If an optometrist bulk-bills, they undertake to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:

- the patient's Medicare number must be quoted on all bulk-bill assignment of benefit forms for that patient;
- the assignment of benefit forms provided are loose leaf to enable the patient details to be imprinted from the Medicare Card;
- the forms include information required by Regulations under Section 19(6) of the *Health Insurance Act 1973*; and
- the optometrist must cause the particulars relating to the professional service to be set out on the assignment of benefit form, before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it.

Where a patient is unable to sign the assignment of benefit form, the signature of the patient's parent, guardian or other responsible person (other than the optometrist, optometrist’s staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff)) is acceptable.

Where the signature space is either left blank or another person signs on the patient's behalf, the form **must** include:

- the notation “Patient unable to sign” and
- in the section headed 'Practitioner's Use', an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand etc.) and this note should be signed or initialled by the optometrist. If in the opinion of the optometrist the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

Use of Medicare cards in bulk-billing
Where a patient presents without a Medicare card and indicates that they have been issued with a card but does not know the details, the optometrist may contact the Department of Human Services on 132 150 to obtain the number.

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

Assignment of benefit forms
Only the approved assignment of benefit forms available from the Department of Human Services website, www.humanservices.gov.au, can be used to bulk-bill patients for optometric services and no other form can be used without its approval.

(a) **Form DB2-OP**
This form is designed for the use of optical scanning equipment and is used to assign benefits for optometrical services. It is loose leaf to enable imprinting of patient details from the Medicare card and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy.

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

The Claim for Assigned Benefits (Form DB1N, DB1H)
Optometrists who accept assigned benefits must claim from the Department of Human Services using either Claim for Assigned Benefits form DB1N or DB1H. The DB1N form should be used where services are rendered to persons for treatment provided out of hospital or day hospital treatment. The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than public patients). Both forms have been designed to enable benefit for a claim to be directed to an optometrist other than the one who rendered the services. The facility is intended for use in situations such as where a short term locum is acting on behalf of the principal optometrist and setting the locum up with a provider number and pay-group link for the principal optometrist's practice is impractical. Optometrists should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.

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

Time limits applicable to lodgement of bulk bill claims for benefits
A time limit of two years applies to the lodgement of claims with the Department of Human Services under the bulk billed (assignment of benefits) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than two years earlier than the date the claim was lodged with the Department of Human Services.

Provision exists whereby in certain circumstances (e.g. hardship cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the Department of Human Services website at www.humanservices.gov.au or the processing centre to which bulk-bill claims are directed.

O.8.. REFERRALS (READ IN CONNECTION WITH THE RELEVANT PARAGRAPHS AT O.6)

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

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

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

A referral letter or note must have been issued by the optometrist for all such services provided by specialist ophthalmologists or optometrists in order for patients to be eligible for Medicare benefits at the referred rate. Unless such a letter or note has been provided, benefits will be paid at the non-referred attendance rate, which has a lower rebate..

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

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

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

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

The exceptions to the requirements in the above paragraph are that:
(a) sub-paragraphs (b) and (c) do not apply to an emergency situation where the specialist ophthalmologist was of the opinion that the service be rendered as quickly as possible (see paragraph below on emergency situations); and
(b) sub-paragraph (c) does not apply to instances where a written referral was completed by a referring optometrist but was lost, stolen or destroyed.

Period for which referral is valid
A referral from an optometrist to an ophthalmologist is valid for twelve months unless the optometrist specifies on the referral that the referral is for a different period (e.g. three, six or eighteen months or valid indefinitely).

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

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

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

A new course of treatment for which Medicare benefits would be payable at the initial consultation rates will also be paid where the referring optometrist:
(a) deems it necessary for the patient's condition to be reviewed; and
(b) the patient is seen by the ophthalmologist outside the currency of the previous referral; and
(c) the patient was last seen by the specialist ophthalmologist more than nine months earlier than the attendance following a new referral.

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

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 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.

Emergency situations
Medicare benefits are payable even though there is no written referral in an emergency situation (as defined in the *Health Insurance Regulations 1975*). The specialist or the consultant physician should be of the opinion that the service must be rendered as quickly as possible and endorses the account, receipt or assignment form as an "Emergency referral".

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

O.9.. PROVISION FOR REVIEW OF THE SCHEDULE

Optometric Benefits Consultative Committee (OBCC)
The OBCC is an advisory committee established in 1990 by arrangement between the Minister and Optometry Australia.

The OBCC's functions are:
(a) to discuss the appropriateness of existing Medicare Benefits Schedule items for the purposes of considering whether an approach to the Medical Services Advisory Committee may be needed;
(b) to undertake reviews of particular services and to report on the appropriateness of the existing structure of the Schedule, having regard to current optometric practice;
(c) to consider and advise on the appropriateness of the participating optometrists' arrangements and the Common Form of Undertaking (as specified in the *Health Insurance Act 1973* and related legislation) and the administrative rules and interpretations which determine the payment of benefits for optometric services or the level of benefits;
(d) to investigate specific matters associated with the participating optometrists' arrangements and to advise on desirable changes.

The OBCC comprises two representatives from the Department of Health, two representatives from the Department of Human Services, and three representatives from Optometry Australia.

O.10.. PROVISION FOR REVIEW OF PRACTITIONER BEHAVIOUR

Professional Services Review (PSR) Scheme
The Professional Services Review (PSR) Scheme is a scheme for reviewing and investigating the provision of services by a health practitioner to determine whether the practitioner has engaged in inappropriate practice in the rendering or initiating of Medicare services or in prescribing under the Pharmaceutical Benefits Scheme (PBS). 'Practitioner' is defined in Section 81 of the *Health Insurance Act 1973* and includes: medical practitioners, dentists, optometrists, chiropractors, midwives, nurse practitioners, physiotherapists, podiatrists and osteopaths.

Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude that it would be unacceptable to the general body of the members of the profession in which the practitioner was practising when he or she rendered or initiated the services. It is also an offence under Section 82 for a person who is an officer of a body corporate to knowingly, recklessly or negligently cause or permit a practitioner employed by the person to engage in such conduct.

The Department of Human Services monitors health practitioners' claiming patterns. Where an anomaly is detected, for which a satisfactory explanation cannot be provided, the Department of Human Services can request that the Director of PSR review the provision of services by the practitioner. On receiving the request, the Director must decide whether to conduct a review and in which manner the review will be conducted. The Director is authorised to require that documents and information be provided.

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

A PSR Committee consists of the Chairperson and two other panel members who must be members of the same profession as the practitioner under review. However, up to two additional Committee members may be appointed to provide a wider range of clinical expertise.

The Committee is authorised to:
(a) 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;
(b) hold hearings and require the person under review to attend and give evidence; and
(c) require the production of documents (including clinical notes).

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. 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 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 on the Professional Services Review is available at www.psr.gov.au and information on Medicare compliance is available at http://www.humanservices.gov.au/health-professionals/subjects/compliance?utm_id=9.

Penalties
Penalties of up to $10,000 or imprisonment for up to five years, or both may be imposed on any person who makes a statement (either orally or in writing) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used with a claim for benefits. In addition, any practitioner who is found guilty of such offences shall be subject to examination by a Medicare Participation Review Committee (MPRC) 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 an assignment of benefit form without necessary details having been entered on the form before the patient signs or who fails to cause a patient to be given a copy of the completed form.

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; or
(b) has been found to have engaged in inappropriate practice under the Professional Services Review scheme.

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).

O.11.. VISITING OPTOMETRISTS SCHEME (VOS)

Special arrangements exist under the provisions of Section 129A of the Health Insurance Act 1973 to ensure that people in rural and remote locations have access to optometry services. Optometrists are encouraged to provide outreach services to national priority locations, particularly remote and very remote locations, Aboriginal and Torres Strait Islander communities and rural locations with an identified need for optometry services.

Under these arrangements, financial assistance may be provided to cover costs associated with delivering outreach services, including travel, accommodation and meals and facility fees.

Funding agreements are currently in place with optometrists for the delivery of services until 30 June 2015. Details of locations receiving services are available at www.ruralhealthaustralia.gov.au. Enquiries can be directed to vos@health.gov.au.

O.12.. TELEHEALTH PATIENT-END SUPPORT SERVICES BY PARTICIPATING OPTOMETRISTS

These notes provide information on the telehealth MBS attendance items for participating optometrists to provide clinical support to their patients, when clinically relevant, during video consultations with ophthalmologists under items 10945, 10946, 10947 and 10948 in Group A10.

Telehealth patient-end support services can only be claimed where:

- a Medicare eligible specialist service is claimed;
- the service is rendered in Australia; and
- this is necessary for the provision of the specialist service.

A video consultation will involve a single participating optometrist attending to the patient, with the possible participation of another medical practitioner, a participating nurse practitioner, a participating midwife, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker at the patient end. The above time-tiered items provide for patient-end support services in various settings, including consulting rooms, other than consulting rooms, eligible residential aged care services and Aboriginal Medical Services.

Clinical indications

The ophthalmologist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the ophthalmologist.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Collaborative Consultation

The participating optometrist, who provides assistance to the patient where this is necessary for the provision of the specialist service, may seek assistance from a health professional (e.g. a medical practitioner, practice nurse, Aboriginal or Torres Strait Islander health practitioner or Aboriginal health worker) but only one item is billable for the patient-end support service. The participating optometrist must be present during part or all of the consultation in order to bill an appropriate time-tiered MBS item. Any time spent by another health professional called to assist with the consultation may not be counted against the overall time taken to complete the video consultation.

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes Hospital in the Home patients). Benefits are not payable for telephone or email consultations. In order to fulfil the item descriptor there must be a visual and audio link between the patient and the ophthalmologist. If the ophthalmologist is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Eligible Geographical Areas

Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are areas that are outside a Major City (RA1) according to ASGC-RA (RA2 – 5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference. This rule will not apply to specialist video consultations with patients who are a care recipient in an eligible residential care service; or at an eligible Aboriginal Medical Service or Aboriginal Community Controlled Health Service for which a direction, made under subsection 19(2) of the *Health Insurance Act 1973*, as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at:
http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/connectinghealthservices-eligible-geo.

Record Keeping

Participating telehealth optometrists must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Multiple attendances on the same day
In some situations a patient may receive a telehealth consultation and a face-to-face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Also, if a patient has an initial consultation via telehealth, they cannot also claim an initial face-to-face consultation as part of the same course of treatment.

Aftercare Rule
Video consultations are subject to the same aftercare rules as face-to-face consultations.

Referrals
The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements
In order to fulfil the item descriptor there must be a visual and audio link between the patient and the ophthalmologist. If the ophthalmologist is unable to establish both a video and audio link with the patient, a MBS rebate for a specialist video consultation is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

Duration of attendance
The participating optometrist attending at the patient end of the video consultation does not need to be present for the entire consultation, only as long as is clinically relevant — this can be established in consultation with the ophthalmologist. The MBS fee payable for the supporting participating optometrist will be determined by the total time spent assisting the patient. This time does not need to be continuous.

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.

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

Higher rates of benefits are also provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons).

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.

1. FEES AND BENEFITS FOR GP ATTENDANCES AT A RESIDENTIAL AGED CARE FACILITY

LEVEL A - ITEM 20		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PER PATIENT)
ONE	63.65	63.65
TWO	40.30	40.30
THREE	32.50	32.50
FOUR	28.60	28.60
FIVE	26.30	26.30
SIX	24.75	24.75
SEVEN	20.25	20.25

LEVEL B - ITEM 35		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PER PATIENT)
ONE	83.75	83.75
TWO	60.40	60.40
THREE	52.60	52.60
FOUR	48.70	48.70
FIVE	46.40	46.40
SIX	44.85	44.85
SEVEN	40.35	40.35

LEVEL C - ITEM 43		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PER PATIENT)
ONE	118.40	118.40
TWO	95.05	95.05
THREE	87.25	87.25
FOUR	83.35	83.35
FIVE	81.05	81.05
SIX	79.50	79.50
SEVEN	75.00	75.00

LEVEL D - ITEM 51		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PER PATIENT)
ONE	152.25	152.25
TWO	128.90	128.90
THREE	121.10	121.10
FOUR	117.20	117.20
FIVE	114.90	114.90
SIX	113.35	113.35
SEVEN	108.85	108.85

2. FEES AND BENEFITS FOR OTHER NON-REFERRED ATTENDANCES AT A RESIDENTIAL AGED CARE FACILITY

BRIEF - ITEM 92		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PER PATIENT)
ONE	36.45	36.45
TWO	22.45	22.45
THREE	17.80	17.80
FOUR	15.50	15.50
FIVE	14.10	14.10
SIX	13.15	13.15
SEVEN	9.75	9.75

STANDARD - ITEM 93		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PER PATIENT)
ONE	47.55	47.55
TWO	31.75	31.75
THREE	26.50	26.50
FOUR	23.90	23.90
FIVE	22.30	22.30
SIX	21.25	21.25
SEVEN	17.25	17.25

LONG - ITEM 95		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PER PATIENT)
ONE	63.45	63.45
TWO	49.45	49.45
THREE	44.80	44.80
FOUR	42.50	42.50
FIVE	41.10	41.10
SIX	40.15	40.15
SEVEN	36.75	36.75

PROLONGED - ITEM 96		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PER PATIENT)
ONE	85.45	85.45
TWO	71.45	71.45
THREE	66.80	66.80
FOUR	64.50	64.50
FIVE	63.10	63.10
SIX	62.15	62.15
SEVEN	58.75	58.75

AFTER HOURS ATTENDANCES

3. FEES AND BENEFITS FOR GP ATTENDANCES AT A RESIDENTIAL AGED CARE FACILITY

LEVEL A - ITEM 5010		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	75.70	75.70
TWO	52.35	52.35
THREE	44.55	44.55
FOUR	40.65	40.65
FIVE	38.35	38.35
SIX	36.80	36.80
SEVEN	32.30	32.30

LEVEL B - ITEM 5028		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	95.70	95.70
TWO	72.35	72.35
THREE	64.55	64.55
FOUR	60.65	60.65
FIVE	58.35	58.35
SIX	56.80	56.80
SEVEN	52.30	52.30

LEVEL C - ITEM 5049		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	130.65	130.65
TWO	107.30	107.30
THREE	99.50	99.50
FOUR	95.60	95.60
FIVE	93.30	93.30
SIX	91.75	91.75
SEVEN	87.25	87.25

LEVEL D - ITEM 5067		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	164.45	164.45
TWO	141.10	141.10
THREE	133.30	133.30
FOUR	129.40	129.40
FIVE	127.10	127.10
SIX	125.55	125.55
SEVEN	121.05	121.05

4. FEES AND BENEFITS FOR OTHER NON REFERRED ATTENDANCES AT A RESIDENTIAL AGED CARE FACILITY

BRIEF - ITEM 5260		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	46.45	46.45
TWO	32.45	32.45
THREE	27.80	27.80
FOUR	25.50	25.50
FIVE	24.10	24.10
SIX	23.15	23.15
SEVEN	19.75	19.75

STANDARD - ITEM 5263		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	57.55	57.55
TWO	41.75	41.75
THREE	36.50	36.50
FOUR	33.90	33.90
FIVE	32.30	32.30
SIX	31.25	31.25
SEVEN	27.25	27.25

LONG - ITEM 5265		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	73.45	73.45
TWO	59.45	59.45
THREE	54.80	54.80
FOUR	52.50	52.50
FIVE	51.10	51.10
SIX	50.15	50.15
SEVEN	46.75	46.75

PROLONGED - ITEM 5267		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	95.45	95.45
TWO	81.45	81.45
THREE	76.80	76.80
FOUR	74.50	74.50
FIVE	73.10	73.10
SIX	72.15	72.15
SEVEN	68.75	68.75

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

LEVEL A - ITEM 4		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	42.90	32.20
TWO	29.90	22.45
THREE	25.60	19.20
FOUR	23.45	17.60
FIVE	22.15	16.65
SIX	21.25	15.95
SEVEN	18.95	14.25

LEVEL B - ITEM 24, 2503, 2518, 2547		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	63.00	47.25
TWO	50.00	37.50
THREE	45.70	34.30
FOUR	43.55	32.70
FIVE	42.25	31.70
SIX	41.35	31.05
SEVEN	39.05	29.30

LEVEL C – ITEM 37, 2506, 2522, 2553		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	97.65	73.25
TWO	84.65	63.50
THREE	80.35	60.30
FOUR	78.20	58.65
FIVE	76.90	57.70
SIX	76.00	57.00
SEVEN	73.70	55.30

LEVEL D – ITEM 47, 2509, 2526, 2559		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	131.50	98.65
TWO	118.50	88.90
THREE	114.20	85.65
FOUR	112.05	84.05
FIVE	110.75	83.10
SIX	109.85	82.40
SEVEN	107.55	80.70

6. FEES AND BENEFITS FOR OTHER NON-REFERRED ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A HOSPITAL, INSTITUTION OR HOME

BRIEF – ITEM 58		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	24.00	18.00
TWO	16.25	12.20
THREE	13.65	10.25
FOUR	12.35	9.30
FIVE	11.60	8.70
SIX	11.10	8.35
SEVEN	9.20	6.90

STANDARD - ITEM 59, 2610, 2631, 2673		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	33.50	25.15
TWO	24.75	18.60
THREE	21.85	16.40
FOUR	20.35	15.30
FIVE	19.50	14.65
SIX	18.90	14.20
SEVEN	16.70	12.55

LONG – ITEM 60, 2613, 2633, 2675		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	51.00	38.25
TWO	43.25	32.45
THREE	40.65	30.50
FOUR	39.35	29.55
FIVE	38.60	28.95
SIX	38.10	28.60
SEVEN	36.20	27.15

PROLONGED – ITEM 65, 2616, 2635, 2677		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	73.00	54.75
TWO	65.25	48.95
THREE	62.65	47.00
FOUR	61.35	46.05
FIVE	60.60	45.45
SIX	60.10	45.10
SEVEN	58.20	43.65

AFTER HOURS ATTENDANCES

7. FEES AND BENEFITS FOR GP ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT AN INSTITUTION OR HOME

LEVEL A – ITEM 5003		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PER PATIENT)
ONE	54.95	54.95
TWO	41.95	41.95
THREE	37.65	37.65
FOUR	35.50	35.50
FIVE	34.20	34.20
SIX	33.30	33.30
SEVEN	31.00	31.00

LEVEL B – ITEM 5023		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PER PATIENT)
ONE	74.95	74.95
TWO	61.95	61.95
THREE	57.65	57.65
FOUR	55.50	55.50
FIVE	54.20	54.20
SIX	53.30	53.30
SEVEN	51.00	51.00

LEVEL C – ITEM 5043		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PER PATIENT)
ONE	109.90	109.90
TWO	96.90	96.90
THREE	92.60	92.60
FOUR	90.45	90.45
FIVE	89.15	89.15
SIX	88.25	88.25
SEVEN	85.95	85.95

LEVEL D – ITEM 5063		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PER PATIENT)
ONE	143.70	143.70
TWO	130.70	130.70
THREE	126.40	126.40
FOUR	124.25	124.25
FIVE	122.95	122.95
SIX	122.05	122.05
SEVEN	119.75	119.75

8. FEES AND BENEFITS FOR OTHER NON REFERRED ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT AN INSTITUTION OR HOME

BRIEF – ITEM 5220		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PER PATIENT)
ONE	34.00	34.00
TWO	26.25	26.25
THREE	23.65	23.65
FOUR	22.35	22.35
FIVE	21.60	21.60
SIX	21.10	21.10
SEVEN	19.20	19.20

STANDARD – ITEM 5223		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PER PATIENT)
ONE	43.50	43.50
TWO	34.75	34.75
THREE	31.85	31.85
FOUR	30.35	30.35
FIVE	29.50	29.50
SIX	28.90	28.90
SEVEN	26.70	26.70

LONG – ITEM 5227		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PER PATIENT)
ONE	61.00	61.00
TWO	53.25	53.25
THREE	50.65	50.65
FOUR	49.35	49.35
FIVE	48.60	48.60
SIX	48.10	48.10
SEVEN	46.20	46.20

PROLONGED – ITEM 5228		
NUMBER OF PATIENTS	FEE (PER PATIENT)	100% BENEFIT (PER PATIENT)
ONE	83.00	83.00
TWO	75.25	75.25
THREE	72.65	72.65
FOUR	71.35	71.35
FIVE	70.60	70.60
SIX	70.10	70.10
SEVEN	68.20	68.20

9. PUBLIC HEALTH PHYSICIAN ATTENDANCES

ITEM 414		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	45.00	33.75
TWO	32.25	24.20
THREE	28.05	21.05
FOUR	25.90	19.45
FIVE	24.65	18.50
SIX	23.80	17.85
SEVEN	21.50	16.15

ITEM 415		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	68.20	51.15
TWO	55.45	41.60
THREE	51.25	38.45
FOUR	49.10	36.85
FIVE	47.85	35.90
SIX	47.00	35.25
SEVEN	44.70	33.55

ITEM 416		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	108.10	81.10
TWO	95.35	71.55
THREE	91.15	68.40
FOUR	89.00	66.75
FIVE	87.75	65.85
SIX	86.90	65.20
SEVEN	84.60	63.45

ITEM 417		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	147.15	110.40
TWO	134.40	100.80
THREE	130.20	97.65
FOUR	128.05	96.05
FIVE	126.80	95.10
SIX	125.95	94.50
SEVEN	123.65	92.75

10. FOCUSSED PSYCHOLOGICAL STRATEGIES

ITEM 2723		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	118.70	118.70
TWO	105.70	105.70
THREE	101.40	101.40
FOUR	99.25	99.25
FIVE	97.95	97.95
SIX	97.05	97.05
SEVEN	94.75	94.75

ITEM 2727		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	158.70	158.70
TWO	145.70	145.70
THREE	141.40	141.40
FOUR	139.25	139.25
FIVE	137.95	137.95
SIX	137.05	137.05
SEVEN	134.75	134.75

TELEHEALTH DERIVED FEES

11. FEES AND BENEFITS FOR MEDICAL PRACTITIONER TELEHEALTH ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A HOME OR OTHER INSTITUTION

LEVEL A – ITEM 2122		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	48.85	48.85
TWO	35.85	35.85
THREE	31.55	31.55
FOUR	29.40	29.40
FIVE	28.10	28.10
SIX	27.20	27.20
SEVEN	24.90	24.90

LEVEL B – ITEM 2137		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	75.90	75.90
TWO	62.90	62.90
THREE	58.60	58.60
FOUR	56.45	56.45
FIVE	55.15	55.15
SIX	54.25	54.25
SEVEN	51.95	51.95

LEVEL C – ITEM 2147		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	122.80	122.80
TWO	109.80	109.80
THREE	105.50	105.50
FOUR	103.35	103.35
FIVE	102.05	102.05
SIX	101.15	101.15
SEVEN	98.85	98.85

LEVEL D – ITEM 2199		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	168.45	168.45
TWO	155.45	155.45
THREE	151.15	151.15
FOUR	149.00	149.00
FIVE	147.70	147.70
SIX	146.80	146.80
SEVEN	144.50	144.50

12. FEES AND BENEFITS FOR MEDICAL PRACTITIONER TELEHEALTH ATTENDANCES AT A RESIDENTIAL AGED CARE FACILITY

LEVEL A – ITEM 2125		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	69.60	69.60
TWO	46.25	46.25
THREE	38.45	38.45
FOUR	34.55	34.55
FIVE	32.25	32.25
SIX	30.70	30.70
SEVEN	26.20	26.20

LEVEL B – ITEM 2138		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	96.65	96.65
TWO	73.30	73.30
THREE	65.50	65.50
FOUR	61.60	61.60
FIVE	59.30	59.30
SIX	57.75	57.75
SEVEN	53.25	53.25

LEVEL C – ITEM 2179		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	143.55	143.55
TWO	120.20	120.20
THREE	112.40	112.40
FOUR	108.50	108.50
FIVE	106.20	106.20
SIX	104.65	104.65
SEVEN	100.15	100.15

LEVEL D – ITEM 2220		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	189.20	189.20
TWO	165.85	165.85
THREE	158.05	158.05
FOUR	154.15	154.15
FIVE	151.85	151.85
SIX	150.30	150.30
SEVEN	145.80	145.80

13. ACUPUNCTURE

LEVEL A – ITEM 195		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	63.00	63.00
TWO	50.00	50.00
THREE	45.70	45.70
FOUR	43.55	43.55
FIVE	42.25	42.25
SIX	41.35	41.35
SEVEN	39.05	39.05

Services that attract the 100% Medicare rebate – as at 1 November 2013

Medicare Benefits Schedule (MBS) Group	Name of Group	Item numbers
Group A1	General practitioner attendances to which no other item applies	3, 4, 20, 23, 24, 35, 36, 37, 43, 44, 47, 51
Group A2	Other non-referred attendances to which no other item applies	52, 53, 54, 57, 58, 59, 60, 65, 92, 93, 95, 96
Group A5	Prolonged attendances to which no other item applies	160, 161, 162, 163, 164
Group A6	Group therapy	170, 171, 172
Group A7	Acupuncture	173, 193, 195, 197, 199
Group A11	Urgent Attendances After hours	597, 598, 599, 600
Group A14	Health assessments	701, 703, 705, 707, 715
Group A15	GP care plans and multidisciplinary case conferences	721, 723, 729, 731, 732, 735, 739, 743, 747, 750, 758
Group A17	Medication management review	900, 903
Group A30	Medical Practitioners – Telehealth Atendances	2100, 2122, 2125, 2126, 2137, 2138, 2143, 2147, 2179, 2195, 2199, 2220
Group A18	General practitioner attendances associated with Practice Incentives Program (PIP) payments	2497, 2501, 2503, 2504, 2506, 2507, 2509, 2517, 2518, 2521, 2522, 2525, 2526, 2546, 2547, 2552, 2553, 2558, 2559,
Group A19	Other non-referred attendances associated with Practice Incentives Program (PIP) payments to which no other item applies	2598, 2600, 2603, 2606, 2610, 2613, 2616, 2620, 2622, 2624, 2631, 2633, 2635, 2664, 2666, 2668, 2673, 2675, 2677
Group A20	GP mental health care	2700, 2701, 2712, 2713, 2715, 2717, 2721, 2723, 2725, 2727
Group A22	General practitioner after-hours attendances to which no other item applies	5000, 5003, 5010, 5020, 5023, 5028, 5040, 5043, 5049, 5060, 5063, 5067
Group A23	Other non-referred after-hours attendances to which no other item applies	5200, 5203, 5207, 5208, 5220, 5223, 5227, 5228, 5260, 5263, 5265, 5267
Group A27	Pregnancy support couselling	4001
Group A29	Early intervention services for children with autism, pervasive developmental disorder or disability	139
Group M12	Services provided by a practice nurse or registered Aboriginal Health Worker on behalf of a medical practitioner	10983, 10984, 10986, 10987, 10988, 10989, 10997

ATTENDANCES	ATTENDANCES
	GROUP A1 - GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	LEVEL A Professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.
3	**CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms. *(See para A5 of explanatory notes to this Category)* **Fee:** $16.95 **Benefit:** 100% = $16.95 **Extended Medicare Safety Net Cap:** $50.85
4	**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS OR A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms or a residential aged care facility. *(See para A5 and A6 and A7 of explanatory notes to this Category)* **Derived Fee:** The fee for item 3, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
20	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion each patient. *(See para A5 and A8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 3, plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
23	**CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms *(See para A5 of explanatory notes to this Category)* **Fee:** $37.05 **Benefit:** 100% = $37.05 **Extended Medicare Safety Net Cap:** $111.15
24	**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS OR A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms or a residential aged care facility. *(See para A5 and A6 and A7 of explanatory notes to this Category)* **Derived Fee:** The fee for item 23, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
35	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion each patient. *(See para A5 and A8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 23, plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

ATTENDANCES		ATTENDANCES
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.	
36	**CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms. *(See para A5 of explanatory notes to this Category)* **Fee:** $71.70 **Benefit:** 100% = $71.70 **Extended Medicare Safety Net Cap:** $215.10	
37	**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS OR A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms or a residential aged care facility. *(See para A5 and A6 and A7 of explanatory notes to this Category)* **Derived Fee:** The fee for item 36, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount	
43	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion each patient. *(See para A5 and A8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 36, plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount	
	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.	
44	**CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms. *(See para A5 of explanatory notes to this Category)* **Fee:** $105.55 **Benefit:** 100% = $105.55 **Extended Medicare Safety Net Cap:** $316.65	
47	**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS OR A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms or a residential aged care facility. **Extended Medicare Safety Net Cap: 300% of the Derived fee for this item, or $500, whichever is the lesser amount** *(See para A5 and A6 and A7 of explanatory notes to this Category)* **Derived Fee:** The fee for item 44, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount	

51	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion each patient. *(See para A5 and A8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 44, plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

	GROUP A2 - OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	SUBGROUP 1 - OTHER MEDICAL PRACTITIONER ATTENDANCES
	CONSULTATION AT CONSULTING ROOMS Professional attendance at consulting rooms
52	**BRIEF CONSULTATION** of not more than 5 minutes duration **Fee:** $11.00 **Benefit:** 100% = $11.00 **Extended Medicare Safety Net Cap:** $33.00
53	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
54	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
57	**PROLONGED CONSULTATION** of more than 45 minutes duration **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
	CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS OR A RESIDENTIAL AGED CARE FACILITY Professional attendance by a medical practitioner (other than a general practitioner) on 1 or more patients on 1 occasion at a place other than consulting rooms or a residential aged care facility.
58	**BRIEF CONSULTATION** of not more than 5 minutes duration **Derived Fee:** An amount equal to $8.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $8.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
59	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
60	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
65	**PROLONGED CONSULTATION** of more than 45 minutes duration **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion - each patient
92	**BRIEF CONSULTATION** of not more than 5 minutes duration *(See para A8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $8.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $8.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
93	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration *(See para A8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $16.00, plus $31.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

ATTENDANCES	OTHER NON-REFERRED
95	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration *(See para A8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $35.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
96	**PROLONGED CONSULTATION** of more than 45 minutes duration *(See para A8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $57.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

	GROUP A3 - SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
99	Professional attendance on a patient by a specialist practising in his or her specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 104 lasting more than 10 minutes; or (ii) provided with item 105; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19 (2) of the Act applies *(See para A57 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee for item 104 or 105. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
104	**SPECIALIST, REFERRED CONSULTATION - SURGERY OR HOSPITAL** (Professional attendance at consulting rooms or hospital by a specialist in the practice of his or her specialty where the patient is referred to him or her) **- INITIAL** attendance in a single course of treatment, not being a service to which ophthalmology items 106, 109 or obstetric item 16401 apply. **Fee:** $85.55 **Benefit:** 75% = $64.20 85% = $72.75 **Extended Medicare Safety Net Cap:** $256.65
105	Each attendance **SUBSEQUENT** to the first in a single course of treatment **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55 **Extended Medicare Safety Net Cap:** $129.00
106	**- INITIAL SPECIALIST OPHTHALMOLOGIST ATTENDANCE, REFERRED CONSULTATION** in a single course of treatment, being an attendance at which the sole service provided is refraction testing for the issue of a prescription for spectacles or contact lenses not being a service to which items 104, 109 or 10801 to 10816 apply **Fee:** $71.00 **Benefit:** 75% = $53.25 85% = $60.35 **Extended Medicare Safety Net Cap:** $213.00
107	**SPECIALIST, REFERRED CONSULTATION - HOME VISITS** (Professional attendance at a place other than consulting rooms or hospital by a specialist in the practice of his or her specialty where the patient is referred to him or her) **- INITIAL** attendance in a single course of treatment **Fee:** $125.50 **Benefit:** 75% = $94.15 85% = $106.70 **Extended Medicare Safety Net Cap:** $376.50
108	Each attendance **SUBSEQUENT** to the first in a single course of treatment **Fee:** $79.45 **Benefit:** 75% = $59.60 85% = $67.55 **Extended Medicare Safety Net Cap:** $238.35
109	INITIAL SPECIALIST OPHTHALMOLOGIST PAEDIATRIC ATTENDANCE, REFERRED CONSULTATION in a single course of treatment, being an attendance at which a comprehensive eye examination, including pupil dilation, is performed on a child aged 9 years or under, or on a child aged 14 years or under with developmental delay, not being a service to which item 104, 106 or any of items 10801 to 10816 applies **Fee:** $192.80 **Benefit:** 75% = $144.60 85% = $163.90 **Extended Medicare Safety Net Cap:** $500.00

	GROUP A4 - CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
110	**CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY), REFERRED CONSULTATION - SURGERY OR HOSPITAL** (Professional attendance at consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than in psychiatry) where the patient is referred to him or her by a referring practitioner) **- INITIAL** attendance in a single course of treatment **Fee:** $150.90 **Benefit:** 75% = $113.20 85% = $128.30 **Extended Medicare Safety Net Cap:** $452.70
112	Professional attendance on a patient by a consultant physician practising in his or her specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 110 lasting more than 10 minutes; or (ii) provided with item 116, 119, 132 or 133; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19 (2) of the Act applies *(See para A57 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee for the associated item. Benefit: 85% of derived fee. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

SPECIALIST		SPECIALIST
	GROUP A3 - SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
113	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist practising in his or her specialty if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19 (2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment. *(See para A57 of explanatory notes to this Category)* **Fee:** $64.20 **Benefit:** 85% = $54.60 **Extended Medicare Safety Net Cap:** $192.60	

	GROUP A4 - CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
114	Initial professional attendance of 10 minutes or less in duration on a patient by a consultant physician practising in his or her specialty if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19 (2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment. *(See para A57 of explanatory notes to this Category)* **Fee:** $113.20 **Benefit:** 85% = $96.25 **Extended Medicare Safety Net Cap:** $339.60
116	- Each attendance (other than a service to which item 119 applies) **SUBSEQUENT** to the first in a single course of treatment **Fee:** $75.50 **Benefit:** 75% = $56.65 85% = $64.20 **Extended Medicare Safety Net Cap:** $226.50
119	- Each **MINOR** attendance **SUBSEQUENT** to the first in a single course of treatment *(See para A11 of explanatory notes to this Category)* **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55 **Extended Medicare Safety Net Cap:** $129.00
122	**CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY), REFERRED CONSULTATION - HOME VISITS** (Professional attendance at a place other than consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than in psychiatry) where the patient is referred to him or her by a referring practitioner) **- INITIAL** attendance in a single course of treatment **Fee:** $183.10 **Benefit:** 75% = $137.35 85% = $155.65 **Extended Medicare Safety Net Cap:** $500.00
128	- Each attendance (other than a service to which item 131 applies) **SUBSEQUENT** to the first in a single course of treatment **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15 **Extended Medicare Safety Net Cap:** $332.25
131	- Each **MINOR** attendance **SUBSEQUENT** to the first in a single course of treatment *(See para A11 of explanatory notes to this Category)* **Fee:** $79.75 **Benefit:** 75% = $59.85 85% = $67.80 **Extended Medicare Safety Net Cap:** $239.25

132	**CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY) REFERRED PATIENT TREATMENT AND MANAGEMENT PLAN - SURGERY OR HOSPITAL** Professional attendance of at least 45 minutes duration for an initial assessment of a patient with at least two morbidities (this can include complex congenital, developmental and behavioural disorders), where the patient is referred by a referring practitioner, and where a) assessment is undertaken that covers: - a comprehensive history, including psychosocial history and medication review; - comprehensive multi or detailed single organ system assessment; - the formulation of differential diagnoses; and b) a consultant physician treatment and management plan of significant complexity is developed and provided to the referring practitioner that involves: - an opinion on diagnosis and risk assessment - treatment options and decisions - medication recommendations Not being an attendance on a patient in respect of whom, an attendance under items 110, 116 and 119 has been received on the same day by the same consultant physician. Not being an attendance on the patient in respect of whom, in the preceding 12 months, payment has been made under this item for attendance by the same consultant physician. *(See para A12 of explanatory notes to this Category)* **Fee:** $263.90 **Benefit:** 75% = $197.95 85% = $224.35 **Extended Medicare Safety Net Cap:** $500.00
133	**CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY) REVIEW OF REFERRED PATIENT TREATMENT AND MANAGEMENT PLAN - SURGERY OR HOSPITAL** Professional attendance of at least 20 minutes duration subsequent to the first attendance in a single course of treatment for a review of a patient with at least two morbidities (this can include complex congenital, developmental and behavioural disorders), where a) a review is undertaken that covers: - review of initial presenting problem/s and results of diagnostic investigations - review of responses to treatment and medication plans initiated at time of initial consultation comprehensive multi or detailed single organ system assessment, - review of original and differential diagnoses; and b) a modified consultant physician treatment and management plan is provided to the referring practitioner that involves, where appropriate: - a revised opinion on the diagnosis and risk assessment - treatment options and decisions - revised medication recommendations Not being an attendance on a patient in respect of whom, an attendance under item 110, 116 and 119 has been received on the same day by the same consultant physician or locum tenens. Being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under item 132. Item 133 can be provided by either the same consultant physician or a locum tenens. Payable no more than twice in any 12 month period. *(See para A12 of explanatory notes to this Category)* **Fee:** $132.10 **Benefit:** 75% = $99.10 85% = $112.30 **Extended Medicare Safety Net Cap:** $396.30

GROUP A29 - EARLY INTERVENTION SERVICES FOR CHILDREN WITH AUTISM, PERVASIVE DEVELOPMENTAL DISORDER OR DISABILITY

CONSULTANT PAEDIATRICIAN, REFERRED CONSULTATION FOR ASSESSMENT, DIAGNOSIS AND DEVELOPMENT OF A TREATMENT AND MANAGEMENT PLAN FOR AUTISM OR ANY OTHER PERVASIVE DEVELOPMENTAL DISORDER - SURGERY OR HOSPITAL

Professional attendance of at least 45 minutes duration at consulting rooms or hospital, by a consultant physician in his or her specialty of paediatrics, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with autism or any other pervasive developmental disorder, who has been referred to the consultant paediatrician by a referring practitioner, if the consultant paediatrician does the following:

(a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate)
(b) develops a treatment and management plan which must include the following:
  (i) the outcomes of the assessment;
  (ii) the diagnosis or diagnoses;
  (iii) opinion on risk assessment;
  (iv) treatment options and decisions;
  (v) appropriate medication recommendations, where necessary.
(c) provides a copy of the treatment and management plan to the:
  (i) referring practitioner; and
  (ii) relevant allied health providers (where appropriate).

Not being an attendance on a child in respect of whom payment has previously been made under this item or items 137, 139 or 289.
(See para A13 of explanatory notes to this Category)
Fee: $263.90 **Benefit:** 75% = $197.95 85% = $224.35
135 **Extended Medicare Safety Net Cap:** $500.00

SPECIALIST OR CONSULTANT PHYSICIAN, REFERRED CONSULTATION FOR ASSESSMENT, DIAGNOSIS AND DEVELOPMENT OF A TREATMENT AND MANAGEMENT PLAN FOR A CHILD WITH AN ELIGIBLE DISABILITY - SURGERY OR HOSPITAL

Professional attendance of at least 45 minutes duration, at consulting rooms or hospital, by a specialist or consultant physician, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with an eligible disability, who has been referred to the specialist or consultant physician by a referring practitioner, if the specialist or consultant physician does the following:

(a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate)
(b) develops a treatment and management plan which must include the following:
  (i) the outcomes of the assessment;
  (ii) the diagnosis or diagnoses;
  (iii) opinion on risk assessment;
  (iv) treatment options and decisions;
  (v) appropriate medication recommendations, where necessary.
(c) provides a copy of the treatment and management plan to the:
  (i) referring practitioner; and
  (ii) relevant allied health providers (where appropriate).

Not being an attendance on a child in respect of whom payment has previously been made under this item or items 135, 139 or 289.
(See para A14 of explanatory notes to this Category)
Fee: $263.90 **Benefit:** 75% = $197.95 85% = $224.35
137 **Extended Medicare Safety Net Cap:** $500.00

	GENERAL PRACTITIONER CONSULTATION FOR ASSESSMENT, DIAGNOSIS AND DEVELOPMENT OF A TREATMENT AND MANAGEMENT PLAN FOR A CHILD WITH AN ELIGIBLE DISABILITY Professional attendance of at least 45 minutes duration, at consulting rooms, by a general practitioner, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with an eligible disability, if the general practitioner does the following: (a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate) (b) develops a treatment and management plan which must include the following: (i) the outcomes of the assessment; (ii) the diagnosis or diagnoses; (iii) opinion on risk assessment; (iv) treatment options and decisions; (v) appropriate medication recommendations, where necessary. (c) provides a copy of the treatment and management plan to the: (i) relevant allied health providers (where appropriate). Not being an attendance on a child in respect of whom payment has previously been made under this item or items 135, 137 or 289. *(See para A14 of explanatory notes to this Category)* **Fee:** $132.50 **Benefit:** 100% = $132.50
139	**Extended Medicare Safety Net Cap:** $397.50

GROUP A28 - GERIATRIC MEDICINE

Consultant Physician or Specialist in Geriatric Medicine, Referred Patient, Initial Comprehensive Assessment and Management – Surgery or Hospital.

Professional attendance of more than 60 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine, if:

(a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and

(b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and

(c) during the attendance:

(i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail using appropriately validated assessment tools if indicated (the *assessment*); and

(ii) the patient's various health problems and care needs are identified and prioritised (the *formulation*); and

(iii) a detailed management plan is prepared (the *management plan*) setting out:

(A) the prioritised list of health problems and care needs; and

(B) short and longer term management goals; and

(C) recommended actions or intervention strategies to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient and the patient's family and carers; and

(iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and

(v) the management plan is communicated in writing to the referring practitioner; and

(d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and

(e) an attendance to which this item or item 145 applies has not been provided to the patient by the same practitioner in the preceding 12 months.

(See para A15 of explanatory notes to this Category)

Fee: $452.65 **Benefit:** 75% = $339.50 85% = $384.80

141 **Extended Medicare Safety Net Cap:** $500.00

Consultant physician or Specialist in Geriatric Medicine, Review of Referred Patient, Initial Comprehensive Assessment and Management – Surgery or Hospital.

Professional attendance of more than 30 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under item 141 or 145, if:

(a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and

(b) during the attendance:
(i) the patient's health status is reassessed; and

(ii) a management plan prepared under item 141 or 145 is reviewed and revised; and

(iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and

(c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies was not provided to the patient on the same day by the same practitioner; and

(d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and

(e) an attendance to which this item or item 147 applies has not been provided to the patient in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review.

(See para A15 of explanatory notes to this Category)

143 **Fee:** $282.95 **Benefit:** 75% = $212.25 85% = $240.55
Extended Medicare Safety Net Cap: $500.00

Consultant Physician or Specialist in Geriatric Medicine, Referred Patient, Initial Comprehensive Assessment and Management – Home Visit.

Professional attendance of more than 60 minutes in duration at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine, if:

(a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and

(b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and

(c) during the attendance:

(i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail utilising appropriately validated assessment tools if indicated (the *assessment*); and

(ii) the patient's various health problems and care needs are identified and prioritised (the *formulation*); and

(iii) a detailed management plan is prepared (the *management plan*) setting out:

(A) the prioritised list of health problems and care needs; and

(B) short and longer term management goals; and

(C) recommended actions or intervention strategies, to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient, the patient's family and any carers; and

(iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and

(v) the management plan is communicated in writing to the referring practitioner; and

(d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and

(e) an attendance to which this item or item 141 applies has not been provided to the patient by the same practitioner in the preceding 12 months.

(See para A15 of explanatory notes to this Category)

Fee: $548.85 **Benefit:** 85% = $469.35

145 **Extended Medicare Safety Net Cap:** $500.00

Consultant physician or Specialist in Geriatric Medicine, Review of Referred Patient, Initial Comprehensive Assessment and Management – Home Visit

Professional attendance of more than 30 minutes in duration at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under items141 or 145, if:

(a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and

(b) during the attendance:
(i) the patient's health status is reassessed; and

(ii) a management plan that was prepared under item 141 or 145 is reviewed and revised; and

(iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and

(c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and

(d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and

(e) an attendance to which this item or 143 applies has not been provided by the same practitioner in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review.

(See para A15 of explanatory notes to this Category)
Fee: $343.10 **Benefit:** 85% = $291.65
147 **Extended Medicare Safety Net Cap:** $500.00

Professional attendance on a patient by a consultant physician or specialist practising in his or her specialty of geriatric medicine if:
(a) the attendance is by video conference; and
(b) item 141 or 143 applies to the attendance; and
(c) the patient is not an admitted patient; and
(d) the patient:
(i) is located both:
(A) within a telehealth eligible area; and
(B) at the time of the attendance—at least 15 kms by road from the physician or specialist; or
(ii) is a care recipient in a residential care service; or
(iii) is a patient of:
(A) an Aboriginal Medical Service; or
(B) an Aboriginal Community Controlled Health Service
for which a direction made under subsection 19 (2) of the Act applies

(See para A57 of explanatory notes to this Category)
Derived Fee: 50% of the fee for item 141 or 143. Benefit: 85% of the derived fee
149 **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

GROUP A5 - PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

PROLONGED PROFESSIONAL ATTENDANCE

Professional attendance (not being a service to which another item in this Category applies) on a patient in imminent danger of death. The time period relates to the total time spent with a single patient, even if the time spent by the practitioner is not continuous. Attendance on one patient at risk of imminent death may be provided by one or more practitioners on the one occasion.

160	- For a period of not less than 1 hour but less than 2 hours *(See para A16 of explanatory notes to this Category)* **Fee:** $221.50 **Benefit:** 75% = $166.15 100% = $221.50 **Extended Medicare Safety Net Cap:** $500.00		
161	- For a period of not less than 2 hours but less than 3 hours *(See para A16 of explanatory notes to this Category)* **Fee:** $369.15 **Benefit:** 75% = $276.90 100% = $369.15 **Extended Medicare Safety Net Cap:** $500.00		
162	- For a period of not less than 3 hours but less than 4 hours *(See para A16 of explanatory notes to this Category)* **Fee:** $516.65 **Benefit:** 75% = $387.50 100% = $516.65 **Extended Medicare Safety Net Cap:** $500.00		
163	- For a period of not less than 4 hours but less than 5 hours *(See para A16 of explanatory notes to this Category)* **Fee:** $664.55 **Benefit:** 75% = $498.45 100% = $664.55 **Extended Medicare Safety Net Cap:** $500.00		
164	- For a period of 5 hours or more *(See para A16 of explanatory notes to this Category)* **Fee:** $738.40 **Benefit:** 75% = $553.80 100% = $738.40 **Extended Medicare Safety Net Cap:** $500.00		

GROUP A6 - GROUP THERAPY

FAMILY GROUP THERAPY

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

170	- each group of 2 patients *(See para A17 of explanatory notes to this Category)* **Fee:** $117.55 **Benefit:** 75% = $88.20 100% = $117.55 **Extended Medicare Safety Net Cap:** $352.65
171	- each group of 3 patients *(See para A17 of explanatory notes to this Category)* **Fee:** $123.85 **Benefit:** 75% = $92.90 100% = $123.85 **Extended Medicare Safety Net Cap:** $371.55
172	- each group of 4 or more patients *(See para A17 of explanatory notes to this Category)* **Fee:** $150.70 **Benefit:** 75% = $113.05 100% = $150.70 **Extended Medicare Safety Net Cap:** $452.10

	GROUP A7 - ACUPUNCTURE
	LEVEL A
173	ATTENDANCE at which ACUPUNCTURE is performed by a medical practitioner by application of stimuli on or through the surface of the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed. *(See para A18 of explanatory notes to this Category)* **Fee:** $21.65 **Benefit:** 75% = $16.25 100% = $21.65 **Extended Medicare Safety Net Cap:** $64.95
	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
193	**CONSULTATION AT A PLACE OTHER THAN A HOSPITAL** Consultation by a general practitioner, who is a qualified medical acupuncturist at a place other than a hospital at which ACUPUNCTURE is performed by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed. *(See para A5 and A18 of explanatory notes to this Category)* **Fee:** $37.05 **Benefit:** 100% = $37.05 **Extended Medicare Safety Net Cap:** $111.15
195	**CONSULTATION AT A HOSPITAL** Consultation by a general practitioner, who is a qualified medical acupuncturist at a hospital on one or more patients on one occasion at which ACUPUNCTURE is performed by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed. *(See para A5 and A18 of explanatory notes to this Category)* **Derived Fee:** The fee for item 193, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 193 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
197	**CONSULTATION AT A PLACE OTHER THAN A HOSPITAL** Consultation by a general practitioner, who is a qualified medical acupuncturist at a place other than a hospital at which ACUPUNCTURE is performed by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed. *(See para A5 and A18 of explanatory notes to this Category)* **Fee:** $71.70 **Benefit:** 100% = $71.70 **Extended Medicare Safety Net Cap:** $215.10

	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
199	**CONSULTATION AT A PLACE OTHER THAN A HOSPITAL** Consultation by a general practitioner, who is a qualified medical acupuncturist at a place other than a hospital at which ACUPUNCTURE is performed by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed. *(See para A5 and A18 of explanatory notes to this Category)* **Fee:** $105.55 **Benefit:** 100% = $105.55 **Extended Medicare Safety Net Cap:** $316.65

GROUP A8 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

Professional attendance on a patient by a consultant physician practising in his or her specialty of psychiatry if:
(a) the attendance is by video conference; and
(b) item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 348, 350 or 352 applies to the attendance; and
(c) the patient is not an admitted patient; and
(d) the patient:
- (i) is located both:
  - (A) within a telehealth eligible area; and
  - (B) at the time of the attendance - at least 15 kms by road from the physician; or
- (ii) is a care recipient in a residential care service; or
- (iii) is a patient of:
  - (A) an Aboriginal Medical Service; or
  - (B) an Aboriginal Community Controlled Health Service;

  for which a direction made under subsection 19 (2) of the Act applies

(See para A57 of explanatory notes to this Category)
Derived Fee: 50% of the fee for item 291, 293,296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 348, 350 or 352.Benefit: 85% of derived fee.

288 **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION FOR ASSESSMENT, DIAGNOSIS AND DEVELOPMENT OF A TREATMENT AND MANAGEMENT PLAN FOR AUTISM OR ANY OTHER PERVASIVE DEVELOPMENTAL DISORDER - SURGERY OR HOSPITAL

Professional attendance of at least 45 minutes duration, at consulting rooms or hospital, by a consultant physician in his or her specialty of psychiatry, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with autism or any other pervasive developmental disorder, who has been referred to the consultant psychiatrist by a referring practitioner, if the consultant psychiatrist does the following:

(a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate)
(b) develops a treatment and management plan which must include the following:
- (i) the outcomes of the assessment;
- (ii) the diagnosis or diagnoses;
- (iii) opinion on risk assessment;
- (iv) treatment options and decisions;
- (v) appropriate medication recommendations, where necessary.

(c) provides a copy of the treatment and management plan to the:
- (i) referring practitioner; and
- (ii) relevant allied health providers (where appropriate).

Not being an attendance on a child in respect of whom payment has previously been made under this item or items 135, 137 or 139.
(See para A13 of explanatory notes to this Category)
Fee: $263.90 **Benefit:** 75% = $197.95 85% = $224.35

289 **Extended Medicare Safety Net Cap:** $500.00

291	**CONSULTANT PSYCHIATRIST, REFERRED PATIENT ASSESSMENT AND MANAGEMENT PLAN** Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY where the patient is referred for the provision of an assessment and management plan by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or participating nurse practitioner, where the attendance is initiated by the referring practitioner and where the consultant psychiatrist provides the referring practitioner with an assessment and management plan to be undertaken by that practitioner for the patient, where clinically appropriate. An attendance of more than 45 minutes duration at consulting rooms during which: - An outcome tool is used where clinically appropriate - A mental state examination is conducted - A psychiatric diagnosis is made - The consultant psychiatrist decides that the patient can be appropriately managed by the referring practitioner without the need for ongoing treatment by the psychiatrist - A 12 month management plan, appropriate to the diagnosis, is provided to the referring practitioner which must: a) comprehensively evaluate biological, psychological and social issues; b) address diagnostic psychiatric issues; c) make management recommendations addressing biological, psychological and social issues; and d) be provided to the referring practitioner within two weeks of completing the assessment of the patient. - The diagnosis and management plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement) - The diagnosis and management plan is communicated in writing to the referring practitioner Not being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under this item *(See para A19 of explanatory notes to this Category)* **Fee:** $452.65 **Benefit:** 85% = $384.80 **Extended Medicare Safety Net Cap:** $500.00
293	**CONSULTANT PSYCHIATRIST, REVIEW OF REFERRED PATIENT ASSESSMENT AND MANAGEMENT** Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY to review a management plan previously prepared by that consultant psychiatrist for a patient and claimed under item 291, where the review is initiated by the referring medical practitioner practising in general practice or participating nurse practitioner. An attendance of more than 30 minutes but not more than 45 minutes duration at consulting rooms where that attendance follows item 291 and during which: - An outcome tool is used where clinically appropriate - A mental state examination is conducted - A psychiatric diagnosis is made - A management plan provided under Item 291 is reviewed and revised - The reviewed management plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement) - The reviewed management plan is communicated in writing to the referring medical practitioner or participating nurse practitioner Being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under item 291, and no payment has been made under item 359, payable no more than once in any 12 month period. *(See para A19 of explanatory notes to this Category)* **Fee:** $282.95 **Benefit:** 85% = $240.55 **Extended Medicare Safety Net Cap:** $500.00
296	**CONSULTANT PSYCHIATRIST, INITIAL CONSULTATION ON A NEW PATIENT, CONSULTING ROOMS** Professional attendance of more than 45 minutes by a consultant physician in the practice of his or her speciality of PSYCHIATRY where a patient is referred to him or her by a referring practitioner, and where the patient: - is a new patient for this consultant psychiatrist; or - is a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months. Not being an attendance on a patient in respect of whom payment has been made under this item, items 297 or 299, or any of items 300 to 346 or 353 to 358 or 361 to 370 in the preceding 24 month period *(See para A19 of explanatory notes to this Category)* **Fee:** $260.30 **Benefit:** 75% = $195.25 85% = $221.30 **Extended Medicare Safety Net Cap:** $500.00

297	**CONSULTANT PSYCHIATRIST, INITIAL CONSULTATION ON A NEW PATIENT, HOSPITAL** Professional attendance of more than 45 minutes at hospital by a consultant physician in the practice of his or her speciality of PSYCHIATRY where a patient is referred to him or her by a referring practitioner, and where the patient: - is a new patient for this consultant psychiatrist; or - is a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months. Not being an attendance on a patient in respect of whom payment has been made under this item, items 296 or 299 or any of items 300 to 346 or 353 to 358 or 361 to 370 in the preceding 24 month period *(See para A19 of explanatory notes to this Category)* **Fee:** $260.30 **Benefit:** 75% = $195.25 85% = $221.30 **Extended Medicare Safety Net Cap:** $500.00
299	**CONSULTANT PSYCHIATRIST, INITIAL CONSULTATION ON A NEW PATIENT, HOME VISITS** Professional attendance of more than 45 minutes at a place other than consulting rooms or hospital by a consultant physician in the practice of his or her speciality of PSYCHIATRY where a patient is referred to him or her by a referring practitioner, and where the patient: - is a new patient for this consultant psychiatrist; or - is a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months. Not being an attendance on a patient in respect of whom payment has been made under this item, items 296 or 297, or any of items 300 to 346 or 353 to 358 or 361 to 370 in the preceding 24 month period *(See para A19 of explanatory notes to this Category)* **Fee:** $311.30 **Benefit:** 75% = $233.50 85% = $264.65 **Extended Medicare Safety Net Cap:** $500.00
300	**CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION, CONSULTING ROOMS** (Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY where the patient is referred to him or her by a referring practitioner) - An attendance of not more than 15 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply have not exceeded the sum of 50 attendances in a calendar year. **Fee:** $43.35 **Benefit:** 75% = $32.55 85% = $36.85 **Extended Medicare Safety Net Cap:** $130.05
302	- An attendance of more than 15 minutes duration but not more than 30 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply have not exceeded the sum of 50 attendances in a calendar year. **Fee:** $86.45 **Benefit:** 75% = $64.85 85% = $73.50 **Extended Medicare Safety Net Cap:** $259.35
304	- An attendance of more than 30 minutes duration but not more than 45 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply have not exceeded the sum of 50 attendances in a calendar year. **Fee:** $133.10 **Benefit:** 75% = $99.85 85% = $113.15 **Extended Medicare Safety Net Cap:** $399.30
306	- An attendance of more than 45 minutes duration but not more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply have not exceeded the sum of 50 attendances in a calendar year. **Fee:** $183.65 **Benefit:** 75% = $137.75 85% = $156.15 **Extended Medicare Safety Net Cap:** $500.00
308	- An attendance of more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply have not exceeded the sum of 50 attendances in a calendar year. **Fee:** $213.15 **Benefit:** 75% = $159.90 85% = $181.20 **Extended Medicare Safety Net Cap:** $500.00
310	- An attendance of not more than 15 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 358 or 361 to 370 apply exceed 50 attendances in a calendar year. **Fee:** $21.60 **Benefit:** 75% = $16.20 85% = $18.40 **Extended Medicare Safety Net Cap:** $64.80

312	- An attendance of more than 15 minutes duration but not more than 30 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 358 or 361 to 370 apply exceed 50 attendances in a calendar year. **Fee:** $43.35 **Benefit:** 75% = $32.55 85% = $36.85 **Extended Medicare Safety Net Cap:** $130.05
314	- An attendance of more than 30 minutes duration but not more than 45 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 358 or 361 to 370 apply exceed 50 attendances in a calendar year. **Fee:** $66.65 **Benefit:** 75% = $50.00 85% = $56.70 **Extended Medicare Safety Net Cap:** $199.95
316	- An attendance of more than 45 minutes duration but not more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 358 or 361 to 370 apply exceed 50 attendances in a calendar year. **Fee:** $91.95 **Benefit:** 75% = $69.00 85% = $78.20 **Extended Medicare Safety Net Cap:** $275.85
318	- An attendance of more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 296, 300 to 318 and items 353 to 358 or 361 to 370 apply exceed 50 attendances in a calendar year. **Fee:** $106.60 **Benefit:** 75% = $79.95 85% = $90.65 **Extended Medicare Safety Net Cap:** $319.80
319	- An attendance of more than 45 minutes duration at consulting rooms, where the patient has: (i) been diagnosed as suffering severe personality disorder, anorexia nervosa, bulimia nervosa, dysthymic disorder, substance-related disorder, somatoform disorder or a pervasive development disorder; and (ii) for persons 18 years and over, been rated with a level of functional impairment within the range 1 to 50 according to the Global Assessment of Functioning Scale where that attendance and any other attendance to which items 296, 300 to 308 and items 353 to 358 or 361 to 370 apply do not exceed 160 attendances in a calendar year. *(See para A20 of explanatory notes to this Category)* **Fee:** $183.65 **Benefit:** 75% = $137.75 85% = $156.15 **Extended Medicare Safety Net Cap:** $500.00
	CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION, HOSPITAL (Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY where the patient is referred to him or her by a referring practitioner)
320	- An attendance of not more than 15 minutes duration at hospital. **Fee:** $43.35 **Benefit:** 75% = $32.55 85% = $36.85 **Extended Medicare Safety Net Cap:** $130.05
322	- An attendance of more than 15 minutes duration but not more than 30 minutes duration at hospital **Fee:** $86.45 **Benefit:** 75% = $64.85 85% = $73.50 **Extended Medicare Safety Net Cap:** $259.35
324	- An attendance of more than 30 minutes duration but not more than 45 minutes duration at hospital **Fee:** $133.10 **Benefit:** 75% = $99.85 85% = $113.15 **Extended Medicare Safety Net Cap:** $399.30
326	- An attendance of more than 45 minutes duration but not more than 75 minutes duration at hospital **Fee:** $183.65 **Benefit:** 75% = $137.75 85% = $156.15 **Extended Medicare Safety Net Cap:** $500.00
328	- An attendance of more than 75 minutes duration at hospital **Fee:** $213.15 **Benefit:** 75% = $159.90 85% = $181.20 **Extended Medicare Safety Net Cap:** $500.00

	CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION, HOME VISITS
330	(Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY where the patient is referred to him or her by a referring practitioner) - An attendance of not more than 15 minutes duration where that attendance is at a place other than consulting rooms or hospital **Fee:** $79.55 **Benefit:** 75% = $59.70 85% = $67.65 **Extended Medicare Safety Net Cap:** $238.65
332	- An attendance of more than 15 minutes duration but not more than 30 minutes duration where that attendance is at a place other than consulting rooms or hospital **Fee:** $124.65 **Benefit:** 75% = $93.50 85% = $106.00 **Extended Medicare Safety Net Cap:** $373.95
334	- An attendance of more than 30 minutes duration but not more than 45 minutes duration where that attendance is at a place other than consulting rooms or hospital **Fee:** $181.65 **Benefit:** 75% = $136.25 85% = $154.45 **Extended Medicare Safety Net Cap:** $500.00
336	- An attendance of more than 45 minutes duration but not more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital **Fee:** $219.75 **Benefit:** 75% = $164.85 85% = $186.80 **Extended Medicare Safety Net Cap:** $500.00
338	- An attendance of more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital **Fee:** $249.55 **Benefit:** 75% = $187.20 85% = $212.15 **Extended Medicare Safety Net Cap:** $500.00
	CONSULTANT PSYCHIATRIST - GROUP PSYCHOTHERAPY
342	Group psychotherapy (including any associated consultation with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hours duration given under the continuous direct supervision of a consultant physician in the practice of his or her specialty of psychiatry where the patients are referred to him or her by a referring practitioner. - GROUP PSYCHOTHERAPY on a group of 2 to 9 unrelated patients OR FAMILY GROUP psychotherapy on a group of more than 3 patients, EACH PATIENT **Fee:** $49.30 **Benefit:** 75% = $37.00 85% = $41.95 **Extended Medicare Safety Net Cap:** $147.90
344	- FAMILY GROUP PSYCHOTHERAPY on a group of 3 patients, EACH PATIENT **Fee:** $65.45 **Benefit:** 75% = $49.10 85% = $55.65 **Extended Medicare Safety Net Cap:** $196.35
346	- FAMILY GROUP PSYCHOTHERAPY on a group of 2 patients, EACH PATIENT **Fee:** $96.80 **Benefit:** 75% = $72.60 85% = $82.30 **Extended Medicare Safety Net Cap:** $290.40
	CONSULTANT PSYCHIATRIST - INTERVIEW OF A PERSON OTHER THAN A PATIENT - SURGERY, HOSPITAL OR RESIDENTIAL AGED CARE FACILITY
348	Professional attendance by a consultant physician in the practice of his or her recognised specialty of psychiatry, where the patient is referred to him or her by a referring practitioner involving an interview of a person other than the patient of not less than 20 minutes duration but less than 45 minutes duration, in the course of initial diagnostic evaluation of a patient, where that interview is at consulting rooms, hospital or residential aged care facility *(See para A21 of explanatory notes to this Category)* **Fee:** $126.75 **Benefit:** 75% = $95.10 85% = $107.75 **Extended Medicare Safety Net Cap:** $380.25
350	- An attendance of not less than 45 minutes duration *(See para A21 of explanatory notes to this Category)* **Fee:** $175.00 **Benefit:** 75% = $131.25 85% = $148.75 **Extended Medicare Safety Net Cap:** $500.00

352	**CONSULTANT PSYCHIATRIST - INTERVIEW OF A PERSON OTHER THAN A PATIENT - IN THE COURSE OF CONTINUING MANAGEMENT OF A PATIENT** Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a referring practitioner, involving an interview of a person other than the patient of not less than 20 minutes duration, in the course of continuing management of a patient - payable not more than 4 times in any 12 month period *(See para A21 of explanatory notes to this Category)* **Fee:** $126.75 **Benefit:** 75% = $95.10 85% = $107.75 **Extended Medicare Safety Net Cap:** $380.25
353	**CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION VIA TELEPSYCHIATRY FOR ASSESSMENT, DIAGNOSIS AND TREATMENT** A telepsychiatry consultation by a consultant physician in the practice of his or her specialty of PSYCHIATRY (not being an attendance to which items 291 to 319 apply), where: -the patient is referred to him or her by a referring practitioner for assessment, diagnosis and/or treatment and is located in a regional, rural or remote area (RRMA3-7), -that consultation and any other consultation to which items 353 to 361 apply, have not exceeded 12 consultations in a calendar year, -any other attendance to which items 300 to 308 and 353 to 358 or 361 to 370 apply, have not exceeded the sum of 50 attendances in a calendar year. A telepsychiatry consultation of not more than 15 minutes duration. *(See para A48 of explanatory notes to this Category)* **Fee:** $57.20 **Benefit:** 75% = $42.90 85% = $48.65 **Extended Medicare Safety Net Cap:** $171.60
355	A telepsychiatry consultation of more than 15 minutes duration but not more than 30 minutes duration. *(See para A48 of explanatory notes to this Category)* **Fee:** $114.45 **Benefit:** 75% = $85.85 85% = $97.30 **Extended Medicare Safety Net Cap:** $343.35
356	A telepsychiatry consultation of more than 30 minutes duration but not more than 45 minutes duration. *(See para A48 of explanatory notes to this Category)* **Fee:** $167.80 **Benefit:** 75% = $125.85 85% = $142.65 **Extended Medicare Safety Net Cap:** $500.00
357	A telepsychiatry consultation of more than 45 minutes duration but not more than 75 minutes duration *(See para A48 of explanatory notes to this Category)* **Fee:** $231.45 **Benefit:** 75% = $173.60 85% = $196.75 **Extended Medicare Safety Net Cap:** $500.00
358	A telepsychiatry consultation of more than 75 minutes duration *(See para A48 of explanatory notes to this Category)* **Fee:** $282.00 **Benefit:** 75% = $211.50 85% = $239.70 **Extended Medicare Safety Net Cap:** $500.00
359	**CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION VIA TELEPSYCHIATRY FOR REVIEW OF REFERRED PATIENT ASSESSMENT AND MANAGEMENT** A telepsychiatry consultation of more than 30 minutes but not more than 45 minutes duration by a consultant physician in the practice of his or her specialty of PSYCHIATRY where: – the patient is located in a regional, rural or remote area (RRMA 3-7) – in the preceding 12 months, payment has been made under item 291 – an outcome tool is used where clinically appropriate – a mental state examination is conducted – a psychiatric diagnosis is made – a management plan provided under Item 291 is reviewed and revised – the reviewed management plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement) – the reviewed management plan is communicated in writing to the referring practitioner Not being an attendance on a patient in respect of whom payment has been made under this item or item 293 in the preceding 12 month period. *(See para A48 of explanatory notes to this Category)* **Fee:** $325.35 **Benefit:** 75% = $244.05 85% = $276.55 **Extended Medicare Safety Net Cap:** $500.00

361	**CONSULTANT PSYCHIATRIST, REFERRED INITIAL CONSULTATION VIA TELEPSYCHIATRY ON A NEW PATIENT** A telepsychiatry consultation of more than 45 minutes by a consultant physician in the practice of his or her specialty of PSYCHIATRY where: – the patient is a new patient for this consultant psychiatrist, or a patient who has not received a professional attendance from this consultant psychiatrist in the preceding 24 months – the patient is located in a regional, rural or remote area (RRMA3-7) Not being an attendance on a patient in respect of whom payment has been made under this item, items 296 to 299, or any of items 300 to 346 or 353 to 370 in the preceding 24 month period. *(See para A48 of explanatory notes to this Category)* **Fee:** $299.30 **Benefit:** 75% = $224.50 85% = $254.45 **Extended Medicare Safety Net Cap:** $500.00
364	**CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION FOR ASSESSMENT, DIAGNOSIS AND TREATMENT FOLLOWING TELEPSYCHIATRY** Professional attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, where: - the patient is referred to him or her by a referring practitioner, - that attendance occurs following a telepsychiatry consultation (items 353 to 361), - that attendance and any other attendance to which items 300 to 308 and 353 to 358 or 361 to 370 apply, have not exceeded the sum of 50 attendances in a calendar year. These items may only be used after telepsychiatry consultation(s) have been conducted in accordance with items 353 to 361. A face-to-face attendance of not more than 15 minutes duration. *(See para A48 of explanatory notes to this Category)* **Fee:** $43.35 **Benefit:** 75% = $32.55 85% = $36.85 **Extended Medicare Safety Net Cap:** $130.05
366	A face-to-face attendance of more than 15 minutes duration but not more than 30 minutes duration *(See para A48 of explanatory notes to this Category)* **Fee:** $86.45 **Benefit:** 75% = $64.85 85% = $73.50 **Extended Medicare Safety Net Cap:** $259.35
367	A face-to-face attendance of more than 30 minutes duration but not more than 45 minutes duration. *(See para A48 of explanatory notes to this Category)* **Fee:** $133.10 **Benefit:** 75% = $99.85 85% = $113.15 **Extended Medicare Safety Net Cap:** $399.30
369	A face-to-face attendance of more than 45 minutes duration but not more than 75 minutes duration *(See para A48 of explanatory notes to this Category)* **Fee:** $183.80 **Benefit:** 75% = $137.85 85% = $156.25 **Extended Medicare Safety Net Cap:** $500.00
370	A face-to-face attendance of more than 75 minutes duration. *(See para A48 of explanatory notes to this Category)* **Fee:** $213.15 **Benefit:** 75% = $159.90 85% = $181.20 **Extended Medicare Safety Net Cap:** $500.00

GROUP A12 - CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

Initial professional attendance of 10 minutes or less in duration on a patient by a consultant occupational physician practising in his or her specialty of occupational medicine if:
(a) the attendance is by video conference; and
(b) the patient is not an admitted patient; and
(c) the patient:
(i) is located both:
(A) within a telehealth eligible area; and
(B) at the time of the attendance—at least 15 kms by road from the physician; or
(ii) is a care recipient in a residential care service; or
(iii) is a patient of:
(A) an Aboriginal Medical Service; or
(B) an Aboriginal Community Controlled Health Service;
for which a direction made under subsection 19 (2) of the Act applies; and
(d) no other initial consultation has taken place for a single course of treatment
(See para A57 of explanatory notes to this Category)
Fee: $64.20 **Benefit:** 85% = $54.60
384 **Extended Medicare Safety Net Cap:** $192.60

CONSULTANT OCCUPATIONAL PHYSICIAN, REFERRED CONSULTATION - SURGERY OR HOSPITAL
(Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine where the patient is referred to him or her by a referring practitioner)

-INITIAL attendance in a single course of treatment
(See para A22 of explanatory notes to this Category)
Fee: $85.55 **Benefit:** 75% = $64.20 85% = $72.75
385 **Extended Medicare Safety Net Cap:** $256.65

- Each attendance **SUBSEQUENT** to the first in a single course of treatment
(See para A22 of explanatory notes to this Category)
Fee: $43.00 **Benefit:** 75% = $32.25 85% = $36.55
386 **Extended Medicare Safety Net Cap:** $129.00

CONSULTANT OCCUPATIONAL PHYSICIAN, REFERRED CONSULTATION - HOME VISITS
(Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine where the patient is referred to him or her by a referring practitioner)

- INITIAL attendance in a single course of treatment
(See para A22 of explanatory notes to this Category)
Fee: $125.50 **Benefit:** 75% = $94.15 85% = $106.70
387 **Extended Medicare Safety Net Cap:** $376.50

- Each attendance **SUBSEQUENT** to the first in a single course of treatment
(See para A22 of explanatory notes to this Category)
Fee: $79.45 **Benefit:** 75% = $59.60 85% = $67.55
388 **Extended Medicare Safety Net Cap:** $238.35

Professional attendance by a consultant occupational physician practising in his or her specialty of occupational medicine:
(a) by video conference; and
(b) the attendance is for a service:
(i) provided with item 385 lasting more than 10 minutes; or
(ii) provided with item 386; and
(c) the patient is not an admitted patient; and
(d) the patient:
(i) is located both:
(A) within a telehealth eligible area; and
(B) at the time of the attendance—at least 15 kms by road from the physician; or
(ii) is a care recipient in a residential care service; or
(iii) is a patient of:
(A) an Aboriginal Medical Service; or
(B) an Aboriginal Community Controlled Health Service;
for which a direction made under subsection 19 (2) of the Act applies

(See para A57 of explanatory notes to this Category)
Derived Fee: 50% of the fee for item 385 or 386. Benefit: 85% of the derived fee
389 **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

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

PUBLIC HEALTH PHYSICIAN ATTENDANCES - AT CONSULTING ROOMS

Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine

LEVEL A

Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.

(See para A39 of explanatory notes to this Category)

410 **Fee:** $19.55 **Benefit:** 75% = $14.70 85% = $16.65
Extended Medicare Safety Net Cap: $58.65

LEVEL B

Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant:

a) taking a patient history;
b) performing a clinical examination;
c) arranging any necessary investigation;
d) implementing a management plan;
e) providing appropriate preventive health care;

in relation to 1 or more health-related issues, with appropriate documentation.

(See para A39 of explanatory notes to this Category)

411 **Fee:** $42.75 **Benefit:** 75% = $32.10 85% = $36.35
Extended Medicare Safety Net Cap: $128.25

LEVEL C

Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant:

a) taking a detailed patient history;
b) performing a clinical examination;
c) arranging any necessary investigation;
d) implementing a management plan;
e) providing appropriate preventive health care;

in relation to 1 or more health-related issues, with appropriate documentation.

(See para A39 of explanatory notes to this Category)

412 **Fee:** $82.65 **Benefit:** 75% = $62.00 85% = $70.30
Extended Medicare Safety Net Cap: $247.95

LEVEL D

Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant:

a) taking an extensive patient history;
b) performing a clinical examination;
c) arranging any necessary investigation;
d) implementing a management plan;
e) providing appropriate preventive health care;

in relation to 1 or more health-related issues, with appropriate documentation.

(See para A39 of explanatory notes to this Category)

413 **Fee:** $121.70 **Benefit:** 75% = $91.30 85% = $103.45
Extended Medicare Safety Net Cap: $365.10

PUBLIC HEALTH PHYSICIAN ATTENDANCES - OTHER THAN AT CONSULTING ROOMS

Professional attendance other than at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine.

LEVEL A

Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.

(See para A39 of explanatory notes to this Category)

Derived Fee: The fee for item 410, plus $25.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 410 plus $1.95 per patient.

414 **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

415	**LEVEL B** Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. *(See para A39 of explanatory notes to this Category)* **Derived Fee:** The fee for item 411, plus $25.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 411 plus $1.95 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
416	**LEVEL C** Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. *(See para A39 of explanatory notes to this Category)* **Derived Fee:** The fee for item 412, plus $25.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 412 plus $1.95 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
417	**LEVEL D** Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. *(See para A39 of explanatory notes to this Category)* **Derived Fee:** The fee for item 413, plus $25.45 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 413 plus $1.95 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

GROUP A21 - MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

SUBGROUP 1 - CONSULTATIONS

MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 1

Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine

Attendance for the unscheduled evaluation and management of a patient requiring the taking of a problem focussed history, limited examination, diagnosis and initiation of appropriate treatment interventions involving straightforward medical decision making.

(See para A49 of explanatory notes to this Category)

Fee: $34.20 **Benefit:** 75% = $25.65 85% = $29.10

501 **Extended Medicare Safety Net Cap:** $102.60

MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 2

Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency medicine physician in the practice of emergency medicine

Attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focussed history, expanded examination of one or more systems and the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of low complexity.

(See para A49 of explanatory notes to this Category)

Fee: $57.80 **Benefit:** 75% = $43.35 85% = $49.15

503 **Extended Medicare Safety Net Cap:** $173.40

MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 3

Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine

Attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focussed history, expanded examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of moderate complexity.

(See para A49 of explanatory notes to this Category)

Fee: $97.05 **Benefit:** 75% = $72.80 85% = $82.50

507 **Extended Medicare Safety Net Cap:** $291.15

MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 4

Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine

Attendance for the unscheduled evaluation and management of a patient requiring the taking of a detailed history, detailed examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives, involving medical decision making of moderate complexity.

(See para A49 of explanatory notes to this Category)

Fee: $137.30 **Benefit:** 75% = $103.00 85% = $116.75

511 **Extended Medicare Safety Net Cap:** $411.90

	MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT LEVEL 5 Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine Attendance for the unscheduled evaluation and management of a patient requiring the taking of a comprehensive history, comprehensive examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives, involving medical decision making of high complexity. *(See para A49 of explanatory notes to this Category)* **Fee:** $212.60 **Benefit:** 75% = $159.45 85% = $180.75 515 **Extended Medicare Safety Net Cap:** $500.00
	SUBGROUP 2 - PROLONGED PROFESSIONAL ATTENDANCES TO WHICH NO OTHER GROUP APPLIES
	MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES – EMERGENCY DEPARTMENT Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine Attendance for emergency evaluation of a critically ill patient with an immediately life threatening problem requiring immediate and rapid assessment, initiation of resuscitation and electronic vital signs monitoring, comprehensive history and evaluation whilst undertaking resuscitative measures, ordering and evaluation of appropriate investigations, transitional evaluation and monitoring, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives prior to admission to an in-patient hospital bed -For a period of not less than 30 minutes but less than 1 hour of total physician time spent with each patient *(See para A50 of explanatory notes to this Category)* **Fee:** $146.20 **Benefit:** 75% = $109.65 85% = $124.30 519 **Extended Medicare Safety Net Cap:** $438.60
	-For a period of not less than 1 hour but less than 2 hours of total physician time spent with each patient *(See para A50 of explanatory notes to this Category)* **Fee:** $280.85 **Benefit:** 75% = $210.65 85% = $238.75 520 **Extended Medicare Safety Net Cap:** $500.00
	-For a period of not less than 2 hours but less than 3 hours of total physician time spent with each patient *(See para A50 of explanatory notes to this Category)* **Fee:** $460.30 **Benefit:** 75% = $345.25 85% = $391.30 530 **Extended Medicare Safety Net Cap:** $500.00
	-For a period of not less than 3 hours but less than 4 hours of total physician time spent with each patient. *(See para A50 of explanatory notes to this Category)* **Fee:** $639.75 **Benefit:** 75% = $479.85 85% = $560.25 532 **Extended Medicare Safety Net Cap:** $500.00
	-For a period of not less than 4 hours but less than 5 hours of total physician time spent with each patient *(See para A50 of explanatory notes to this Category)* **Fee:** $819.35 **Benefit:** 75% = $614.55 85% = $739.85 534 **Extended Medicare Safety Net Cap:** $500.00
	-For a period of 5 hours or more of total physician time spent with each patient. *(See para A50 of explanatory notes to this Category)* **Fee:** $909.10 **Benefit:** 75% = $681.85 85% = $829.60 536 **Extended Medicare Safety Net Cap:** $500.00

GROUP A11 - URGENT ATTENDANCE AFTER HOURS

SUBGROUP 1 - URGENT ATTENDANCE - AFTER HOURS

597

Professional attendance by a general practitioner on not more than 1 patient on the 1 occasion – each attendance ***(other than an attendance between 11pm and 7am)*** in an after-hours period if:
a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken urgent after-hours period;
b) the patient's condition requires urgent medical treatment; and
c) if the attendance is undertaken at consulting rooms, it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance.
(See para A5 and A10 of explanatory notes to this Category)
Fee: $129.80 **Benefit:** 75% = $97.35 100% = $129.80
Extended Medicare Safety Net Cap: $389.40

598

Professional attendance by a medical practitioner (other than a general practitioner) on not more than 1 patient on the 1 occasion – each attendance ***(other than an attendance between 11pm and 7am)*** in an after-hours period if:
a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken urgent after-hours period;
b) the patient's condition requires urgent medical treatment; and
c) if the attendance is undertaken at consulting rooms, it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance.
Fee: $104.75 **Benefit:** 75% = $78.60 100% = $104.75
Extended Medicare Safety Net Cap: $314.25

SUBGROUP 2 - URGENT ATTENDANCE UNSOCIABLE AFTER HOURS

599

Professional attendance, by a general practitioner on not more than 1 patient on the 1 occasion – each attendance ***between 11pm and 7am***, if:
a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period; and
b) the patient's condition requires urgent medical treatment; and
c) if the attendance is undertaken at consulting rooms, it is necessary for the practitioner to return to and specially open, the consulting rooms for the attendance.
(See para A5 and A10 of explanatory notes to this Category)
Fee: $153.00 **Benefit:** 75% = $114.75 100% = $153.00
Extended Medicare Safety Net Cap: $459.00

600

Professional attendance, by a medical practitioner, (other than a general practitioner) on not more than 1 patient on the 1 occasion – each attendance ***between 11pm and 7am***, if:
a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period; and
b) the patient's condition requires urgent medical treatment; and
c) if the attendance is undertaken at consulting rooms, it is necessary for the practitioner to return to and specially open, the consulting rooms for the attendance.
(See para A10 of explanatory notes to this Category)
Fee: $124.25 **Benefit:** 75% = $93.20 100% = $124.25
Extended Medicare Safety Net Cap: $372.75

GROUP A14 - HEALTH ASSESSMENTS

HEALTH ASSESSMENTS

The category of people eligible for health assessments are :

a) Healthy Kids Check for children who have received or are receiving their four year old immunisation

b) People aged 40 to 49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool

c) People between the age of 45 and 49 (inclusive) who are at risk of developing a chronic disease

d) People aged 75 years and older

e) Permanent residents of a Residential Aged Care Facility

f) People who have an intellectual disability

g) Humanitarian entrants who are resident in Australia with access to Medicare services, including Refugees and Special Humanitarian Program and Protection Program entrants

h) Former serving members of the Australian Defence Force including former members of permanent and reserve forces

701

HEALTH ASSESSMENT - BRIEF

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a brief health assessment, lasting not more than 30 minutes and, including:

a) Collection of relevant information, including taking a patient history;

b) A basic physical examination;

c) Initiating interventions and referrals as indicated; and

d) Providing the patient with preventive health care advice and information.

(See para A25 and A26 and A27 and A28 and A29 and A30 and A31 and A58 of explanatory notes to this Category)

Fee: $59.35 **Benefit:** 100% = $59.35

Extended Medicare Safety Net Cap: $178.05

703

HEALTH ASSESSMENT - STANDARD

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including:

a) Detailed information collection, including taking a patient history;

b) An extensive physical examination;

c) Initiating interventions and referrals as indicated; and

d) Providing a preventive health care strategy for the patient.

(See para A25 and A26 and A27 and A28 and A29 and A30 and A31 and A58 of explanatory notes to this Category)

Fee: $137.90 **Benefit:** 100% = $137.90

Extended Medicare Safety Net Cap: $413.70

705

HEALTH ASSESSMENT - LONG

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including:

a) Comprehensive information collection, including taking a patient history;

b) An extensive examination of the patient's medical condition and physical function;

c) Initiating interventions and referrals as indicated; and

d) Providing a basic preventive health care management plan for the patient.

(See para A25 and A26 and A27 and A28 and A29 and A30 and A31 and A58 of explanatory notes to this Category)

Fee: $190.30 **Benefit:** 100% = $190.30

Extended Medicare Safety Net Cap: $500.00

707

HEALTH ASSESSMENT - PROLONGED

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to perform a prolonged health assessment, lasting at least 60 minutes, including:

a) Comprehensive information collection, including taking a patient history;

b) An extensive examination of the patient's medical condition, and physical, psychological and social function.

c) Initiating interventions and referrals as indicated; and

d) Providing a comprehensive preventive health care management plan for the patient.

(See para A25 and A26 and A27 and A28 and A29 and A30 and A31 and A58 of explanatory notes to this Category)

Fee: $268.80 **Benefit:** 100% = $268.80

Extended Medicare Safety Net Cap: $500.00

	ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES HEALTH ASSESSMENT Details of the requirements for the Aboriginal and Torres Strait Islander Peoples Health Assessment, The Aboriginal and Torres Strait Islander Peoples Health Assessment is available to: a) Children between ages of 0 and 14 years, b) Adults between the ages of 15 and 54 years, c) Older people over the age of 55 years.
715	**ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES HEALTH ASSESSMENT** Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) at consulting rooms or in another place other than a hospital or Residential Aged Care Facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent - not more than once in a 9 month period. *(See para A32 and A33 and A34 and A35 of explanatory notes to this Category)* **Fee:** $212.25 **Benefit:** 100% = $212.25 **Extended Medicare Safety Net Cap:** $500.00

GROUP A15 - GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS

SUBGROUP 1 - GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND MULTIDISCIPLINARY CARE PLANS

721

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) for the PREPARATION of a **GP MANAGEMENT PLAN** (GPMP) for a patient (not being a service associated with a service to which **items 735 to 758** apply).

This CDM service is for a patient who has at least one medical condition that:
(a) has been (or is likely to be) present for at least six months; or
(b) is terminal.

A rebate will not be paid within twelve months of a previous claim for item 721, or within three months of a claim for items 729, 731 or 732 (for a review of a GPMP), except where there are exceptional circumstances that require the preparation of a new GPMP.
(See para A36 of explanatory notes to this Category)
Fee: $144.25 **Benefit:** 75% = $108.20 100% = $144.25
Extended Medicare Safety Net Cap: $432.75

723

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to **COORDINATE** the development of **TEAM CARE ARRANGEMENTS** (TCAs) for a patient (not being a service associated with a service to which **items 735 to 758** apply).

This CDM service is for a patient who:
(a) has at least one medical condition that:
i. has been (or is likely to be) present for at least six months; or
ii. is terminal; and
(b) requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner.

A rebate will not be paid within twelve months of a previous claim for item 723, or within three months of a claim for item 732 (for a review of TCAs), except where there are exceptional circumstances that require the coordination of new TCAs.
(See para A36 of explanatory notes to this Category)
Fee: $114.30 **Benefit:** 75% = $85.75 100% = $114.30
Extended Medicare Safety Net Cap: $342.90

729

CONTRIBUTION by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **TO A MULTIDISCIPLINARY CARE PLAN prepared by another provider OR TO A REVIEW OF A MULTIDISCIPLINARY CARE PLAN** prepared by another provider (not being a service associated with a service to which **items 735 to 758** apply).

This CDM service is for a patient who:
(a) has at least one medical condition that:
i. has been (or is likely to be) present for at least six months; or
ii. is terminal; and
(b) requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner; and
(c) is not a care recipient in a residential aged care facility.

A rebate will not be paid within twelve months of a claim by the same practitioner for item 721 or 723, within three months of a claim for item 729 or within three months of a claim for item 731 or 732, except where there are exceptional circumstances that require a new contribution to the multidisciplinary care plan.
(See para A36 of explanatory notes to this Category)
Fee: $70.40 **Benefit:** 100% = $70.40
Extended Medicare Safety Net Cap: $211.20

731	**CONTRIBUTION** by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to: (a) **a multidisciplinary care plan for a patient in A RESIDENTIAL AGED CARE FACILITY (RACF)**, prepared by that facility, **or to a REVIEW of such a plan** prepared by a RACF; or (b) a multidisciplinary care plan prepared for a resident by another provider before the resident is discharged from a hospital or an approved day-hospital facility, or to a review of such a plan prepared by another provider; (not being a service associated with a service to which **items 735 to 758** apply). This CDM service is for a patient who: (a) has at least one medical condition that: i has been (or is likely to be) present for at least six months; or ii is terminal; and (b) requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner; and (c) is a care recipient in a residential aged care facility. A rebate will not be paid within three months of a previous claim for item 731 or within three months of a claim for item 721, 723, 729 or 732 except where there are exceptional circumstances that require a new contribution to the multidisciplinary care plan. *(See para A36 of explanatory notes to this Category)* **Fee:** $70.40 **Benefit:** 100% = $70.40 **Extended Medicare Safety Net Cap:** $211.20
732	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to: (a) **REVIEW A GP MANAGEMENT PLAN** to which item 721 applies. Where these services were provided by that medical practitioner (or an associated medical practitioner), and not being a service associated with a service to which items 735-758 apply. This CDM service is for a patient who has at least one medical condition that: i. has been (or is likely to be) present for at least six months; or ii. is terminal. or (b) **COORDINATE A REVIEW OF TEAM CARE ARRANGEMENTS** to which item 723 applies. This CDM service is for a patient who: i. has at least one medical condition that has been (or is likely to be) present for at least six months; or is terminal, and ii. also requires ongoing care from at least three collaborating health or care providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner. Each service to which item 732 applies may only be claimed once in a three-month period, except where there are exceptional circumstances that necessitate earlier performance of the service to the patient. *(See para A36 of explanatory notes to this Category)* **Fee:** $72.05 **Benefit:** 75% = $54.05 100% = $72.05 **Extended Medicare Safety Net Cap:** $216.15

SUBGROUP 2 - CASE CONFERENCES

MULTIDISCIPLINARY CASE CONFERENCE - MEDICAL PRACTITIONER (OTHER THAN A SPECIALIST OR CONSULTANT PHYSICIAN)

These services are for patients who:

(a) have at least one medical condition that:
  i. has been (or is likely to be) present for at least six months; or
  ii. is terminal; and
(b) require ongoing care from a multidisciplinary case conference team which includes:
  i. a medical practitioner; and
  ii. at least two other members, each of whom provides a different kind of care or service to the patient and is not a family carer of the patient, and one of whom may be another medical practitioner.

For the purposes of items 735-758, a multidisciplinary case conference is a process by which a multidisciplinary case conference team:

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

Participation in a multidisciplinary case conference must be at the request of the person who organises and coordinates the conference.

735

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND COORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY OR A COMMUNITY CASE CONFERENCE OR A DISCHARGE CASE CONFERENCE** (not being a service associated with a service to which items **721 to 732** apply)

where the conference time is **at least 15 minutes and less than 20 minutes**
(See para A38 of explanatory notes to this Category)
Fee: $70.65 **Benefit:** 75% = $53.00 100% = $70.65
Extended Medicare Safety Net Cap: $211.95

739

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND COORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY OR A COMMUNITY CASE CONFERENCE OR A DISCHARGE CASE CONFERENCE** (not being a service associated with a service to which items **721 to 732** apply)

where the conference time is **at least 20 minutes and less than 40 minutes**
(See para A38 of explanatory notes to this Category)
Fee: $120.95 **Benefit:** 75% = $90.75 100% = $120.95
Extended Medicare Safety Net Cap: $362.85

743

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND COORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY OR A COMMUNITY CASE CONFERENCE OR A DISCHARGE CASE CONFERENCE** (not being a service associated with a service to which items **721 to 732** apply)

where the conference time is **at least 40 minutes**
(See para A38 of explanatory notes to this Category)
Fee: $201.65 **Benefit:** 75% = $151.25 100% = $201.65
Extended Medicare Safety Net Cap: $500.00

CHRONIC DISEASE MANAGEMENT	CASE CONFERENCES
747	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY OR A COMMUNITY CASE CONFERENCE OR A DISCHARGE CASE CONFERENCE** (not being a service associated with a service to which items **721 to 732** apply) where the conference time is **at least 15 minutes and less than 20 minutes** *(See para A38 of explanatory notes to this Category)* **Fee:** $51.90 **Benefit:** 75% = $38.95 100% = $51.90 **Extended Medicare Safety Net Cap:** $155.70
750	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY OR A COMMUNITY CASE CONFERENCE OR A DISCHARGE CASE CONFERENCE** (not being a service associated with a service to which items **721 to 732** apply) where the conference time is **at least 20 minutes and less than 40 minutes** *(See para A38 of explanatory notes to this Category)* **Fee:** $89.00 **Benefit:** 75% = $66.75 100% = $89.00 **Extended Medicare Safety Net Cap:** $267.00
758	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY OR A COMMUNITY CASE CONFERENCE OR A DISCHARGE CASE CONFERENCE** (not being a service associated with a service to which items **721 to 732** apply) where the conference time is **at least 40 minutes** **Fee:** $148.20 **Benefit:** 75% = $111.15 100% = $148.20 **Extended Medicare Safety Net Cap:** $444.60
820	**CASE CONFERENCE - CONSULTANT PHYSICIAN** Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE** of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A40 of explanatory notes to this Category)* **Fee:** $139.10 **Benefit:** 75% = $104.35 85% = $118.25 **Extended Medicare Safety Net Cap:** $417.30
822	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE** of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A40 of explanatory notes to this Category)* **Fee:** $208.70 **Benefit:** 75% = $156.55 85% = $177.40 **Extended Medicare Safety Net Cap:** $500.00
823	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE** of at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A40 of explanatory notes to this Category)* **Fee:** $278.15 **Benefit:** 75% = $208.65 85% = $236.45 **Extended Medicare Safety Net Cap:** $500.00
825	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and to coordinate the conference) of a least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A40 of explanatory notes to this Category)* **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95 **Extended Medicare Safety Net Cap:** $299.70
826	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and to coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A40 of explanatory notes to this Category)* **Fee:** $159.30 **Benefit:** 75% = $119.50 85% = $135.45 **Extended Medicare Safety Net Cap:** $477.90

CHRONIC DISEASE MANAGEMENT	CASE CONFERENCES
828	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and to coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A40 of explanatory notes to this Category)* **Fee:** $218.75 **Benefit:** 75% = $164.10 85% = $185.95 **Extended Medicare Safety Net Cap:** $500.00
830	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE** of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A40 of explanatory notes to this Category)* **Fee:** $139.10 **Benefit:** 75% = $104.35 85% = $118.25 **Extended Medicare Safety Net Cap:** $417.30
832	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE** of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A40 of explanatory notes to this Category)* **Fee:** $208.70 **Benefit:** 75% = $156.55 85% = $177.40 **Extended Medicare Safety Net Cap:** $500.00
834	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE** of at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A40 of explanatory notes to this Category)* **Fee:** $278.15 **Benefit:** 75% = $208.65 85% = $236.45 **Extended Medicare Safety Net Cap:** $500.00
835	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A40 of explanatory notes to this Category)* **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95 **Extended Medicare Safety Net Cap:** $299.70
837	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A40 of explanatory notes to this Category)* **Fee:** $159.30 **Benefit:** 75% = $119.50 85% = $135.45 **Extended Medicare Safety Net Cap:** $477.90
838	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** of at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A40 of explanatory notes to this Category)* **Fee:** $218.75 **Benefit:** 75% = $164.10 85% = $185.95 **Extended Medicare Safety Net Cap:** $500.00
855	**CASE CONFERENCE - CONSULTANT PSYCHIATRIST** Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE** of at least 15 minutes, but less than 30 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A51 of explanatory notes to this Category)* **Fee:** $139.10 **Benefit:** 75% = $104.35 85% = $118.25 **Extended Medicare Safety Net Cap:** $417.30
857	Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE** of at least 30 minutes, but less than 45 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A51 of explanatory notes to this Category)* **Fee:** $208.70 **Benefit:** 75% = $156.55 85% = $177.40 **Extended Medicare Safety Net Cap:** $500.00

858	Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE** of at least 45 minutes with a multidisciplinary team of at least two other formal care providers, of different disciplines *(See para A51 of explanatory notes to this Category)* **Fee:** $278.15 **Benefit:** 75% = $208.65 85% = $236.45 **Extended Medicare Safety Net Cap:** $500.00
861	**CASE CONFERENCE - CONSULTANT PSYCHIATRIST** Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE**, of at least 15 minutes, but less than 30 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A51 of explanatory notes to this Category)* **Fee:** $139.10 **Benefit:** 75% = $104.35 85% = $118.25 **Extended Medicare Safety Net Cap:** $417.30
864	Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE**, of at least 30 minutes, but less than 45 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A51 of explanatory notes to this Category)* **Fee:** $208.70 **Benefit:** 75% = $156.55 85% = $177.40 **Extended Medicare Safety Net Cap:** $500.00
866	Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE**, of at least 45 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A51 of explanatory notes to this Category)* **Fee:** $278.15 **Benefit:** 75% = $208.65 85% = $236.45 **Extended Medicare Safety Net Cap:** $500.00
871	**MULTIDISCIPLINARY CANCER CARE CASE CONFERENCE** Attendance by a medical practitioner (including a specialist or consultant physician in the practice of his or her specialty or a general practitioner), as a member of a case conference team, to **LEAD AND COORDINATE A MULTIDISCIPLINARY CASE CONFERENCE ON A PATIENT WITH CANCER TO DEVELOP A MULTIDISCIPLINARY TREATMENT PLAN**, where the case conference is of at least 10 minutes, with a multidisciplinary team of at least three other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers. *(See para A54 of explanatory notes to this Category)* **Fee:** $80.30 **Benefit:** 75% = $60.25 85% = $68.30 **Extended Medicare Safety Net Cap:** $240.90
872	Attendance by a medical practitioner (including a specialist or consultant physician in the practice of his or her specialty or a general practitioner), as a member of a case conference team, to **PARTICIPATE IN A MULTIDISCIPLINARY CASE CONFERENCE ON A PATIENT WITH CANCER TO DEVELOP A MULTIDISCIPLINARY TREATMENT PLAN**, where the case conference is of at least 10 minutes, with a multidisciplinary team of at least four medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers. *(See para A54 of explanatory notes to this Category)* **Fee:** $37.40 **Benefit:** 75% = $28.05 85% = $31.80 **Extended Medicare Safety Net Cap:** $112.20
880	**CASE CONFERENCE - SPECIALIST OR CONSULTANT PHYSICIAN IN GERIATRIC OR REHABILITATION MEDICINE** Attendance by a specialist or consultant physician in the practice of his or her specialty of GERIATRIC OR REHABILITATION MEDICINE, as a member of a case conference team, to **COORDINATE A CASE CONFERENCE ON AN ADMITTED HOSPITAL PATIENT** of at least 10 minutes but less than 30 minutes for any particular patient, one attendance only in a 7 day period (other than attendance on the same day as an attendance for which item 832, 834, 835, 837 or 838 was applicable in relation to the patient). *(See para A52 of explanatory notes to this Category)* **Fee:** $48.65 **Benefit:** 75% = $36.50 **Extended Medicare Safety Net Cap:** $145.95

ATTENDANCE		ATTENDANCE
	GROUP A17 - DOMICILIARY AND RESIDENTIAL MANAGEMENT REVIEWS	
900	Participation by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) in a **Domiciliary Medication Management Review (DMMR)** for patients living in the community setting, where the medical practitioner: - assesses a patient's medication management needs, and following that assessment, refers the patient to a community pharmacy or an accredited pharmacist for a DMMR, and provides relevant clinical information required for the review, with the patient's consent; and - discusses with the reviewing pharmacist the results of that review including suggested medication management strategies; and - develops a written medication management plan following discussion with the patient. Benefits under this item are payable not more than once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR. *(See para A41 of explanatory notes to this Category)* **Fee:** $154.80 **Benefit:** 100% = $154.80 **Extended Medicare Safety Net Cap:** $464.40	
903	Participation by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) in a collaborative **Residential Medication Management Review (RMMR)** for a permanent **resident** of a residential aged care facility, where the medical practitioner: - discusses and seeks consent for an RMMR from the new or existing resident; - collaborates with the reviewing pharmacist regarding the pharmacy component of the review; - provides input from the resident's Comprehensive Medical Assessment (CMA), or if a CMA has not been undertaken, provides relevant clinical information for the resident's RMMR; - discusses findings of the pharmacist review and proposed medication management strategies with the reviewing pharmacist (unless exceptions apply); - develops and/or revises a written medication plan for the resident; and - consults with the resident to discuss the medication management plan and its implementation. Benefits under this item are payable for one RMMR service for new residents on admission to a Residential Aged Care Facility and for continuing residents on an as required basis, with a maximum of one RMMR for a resident in any 12 month period, except where there has been a significant change in medical condition or medication regimen requiring a new RMMR. *(See para A41 of explanatory notes to this Category)* **Fee:** $106.00 **Benefit:** 100% = $106.00 **Extended Medicare Safety Net Cap:** $318.00	

GROUP A30 - MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES

SUBGROUP 1 - TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS

Level A - Telehealth attendance at consulting rooms
Professional attendance at consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who:
(a) is participating in a video conferencing consultation with a specialist or consultant physician; and
(b) is not an admitted patient; and
(c) either:
(i) is located both:
(A) within a telehealth eligible area; and
(B) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or
(ii) is a patient of:
(A) an Aboriginal Medical Service; or
(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies

(See para A56 of explanatory notes to this Category)
Fee: $22.90 **Benefit:** 100% = $22.90
2100 **Extended Medicare Safety Net Cap:** $68.70

Level A - Telehealth attendance other than at consulting rooms
Professional attendance not in consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who:
(a) is participating in a video conferencing consultation with a specialist or consultant physician; and
(b) is not an admitted patient; and
(c) is not a care recipient in a residential care service; and
(d) is located both:
(i) within a telehealth eligible area; and
(ii) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a);
for an attendance on one or more patients at one place on one occasion—each patient
(See para A56 of explanatory notes to this Category)
Derived Fee: The fee for item 2100 plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2100 plus $2.00 per patient.
2122 **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

SUBGROUP 2 - TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY

Level A - Telehealth attendance at a residential aged care facility
A professional attendance by a medical practitioner (not being a service to which any other item applies) lasting at least 5 minutes (whether or not continuous) that requires the provision of clinical support to a patient who is:
a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or
b) at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit)
and who is participating in a video consultation with a specialist or consultant physician, on 1 occasion - each patient.
(See para A56 of explanatory notes to this Category)
Derived Fee: The fee for item 2100 plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2100 plus $3.30 per patient.
2125 **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

	SUBGROUP 1 - TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS
2126	**Level B - Telehealth attendance at consulting rooms** Professional attendance at consulting rooms of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies *(See para A56 of explanatory notes to this Category)* **Fee:** $49.95 **Benefit:** 100% = $49.95 **Extended Medicare Safety Net Cap:** $149.85
2137	**Level B - Telehealth attendance other than at consulting rooms** Professional attendance not in consulting rooms of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion—each patient *(See para A56 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2126 plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2126 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	SUBGROUP 2 - TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
2138	**Level B - Telehealth attendance at residential aged care facility** Professional attendance of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion—each patient *(See para A56 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2126 plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2126 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

	SUBGROUP 1 - TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS
2143	**Level C - Telehealth attendance at consulting rooms** Professional attendance at consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner who provides clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance - at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies *(See para A56 of explanatory notes to this Category)* **Fee:** $96.85 **Benefit:** 100% = $96.85 **Extended Medicare Safety Net Cap:** $290.55
2147	**Level C - Telehealth attendance other than at consulting rooms** Professional attendance not in consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance - at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion—each patient *(See para A56 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2143 plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2143 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	SUBGROUP 2 - TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
2179	**Level C - Telehealth attendance at residential aged care facility** A professional attendance by a medical practitioner (not being a service to which any other item applies) lasting at least 20 minutes (whether or not continuous) that requires the provision of clinical support to a patient who is: a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or b) at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit); and who is participating in a video consultation with a specialist or consultant physician, on 1 occasion - each patient. *(See para A56 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2143 plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2143 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

	SUBGROUP 1 - TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS
2195	**Level D - Telehealth attendance at consulting rooms** Professional attendance at consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance - at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies *(See para A56 of explanatory notes to this Category)* **Fee:** $142.50 **Benefit:** 100% = $142.50 **Extended Medicare Safety Net Cap:** $427.50
2199	**Level D - Telehealth attendance other than at consulting rooms** Professional attendance not in consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance - at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion—each patient *(See para A56 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2195 plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2195 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	SUBGROUP 2 - TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
2220	**Level D - Telehealth attendance at residential aged care facility** A professional attendance by a medical practitioner (not being a service to which any other item applies) lasting at least 40 minutes (whether or not continuous) that requires the provision of clinical support to a patient who is: a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or b) at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit); and who is participating in a video consultation with a specialist or consultant physician, on 1 occasion - each patient. *(See para A56 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2195 plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2195 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

	GROUP A18 - GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS
	SUBGROUP 1 - TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED PERSON
	LEVEL A Professional attendance involving taking a short patient history and, if required, limited examination and management **and** at which a cervical smear is taken from a person at least 20 years old and not older than 69 years old, who has not had a cervical smear in the last 4 years.
2497	**CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms *(See para A5 and A42 of explanatory notes to this Category)* **Fee:** $16.95 **Benefit:** 100% = $16.95 **Extended Medicare Safety Net Cap:** $50.85
	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation **and** at which a cervical smear is taken from a person at least 20 years old and not older than 69 years old, who has not had a cervical smear in the last 4 years.
2501	**CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms *(See para A5 and A42 of explanatory notes to this Category)* **Fee:** $37.05 **Benefit:** 100% = $37.05 **Extended Medicare Safety Net Cap:** $111.15
2503	**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS** Professional attendance at a place other than consulting rooms. *(See para A5 and A42 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2501, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2501 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: f) taking a detailed patient history; g) performing a clinical examination; h) arranging any necessary investigation; i) implementing a management plan; j) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation **and** at which a cervical smear is taken from a person at least 20 years old and not older than 69 years old, who has not had a cervical smear in the last 4 years.
2504	**CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms. *(See para A5 and A42 of explanatory notes to this Category)* **Fee:** $71.70 **Benefit:** 100% = $71.70 **Extended Medicare Safety Net Cap:** $215.10

INCENTIVE ITEMS	GENERAL PRACTITIONER
2506	**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS** Professional attendance at a place other than consulting rooms. *(See para A5 and A42 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2504, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2504 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation **and** at which a cervical smear is taken from a person at least 20 years old and not older than 69 years old, who has not had a cervical smear in the last 4 years.
2507	**CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms *(See para A5 and A42 of explanatory notes to this Category)* **Fee:** $105.55 **Benefit:** 100% = $105.55 **Extended Medicare Safety Net Cap:** $316.65
2509	**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS** Professional attendance at a place other than consulting rooms. *(See para A5 and A42 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2507, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2507 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

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

The minimum requirements of care to complete an annual Diabetes Cycle of Care for patients with established diabetes mellitus must be completed over a period of at least 11 months and up to 13 months, and must include:

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

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

LEVEL B

Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant:
a) taking a patient history;
b) performing a clinical examination;
c) arranging any necessary investigation;
d) implementing a management plan;
e) providing appropriate preventive health care;
in relation to 1 or more health-related issues, with appropriate documentation

AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus.

2517

CONSULTATION AT CONSULTING ROOMS
Professional attendance at consulting rooms.
(See para A5 and A43 of explanatory notes to this Category)
Fee: $37.05 **Benefit:** 100% = $37.05
Extended Medicare Safety Net Cap: $111.15

2518

CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS
Professional attendance at a place other than consulting rooms.
(See para A5 and A43 of explanatory notes to this Category)
Derived Fee: The fee for item 2517, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2517 plus $2.00 per patient.
Extended Medicare Safety Net Cap: 300% of the Derived fee for this item, or $500, whichever is the lesser amount

LEVEL C

Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant:
a) taking a detailed patient history;
b) performing a clinical examination;
c) arranging any necessary investigation;
d) implementing a management plan;
e) providing appropriate preventive health care;
in relation to 1 or more health-related issues, with appropriate documentation

AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus.

2521

CONSULTATION AT CONSULTING ROOMS
Professional attendance at consulting rooms.
(See para A5 and A43 of explanatory notes to this Category)
Fee: $71.70 **Benefit:** 100% = $71.70
Extended Medicare Safety Net Cap: $215.10

INCENTIVE ITEMS	GENERAL PRACTITIONER
2522	**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS** Professional attendance at a place other than consulting rooms. *(See para A5 and A43 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2521, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2521 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus.
2525	**CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms. *(See para A5 and A43 of explanatory notes to this Category)* **Fee:** $105.55 **Benefit:** 100% = $105.55 **Extended Medicare Safety Net Cap:** $316.65
2526	**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS** Professional attendance at a place other than consulting rooms. *(See para A43 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2525, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2525 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	SUBGROUP 3 - COMPLETION OF THE ASTHMA CYCLE OF CARE Note: Benefits are payable for only one service included in Subgroup 3 or A19, Subgroup 3 in a 12-month period, unless a further Asthma Cycle of Care is clinically indicated. At a minimum the Asthma Cycle of Care must include: - at least 2 asthma related consultations within 12 months for a patient with moderate to severe asthma (at least 1 of which (the review consultation) is a consultation that was planned at a previous consultation) - documented diagnosis and assessment of level of asthma control and severity of asthma - review of the patient's use of and access to asthma related medication and devices - provision to the patient of a written asthma action plan (if the patient is unable to use a written asthma action plan – discussion with the patient about an alternative method of providing an asthma action plan, and documentation of the discussion in the patient's medical records) - provision of asthma self-management education to the patient - review of the written or documented asthma action plan.
	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of the Asthma Cycle of Care.
2546	**CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms. *(See para A5 and A44 of explanatory notes to this Category)* **Fee:** $37.05 **Benefit:** 100% = $37.05 **Extended Medicare Safety Net Cap:** $111.15

INCENTIVE ITEMS	GENERAL PRACTITIONER
2547	**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS** Professional attendance at a place other than consulting rooms. *(See para A5 and A44 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2546, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2546 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of the Asthma Cycle of Care.
2552	**CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms. *(See para A5 and A44 of explanatory notes to this Category)* **Fee:** $71.70 **Benefit:** 100% = $71.70 **Extended Medicare Safety Net Cap:** $215.10
2553	**CONSULTATION AT A PLACE OTHER CONSULTING ROOMS** Professional attendance at a place other than consulting rooms. *(See para A44 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2552, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2552 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of the Asthma Cycle of Care.
2558	**CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms. *(See para A5 and A44 of explanatory notes to this Category)* **Fee:** $105.55 **Benefit:** 100% = $105.55 **Extended Medicare Safety Net Cap:** $316.65
2559	**CONSULTATION AT A APLACE OTHER THAN CONSULTING ROOMS** Professional attendance at a place other than consulting rooms. *(See para A5 and A44 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2558, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2558 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

	GROUP A19 - OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES
	SUBGROUP 1 - TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED PERSON
2598	**SURGERY CONSULTATIONS** Professional attendance at consulting rooms **BRIEF CONSULTATION** of not more than 5 minutes duration **and** at which a cervical smear is taken from a person between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. *(See para A42 of explanatory notes to this Category)* **Fee:** $11.00 **Benefit:** 100% = $11.00 **Extended Medicare Safety Net Cap:** $33.00
2600	**SURGERY CONSULTATIONS** Professional attendance at consulting rooms **STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration **and** at which a cervical smear is taken from a person between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. *(See para A42 of explanatory notes to this Category)* **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
2603	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration **and** at which a cervical smear is taken from a person between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. *(See para A42 of explanatory notes to this Category)* **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
2606	**PROLONGED CONSULTATION** of more than 45 minutes duration **and** at which a cervical smear is taken from a person between the ages of 20 and 69 years inclusive who has not had a cervical smear in the last 4 years. *(See para A42 of explanatory notes to this Category)* **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
2610	**OUT-OF-SURGERY CONSULTATIONS** Professional attendance at a place other than consulting rooms **STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration **and** at which a cervical smear is taken from a person between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. *(See para A42 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

INCENTIVE ITEMS	OTHER NON-REFERRED
2613	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration **and** at which a cervical smear is taken from a person between the ages of 20 and 69 years inclusive, who has not had a cervical smear in the last 4 years. *(See para A42 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
2616	**PROLONGED CONSULTATION** of more than 45 minutes duration **and** at which a cervical smear is taken from a person between the ages of 20 and 69 years inclusive who has not had a cervical smear in the last 4 years. *(See para A42 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	SUBGROUP 2 - COMPLETION OF AN ANNUAL CYCLE OF CARE FOR PATIENTS WITH ESTABLISHED DIABETES MELLITUS
2620	The minimum requirements of care to complete an annual Diabetes Cycle of Care for patients with established diabetes mellitus must be completed over a period of at least 11 months and up to 13 months, and must include: - Assess diabetes control by measuring HbA_{1c} — At least once every year - Ensure that a comprehensive eye examination is carried out* — At least once every two years - Measure weight and height and calculate BMI** — At least twice every cycle of care - Measure blood pressure — At least twice every cycle of care - Examine feet*** — At least twice every cycle of care - Measure total cholesterol, triglycerides and HDL cholesterol — At least once every year - Test for microalbuminuria — At least once every year - Provide self-care education — Patient education regarding diabetes management - Review diet — Reinforce information about appropriate dietary choices - Review levels of physical activity — Reinforce information about appropriate levels of physical activity - Check smoking status — Encourage cessation of smoking (if relevant) - Review of medication — Medication review * Not required if the patient is blind or does not have both eyes. ** Initial visit: measure height and weight and calculate BMI as part of the initial patient assessment. Subsequent visits: measure weight. *** Not required if the patient does not have both feet. **SURGERY CONSULTATIONS** (Professional attendance at consulting rooms) **STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus. *(See para A43 of explanatory notes to this Category)* **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
2622	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus *(See para A43 of explanatory notes to this Category)* **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00

INCENTIVE ITEMS	OTHER NON-REFFERED
2624	**PROLONGED CONSULTATION** of more than 45 minutes duration AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus *(See para A43 of explanatory notes to this Category)* **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
2631	**OUT-OF-SURGERY CONSULTATIONS** (Professional attendance at a place other than the consulting rooms) **STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus **Extended Medicare Safety Net Cap: 300% of the Derived fee for this item, or $500, whichever is the lesser amount** *(See para A43 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
2633	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus *(See para A43 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
2635	**PROLONGED CONSULTATION** of more than 45 minutes duration AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus *(See para A43 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	SUBGROUP 3 - COMPLETION OF THE ASTHMA CYCLE OF CARE
2664	**Note: Benefits are payable for only one service included in Subgroup 3 or A18, Subgroup 3 in a 12-month period, unless a further Asthma Cycle of Care is clinically indicated.** At a minimum the Asthma Cycle of Care must include: - at least 2 asthma related consultations within 12 months for a patient with **moderate to severe** asthma (at least 1 of which (the review consultation) is a consultation that was planned at a previous consultation) - documented diagnosis and assessment of level of asthma control and severity of asthma - review of the patient's use of and access to asthma related medication and devices - provision to the patient of a written asthma action plan (if the patient is unable to use a written asthma action plan – discussion with the patient about an alternative method of providing an asthma action plan, and documentation of the discussion in the patient's medical records) - provision of asthma self-management education to the patient - review of the written or documented asthma action plan **SURGERY CONSULTATIONS** (Professional attendance at consulting rooms) **STANDARD CONSULTATIONS** of more than 5 minutes duration but not more than 25 minutes duration AND which completes the minimum requirements of the Asthma Cycle of Care. *(See para A44 of explanatory notes to this Category)* **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00

INCENTIVE ITEMS	OTHER NON-REFFERED
2666	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration AND which completes the minimum requirements of the Asthma Cycle of Care. *(See para A44 of explanatory notes to this Category)* **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
2668	**PROLONGED CONSULTATION** of more than 45 minutes duration AND which completes the minimum requirements of the Asthma Cycle of Care. *(See para A44 of explanatory notes to this Category)* **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
2673	**OUT-OF-SURGERY CONSULTATIONS** (Professional attendance at a place other than the consulting rooms) **STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration AND which completes the minimum requirements of the Asthma Cycle of Care *(See para A44 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $0.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
2675	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration AND which completes the minimum requirements of the Asthma Cycle of Care. *(See para A44 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
2677	**PROLONGED CONSULTATION** of more than 45 minutes duration AND which completes the minimum requirements of the Asthma Cycle of Care. *(See para A44 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

GROUP A20 - GP MENTAL HEALTH TREATMENT

SUBGROUP 1 - GP MENTAL HEALTH TREATMENT PLANS

2700

PREPARATION by a medical practitioner who has not undertaken mental health skills training (including a general practitioner, but not including a specialist or consultant physician) of a GP MENTAL HEALTH TREATMENT PLAN for a patient (not being a service associated with a service to which items 2713 or 735 to 758 apply) lasting at least 20 minutes.

A rebate will not be paid within twelve months of a previous claim for the same item or item 2701, 2715 or 2717 or within three months following a claim for item 2712, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new GP Mental Health Treatment Plan.
(See para A45 of explanatory notes to this Category)
Fee: $71.70 **Benefit:** 75% = $53.80 100% = $71.70
Extended Medicare Safety Net Cap: $215.10

2701

PREPARATION by a medical practitioner who has not undertaken mental health skills training (including a general practitioner, but not including a specialist or consultant physician) of a GP MENTAL HEALTH TREATMENT PLAN for a patient (not being a service associated with a service to which items 2713 or 735 to 758 apply) lasting at least 40 minutes.

A rebate will not be paid within twelve months of a previous claim for the same item or item 2700, 2715 or 2717 or within three months following a claim for item 2712, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new GP Mental Health Treatment Plan
(See para A45 of explanatory notes to this Category)
Fee: $105.55 **Benefit:** 75% = $79.20 100% = $105.55
Extended Medicare Safety Net Cap: $316.65

2712

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to **REVIEW** a **GP MENTAL HEALTH TREATMENT PLAN** prepared by that medical practitioner (or an associated medical practitioner) to which item 2700, 2701, 2715, 2717 or former items 2702 and 2710 applies or to **REVIEW** a **PSYCHIATRIST ASSESSMENT AND MANAGEMENT PLAN** to which item 291 applies (not being a service associated with a service to which **items 2713 or 735 to 758** apply).

A rebate will not be paid within three months of a previous claim for item 2712 or within four weeks following a claim for item 2700, 2701, 2715 or 2717, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new review of a GP Mental Health Treatment Plan.
(See para A45 of explanatory notes to this Category)
Fee: $71.70 **Benefit:** 75% = $53.80 100% = $71.70
Extended Medicare Safety Net Cap: $215.10

2713

Professional **ATTENDANCE** by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) involving taking relevant history, identifying presenting problem(s), providing treatment, advice and/or referral for other services or treatments and documenting the outcomes of the consultation, on a patient in relation to a mental disorder and lasting at least 20 minutes (not being a service associated with a service to which **items 2700, 2701, 2715, 2717 or 2712** apply).

SURGERY CONSULTATION
(Professional attendance at consulting rooms)
(See para A45 of explanatory notes to this Category)
Fee: $71.70 **Benefit:** 100% = $71.70
Extended Medicare Safety Net Cap: $215.10

2715

PREPARATION by a medical practitioner who has undertaken mental health skills training (including a general practitioner, but not including a specialist or consultant physician) of a GP MENTAL HEALTH TREATMENT PLAN for a patient (not being a service associated with a service to which items 2713 or 735 to 758 apply) lasting at least 20 minutes.

A rebate will not be paid within twelve months of a previous claim for the same item or item 2700, 2701 or 2717 or within three months following a claim for item 2712, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new GP Mental Health Treatment Plan.
(See para A45 of explanatory notes to this Category)
Fee: $91.05 **Benefit:** 75% = $68.30 100% = $91.05
Extended Medicare Safety Net Cap: $273.15

2717	PREPARATION by a medical practitioner who has undertaken mental health skills training (including a general practitioner, but not including a specialist or consultant physician) of a GP MENTAL HEALTH TREATMENT PLAN for a patient (not being a service associated with a service to which items 2713 or 735 to 758 apply) lasting at least 40 minutes. A rebate will not be paid within twelve months of a previous claim for the same item or item 2700, 2701 or 2715 or within three months following a claim for item 2712, except where there has been a significant change in the patient's clinical condition or care circumstances that requires the preparation of a new GP Mental Health Treatment Plan. *(See para A45 of explanatory notes to this Category)* **Fee:** $134.10 **Benefit:** 75% = $100.60 100% = $134.10 **Extended Medicare Safety Net Cap:** $402.30
	SUBGROUP 2 - FOCUSSED PSYCHOLOGICAL STRATEGIES
2721	**MEDICAL PRACTITIONER ATTENDANCE (INCLUDING A GENERAL PRACTITIONER, BUT NOT INCLUDING A SPECIALIST OR CONSULTANT PHYSICIAN) ASSOCIATED WITH PROVISION OF FOCUSSED PSYCHOLOGICAL STRATEGIES** **Note: These services may only be provided by a medical practitioner who is registered with Medicare Australia as having satisfied the requirements for higher level mental health skills for the provision of the service.** Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies, that have been shown to integrate the best external evidence of clinical effectiveness with general practice clinical expertise. These strategies are required to be provided to patients by a credentialed medical practitioner and are time limited; being deliverable, in up to ten planned sessions per calendar year. In exceptional circumstances, following review by the practitioner managing the patient either under the GP Mental Health Treatment Plan or under the Psychiatric Assessment and Management Plan, up to a further 6 services may be approved from 1 March 2012 to 31 December 2012 to an individual patient. Medical practitioners must be notified to Medicare Australia by the General Practice Mental Health Standards Collaboration that they have met the required standards for higher level mental health skills. A session should last for a minimum of 30 minutes. **FPS ATTENDANCE** Professional attendance for the purpose of providing focussed psychological strategies (from the list included in the Explanatory Notes) for assessed mental disorders by a medical practitioner registered with Medicare Australia as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes to less than 40 minutes. **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A46 of explanatory notes to this Category)* **Fee:** $92.75 **Benefit:** 100% = $92.75 **Extended Medicare Safety Net Cap:** $278.25
2723	**OUT-OF-SURGERY CONSULTATION** (Professional attendance at a place other than consulting rooms) *(See para A46 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2721, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2721 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
2725	**FPS EXTENDED ATTENDANCE** Professional attendance for the purpose of providing focussed psychological strategies (from the list included in the Explanatory Notes) for assessed mental health disorders, by a medical practitioner registered with Medicare Australia as meeting the credentialing requirements for provision of this service, and lasting at least 40 minutes. **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A46 of explanatory notes to this Category)* **Fee:** $132.75 **Benefit:** 100% = $132.75 **Extended Medicare Safety Net Cap:** $398.25
2727	**OUT-OF-SURGERY CONSULTATION** (Professional attendance at a place other than consulting rooms) *(See para A46 of explanatory notes to this Category)* **Derived Fee:** The fee for item 2725, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2725 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

GROUP A24 - PAIN AND PALLIATIVE MEDICINE

SUBGROUP 1 - PAIN MEDICINE ATTENDANCES

Initial professional attendance of 10 minutes or less in duration on a patient by a specialist or consultant physician practising in his or her specialty of pain medicine if:
(a) the attendance is by video conference; and
(b) the patient is not an admitted patient; and
(c) the patient:
(i) is located both:
(A) within a telehealth eligible area; and
(B) at the time of the attendance—at least 15 kms by road from the specialist or physician; or
(ii) is a care recipient in a residential care service; or
(iii) is a patient of:
(A) an Aboriginal Medical Service; or
(B) an Aboriginal Community Controlled Health Service;
for which a direction made under subsection 19 (2) of the Act applies; and
(d) no other initial consultation has taken place for a single course of treatment
(See para A57 of explanatory notes to this Category)
Fee: $113.20 **Benefit:** 85% = $96.25
2799 **Extended Medicare Safety Net Cap:** $339.60

MEDICAL PRACTITIONER (PAIN MEDICINE SPECIALIST) ATTENDANCE - SURGERY OR HOSPITAL

Professional attendance at consulting rooms or hospital by a consultant physician or specialist practising in the specialty of pain medicine, where the patient was referred to him or her by a referring practitioner

- INITIAL attendance in a single course of treatment
(See para A47 of explanatory notes to this Category)
Fee: $150.90 **Benefit:** 75% = $113.20 85% = $128.30
2801 **Extended Medicare Safety Net Cap:** $452.70

- Each attendance (other than a service to which item 2814 applies) **SUBSEQUENT** to the first in a single course of treatment
(See para A47 of explanatory notes to this Category)
Fee: $75.50 **Benefit:** 75% = $56.65 85% = $64.20
2806 **Extended Medicare Safety Net Cap:** $226.50

- Each **MINOR** attendance **SUBSEQUENT** to the first in a single course of treatment
(See para A47 of explanatory notes to this Category)
Fee: $43.00 **Benefit:** 75% = $32.25 85% = $36.55
2814 **Extended Medicare Safety Net Cap:** $129.00

Professional attendance on a patient by a specialist or consultant physician practising in his or her specialty of pain medicine if:
(a) the attendance is by video conference;
(b) and the attendance is for a service:
(i) provided with item 2801 lasting more than 10 minutes; or
(ii) provided with item 2806 or 2814; and
(c) the patient is not an admitted patient; and
(d) the patient:
(i) is located both:
(A) within a telehealth eligible area; and
(B) at the time of the attendance—at least 15 kms by road from the specialist or physician; or
(ii) is a care recipient in a residential care service; or
(iii) is a patient of:
(A) an Aboriginal Medical Service; or
(B) an Aboriginal Community Controlled Health Service;
for which a direction made under subsection 19 (2) of the Act applies
(See para A57 of explanatory notes to this Category)
Derived Fee: 50% of the fee for item 2801, 2806 or 2814. Benefit: 85% of the derived fee
2820 **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

	MEDICAL PRACTITIONER (PAIN MEDICINE SPECIALIST) ATTENDANCE - HOME VISIT Professional attendance at a place other than consulting rooms or hospital by a consultant physician or specialist practising in the specialty of pain medicine, where the patient was referred to him or her by a medical practitioner **- INITIAL** attendance in a single course of treatment *(See para A47 of explanatory notes to this Category)* **Fee:** $183.10 **Benefit:** 85% = $155.65 **Extended Medicare Safety Net Cap:** $500.00
2824	
	- Each attendance (other than a service to which item 2840 applies) **SUBSEQUENT** to the first in a single course of treatment *(See para A47 of explanatory notes to this Category)* **Fee:** $110.75 **Benefit:** 85% = $94.15 **Extended Medicare Safety Net Cap:** $332.25
2832	
	- Each **MINOR** attendance **SUBSEQUENT** to the first in a single course of treatment *(See para A47 of explanatory notes to this Category)* **Fee:** $79.75 **Benefit:** 85% = $67.80 **Extended Medicare Safety Net Cap:** $239.25
2840	
	SUBGROUP 2 - PAIN MEDICINE CASE CONFERENCES
	CASE CONFERENCES - PAIN MEDICINE SPECIALIST Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $139.10 **Benefit:** 75% = $104.35 85% = $118.25 **Extended Medicare Safety Net Cap:** $417.30
2946	
	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $208.70 **Benefit:** 75% = $156.55 85% = $177.40 **Extended Medicare Safety Net Cap:** $500.00
2949	
	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $278.15 **Benefit:** 75% = $208.65 85% = $236.45 **Extended Medicare Safety Net Cap:** $500.00
2954	
	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE**, (other than to organise and to coordinate the conference) where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95 **Extended Medicare Safety Net Cap:** $299.70
2958	
	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE**, (other than to organise and to coordinate the conference) where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $159.30 **Benefit:** 75% = $119.50 85% = $135.45 **Extended Medicare Safety Net Cap:** $477.90
2972	

PAIN AND PALLIATIVE MEDICINE	PALLIATIVE MEDICINE
2974	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE**, (other than to organise and to coordinate the conference) where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $218.75 **Benefit:** 75% = $164.10 85% = $185.95 **Extended Medicare Safety Net Cap:** $500.00
2978	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $139.10 **Benefit:** 75% = $104.35 85% = $118.25 **Extended Medicare Safety Net Cap:** $417.30
2984	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $208.70 **Benefit:** 75% = $156.55 85% = $177.40 **Extended Medicare Safety Net Cap:** $500.00
2988	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $278.15 **Benefit:** 75% = $208.65 85% = $236.45 **Extended Medicare Safety Net Cap:** $500.00
2992	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95 **Extended Medicare Safety Net Cap:** $299.70
2996	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $159.30 **Benefit:** 75% = $119.50 85% = $135.45 **Extended Medicare Safety Net Cap:** $477.90
3000	Attendance by a consultant physician or specialist practising in the specialty of pain medicine, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE**, where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $218.75 **Benefit:** 75% = $164.10 85% = $185.95 **Extended Medicare Safety Net Cap:** $500.00

SUBGROUP 3 - PALLIATIVE MEDICINE ATTENDANCES

3003

Initial professional attendance of 10 minutes or less in duration on a patient by a specialist or consultant physician practising in his or her specialty of palliative medicine if:
(a) the attendance is by video conference; and
(b) the patient is not an admitted patient; and
(c) the patient:
(i) is located both:
(A) within a telehealth eligible area; and
(B) at the time of the attendance—at least 15 kms by road from the specialist or physician; or
(ii) is a care recipient in a residential care service; or
(iii) is a patient of:
(A) an Aboriginal Medical Service; or
(B) an Aboriginal Community Controlled Health Service;
for which a direction made under subsection 19 (2) of the Act applies; and
(d) no other initial consultation has taken place for a single course of treatment
(See para A57 of explanatory notes to this Category)
Fee: $113.20 **Benefit:** 85% = $96.25
Extended Medicare Safety Net Cap: $339.60

3005

MEDICAL PRACTITIONER (PALLIATIVE MEDICINE SPECIALIST) ATTENDANCE - SURGERY OR HOSPITAL

Professional attendance at consulting rooms or hospital by a consultant physician or specialist practising in the specialty of palliative medicine, where the patient was referred to him or her by a referring practitioner

- INITIAL attendance in a single course of treatment
(See para A47 of explanatory notes to this Category)
Fee: $150.90 **Benefit:** 75% = $113.20 85% = $128.30
Extended Medicare Safety Net Cap: $452.70

3010

- Each attendance (other than a service to which item 3014 applies) **SUBSEQUENT** to the first in a single course of treatment
(See para A47 of explanatory notes to this Category)
Fee: $75.50 **Benefit:** 75% = $56.65 85% = $64.20
Extended Medicare Safety Net Cap: $226.50

3014

- Each **MINOR** attendance **SUBSEQUENT** to the first in a single course of treatment
(See para A47 of explanatory notes to this Category)
Fee: $43.00 **Benefit:** 75% = $32.25 85% = $36.55
Extended Medicare Safety Net Cap: $129.00

3015

Professional attendance on a patient by a specialist or consultant physician practising in his or her specialty of palliative medicine if:
(a) the attendance is by video conference; and
(b) the attendance is for a service:
(i) provided with item 3005 lasting more than 10 minutes; or
(ii) provided with item 3010 or 3014; and
(c) the patient is not an admitted patient; and
(d) the patient:
(i) is located both:
(A) within a telehealth eligible area; and
(B) at the time of the attendance—at least 15 kms by road from the specialist or physician; or
(ii) is a care recipient in a residential care service; or
(iii) is a patient of:
(A) an Aboriginal Medical Service; or
(A) an Aboriginal Community Controlled Health Service;
for which a direction made under subsection 19 (2) of the Act applies

(See para A57 of explanatory notes to this Category)
Derived Fee: 50% of the fee for item 3005, 3010 or 3014. Benefit: 85% of the derived fee
Extended Medicare Safety Net Cap: 300% of the Derived fee for this item, or $500, whichever is the lesser amount

	MEDICAL PRACTITIONER (PALLIATIVE MEDICINE SPECIALIST) ATTENDANCE - HOME VISIT Professional attendance at a place other than consulting rooms or hospital by a consultant physician or specialist practising in the specialty of palliative medicine, where the patient was referred to him or her by a referring practitioner **- INITIAL** attendance in a single course of treatment *(See para A47 of explanatory notes to this Category)* **Fee:** $183.10 **Benefit:** 85% = $155.65 **Extended Medicare Safety Net Cap:** $500.00
3018	
	- Each attendance (other than a service to which item 3028 applies) **SUBSEQUENT** to the first in a single course of treatment *(See para A47 of explanatory notes to this Category)* **Fee:** $110.75 **Benefit:** 85% = $94.15 **Extended Medicare Safety Net Cap:** $332.25
3023	
	- Each **MINOR** attendance **SUBSEQUENT** to the first in a single course of treatment *(See para A47 of explanatory notes to this Category)* **Fee:** $79.75 **Benefit:** 85% = $67.80 **Extended Medicare Safety Net Cap:** $239.25
3028	
	SUBGROUP 4 - PALLIATIVE MEDICINE CASE CONFERENCES
	CASE CONFERENCES - PALLIATIVE MEDICINE SPECIALIST Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $139.10 **Benefit:** 75% = $104.35 85% = $118.25 **Extended Medicare Safety Net Cap:** $417.30
3032	
	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $208.70 **Benefit:** 75% = $156.55 85% = $177.40 **Extended Medicare Safety Net Cap:** $500.00
3040	
	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $278.15 **Benefit:** 75% = $208.65 85% = $236.45 **Extended Medicare Safety Net Cap:** $500.00
3044	
	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE**, (other than to organise and to coordinate the conference) where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95 **Extended Medicare Safety Net Cap:** $299.70
3051	
	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE**, (other than to organise and to coordinate the conference) where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $159.30 **Benefit:** 75% = $119.50 85% = $135.45 **Extended Medicare Safety Net Cap:** $477.90
3055	

PAIN AND PALLIATIVE MEDICINE	PALLIATIVE MEDICINE
3062	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE**, (other than to organise and to coordinate the conference) where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $218.75 **Benefit:** 75% = $164.10 85% = $185.95 **Extended Medicare Safety Net Cap:** $500.00
3069	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $139.10 **Benefit:** 75% = $104.35 85% = $118.25 **Extended Medicare Safety Net Cap:** $417.30
3074	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $208.70 **Benefit:** 75% = $156.55 85% = $177.40 **Extended Medicare Safety Net Cap:** $500.00
3078	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $278.15 **Benefit:** 75% = $208.65 85% = $236.45 **Extended Medicare Safety Net Cap:** $500.00
3083	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95 **Extended Medicare Safety Net Cap:** $299.70
3088	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $159.30 **Benefit:** 75% = $119.50 85% = $135.45 **Extended Medicare Safety Net Cap:** $477.90
3093	Attendance by a consultant physician or specialist practising in the specialty of palliative medicine, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE**, where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines *(See para A47 of explanatory notes to this Category)* **Fee:** $218.75 **Benefit:** 75% = $164.10 85% = $185.95 **Extended Medicare Safety Net Cap:** $500.00

GROUP A27 - PREGNANCY SUPPORT COUNSELLING

MEDICAL PRACTITIONER ATTENDANCE (INCLUDING A GENERAL PRACTITIONER, BUT NOT INCLUDING A SPECIALIST OR CONSULTANT PHYSICIAN) ASSOCIATED WITH PROVISION OF NON-DIRECTIVE PREGNANCY SUPPORT COUNSELLING SERVICES

Professional attendance for the purpose of providing non-directive pregnancy support counselling to a person who is currently pregnant or who has been pregnant in the preceding 12 months, by a medical practitioner registered with Medicare Australia as meeting the credentialing requirements for provision of this service, and lasting at least 20 minutes. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

This service may not be provided by a medical practitioner who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.

To a maximum of 3 non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items – 4001, 81000, 81005 and 81010 *(see Explanatory note M.8)*.

4001

SURGERY CONSULTATION
(professional attendance at consulting rooms)
(See para A55 of explanatory notes to this Category)
Fee: $76.60 **Benefit:** 100% = $76.60
Extended Medicare Safety Net Cap: $229.80

	GROUP A22 - GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	LEVEL A Professional attendance by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.
5000	**CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A5 and A10 of explanatory notes to this Category)* **Fee:** $29.00 **Benefit:** 100% = $29.00 **Extended Medicare Safety Net Cap:** $87.00
5003	**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS, HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12noon on a Saturday, or before 8am or after 6pm on any other day *(See para A5 and A6 and A10 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5000, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
5010	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12noon on a Saturday, or before 8am or after 6 pm on any other day. *(See para A5 and A8 and A10 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5000, plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
5020	**CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A5 and A10 of explanatory notes to this Category)* **Fee:** $49.00 **Benefit:** 100% = $49.00 **Extended Medicare Safety Net Cap:** $147.00
5023	**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS, HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12noon on a Saturday, or before 8am or after 6pm on any other day. *(See para A5 and A6 and A10 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5020, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

5028	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12noon on a Saturday, or before 8am or after 6pm on any other day *(See para A5 and A8 and A10 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5020, plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
5040	**CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A5 and A10 of explanatory notes to this Category)* **Fee:** $83.95 **Benefit:** 100% = $83.95 **Extended Medicare Safety Net Cap:** $251.85
5043	**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS, HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital or residential aged care facility. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12noon on a Saturday, or before 8am or after 6pm on any other day. *(See para A5 and A6 and A10 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5040, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
5049	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12noon on a Saturday, or before 8am or after 6pm on any other day *(See para A5 and A8 and A10 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5040, plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
5060	**CONSULTATION AT CONSULTING ROOMS** Professional attendance at consulting rooms. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. *(See para A5 and A10 of explanatory notes to this Category)* **Fee:** $117.75 **Benefit:** 100% = $117.75 **Extended Medicare Safety Net Cap:** $353.25

5063	**CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS, HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12noon on a Saturday, or before 8am or after 6pm on any other day *(See para A5 and A6 and A10 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5060, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
5067	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12noon on a Saturday, or before 8am or after 6pm on any other day. *(See para A5 and A8 and A10 of explanatory notes to this Category)* **Derived Fee:** The fee for item 5060, plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

	GROUP A23 - OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	CONSULTATION AT CONSULTING ROOMS Professional attendance by a medical practitioner (other than a general practitioner) at consulting rooms
5200	**BRIEF CONSULTATION** of not more than 5 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
5203	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Fee:** $31.00 **Benefit:** 100% = $31.00 **Extended Medicare Safety Net Cap:** $93.00
5207	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Fee:** $48.00 **Benefit:** 100% = $48.00 **Extended Medicare Safety Net Cap:** $144.00
5208	**PROLONGED CONSULTATION** of more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or before 8am or after 8pm on any other day. **Fee:** $71.00 **Benefit:** 100% = $71.00 **Extended Medicare Safety Net Cap:** $213.00
	CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS, HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY Professional attendance by a medical practitioner (other than a general practitioner) on 1 or more patients on 1 occasion at a place other than consulting rooms, a hospital or residential aged care facility.
5220	**BRIEF CONSULTATION** in an after hours period of not more than 5 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12 noon on a Saturday, or before 8am or after 6pm on any other day *(See para A6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $18.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $18.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
5223	**STANDARD CONSULTATION** in an after hours period of more than 5 minutes duration but not more than 25 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12 noon on a Saturday, or before 8am or after 6pm on any other day. *(See para A6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $26.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $26.00 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
5227	**LONG CONSULTATION** in an after hours period of more than 25 minutes duration but not more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12 noon on a Saturday, or before 8am or after 6pm on any other day. *(See para A6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $45.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $45.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
5228	**PROLONGED CONSULTATION** in an after hours period of more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12 noon on a Saturday, or before 8am or after 6pm on any other day. *(See para A6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $67.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $67.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

	CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY Professional attendance on 1 or more patients on 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion – each patient
5260	**BRIEF CONSULTATION** of not more than 5 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12noon on a Saturday, or before 8am or after 6pm on any other day. *(See para A8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $18.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $18.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
5263	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12noon on a Saturday, or before 8am or after 6pm on any other day. *(See para A8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $26.00, plus $31.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $26.00 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
5265	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12noon on a Saturday, or before 8am or after 6pm on any other day. *(See para A8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $45.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $45.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount
5267	**PROLONGED CONSULTATION** of more than 45 minutes duration. The attendance must be initiated either on a public holiday, on a Sunday, before 8am or after 12noon on a Saturday, or before 8am or after 6pm on any other day. *(See para A8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $67.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $67.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

GROUP A26 - NEUROSURGERY ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

Initial professional attendance of 10 minutes or less in duration on a patient by a specialist practising in his or her specialty of neurosurgery if:
(a) the attendance is by video conference; and
(b) the patient is not an admitted patient; and
(c) the patient:
(i) is located both:
(A) within a telehealth eligible area; and
(B) at the time of the attendance—at least 15 kms by road from the specialist; or
(ii) is a care recipient in a residential care service; or
(iii) is a patient of:
(A) an Aboriginal Medical Service; or
(B) an Aboriginal Community Controlled Health Service;
for which a direction made under subsection 19 (2) of the Act applies; and
(d) no other initial consultation has taken place for a single course of treatment
(See para A57 of explanatory notes to this Category)
Fee: $97.20 **Benefit:** 85% = $82.65
6004 **Extended Medicare Safety Net Cap:** $291.60

NEUROSURGERY SPECIALIST, REFERRED CONSULTATION, - SURGERY OR HOSPITAL

- Professional attendance at consulting rooms or hospital by a specialist practising in the specialty of neurosurgery, where the patient was referred to him or her by a medical practitioner.

- **Initial** attendance in a single course of treatment.
(See para A53 of explanatory notes to this Category)
Fee: $129.60 **Benefit:** 75% = $97.20 85% = $110.20
6007 **Extended Medicare Safety Net Cap:** $388.80

LEVEL 1

Each **MINOR** attendance **SUBSEQUEN**T to the first in a single course of treatment.

- An attendance of not more than 15 minutes duration.
(See para A53 of explanatory notes to this Category)
Fee: $43.00 **Benefit:** 75% = $32.25 85% = $36.55
6009 **Extended Medicare Safety Net Cap:** $129.00

LEVEL 2

Each attendance **SUBSEQUENT** to the first in a single course of treatment being an attendance involving a detailed and comprehensive examination, arranging or evaluating any necessary investigations in relation to one or more complex problems.

- An attendance of more than 15 minutes duration but not more than 30 minutes duration.
(See para A53 of explanatory notes to this Category)
Fee: $85.55 **Benefit:** 75% = $64.20 85% = $72.75
6011 **Extended Medicare Safety Net Cap:** $256.65

LEVEL 3

Each attendance **SUBSEQUENT** to the first in a single course of treatment being an attendance involving an extensive and comprehensive examination, arranging or evaluating any necessary investigations in relation to one or more complex problems.

- An attendance of more than 30 minutes duration but not more than 45 minutes duration.
(See para A53 of explanatory notes to this Category)
Fee: $118.50 **Benefit:** 75% = $88.90 85% = $100.75
6013 **Extended Medicare Safety Net Cap:** $355.50

LEVEL 4

Each attendance **SUBSEQUENT** to the first in a single course of treatment being an attendance involving an exhaustive and comprehensive examination, arranging or evaluating any necessary investigations in relation to one or more complex problems

- An attendance of more than 45 minutes duration.
(See para A53 of explanatory notes to this Category)
Fee: $150.90 **Benefit:** 75% = $113.20 85% = $128.30
6015 **Extended Medicare Safety Net Cap:** $452.70

6016	Professional attendance on a patient by a specialist practising in his or her specialty of neurosurgery if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6007 lasting more than 10 minutes; or (ii) provided with item 6009, 6011, 6013 or 6015; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19 (2) of the Act applies. *(See para A57 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee for item 6007, 6009, 6011, 6013 or 6015. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

GROUP A9 - CONTACT LENSES - ATTENDANCES

CONTACT LENSES FOR SPECIFIED CLASSES OF PATIENTS

Note: Benefits may not be claimed under Item 10809 where the patient wants the contact lenses for appearance, sporting, work or psychological reasons

ATTENDANCE FOR THE INVESTIGATION and EVALUATION of a patient for the fitting of CONTACT LENSES, with keratometry and testing with trial lenses and the issue of a prescription - 1 SERVICE IN ANY PERIOD OF 36 CONSECUTIVE MONTHS

10801	- patients with ***myopia of 5.0 dioptres or greater*** (spherical equivalent) in 1 eye *(See para A23 of explanatory notes to this Category)* **Fee:** $121.65 **Benefit:** 75% = $91.25 85% = $103.45 **Extended Medicare Safety Net Cap:** $364.95
10802	- patients with ***manifest hyperopia of 5.0 dioptres or greater*** (spherical equivalent) in 1 eye *(See para A23 of explanatory notes to this Category)* **Fee:** $121.65 **Benefit:** 75% = $91.25 85% = $103.45 **Extended Medicare Safety Net Cap:** $364.95
10803	- patients with ***astigmatism of 3.0 dioptres or greater*** in 1 eye *(See para A23 of explanatory notes to this Category)* **Fee:** $121.65 **Benefit:** 75% = $91.25 85% = $103.45 **Extended Medicare Safety Net Cap:** $364.95
10804	- patients with ***irregular astigmatism*** in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens *(See para A23 of explanatory notes to this Category)* **Fee:** $121.65 **Benefit:** 75% = $91.25 85% = $103.45 **Extended Medicare Safety Net Cap:** $364.95
10805	- patients with ***anisometropia of 3.0 dioptres or greater*** (difference between spherical equivalents) *(See para A23 of explanatory notes to this Category)* **Fee:** $121.65 **Benefit:** 75% = $91.25 85% = $103.45 **Extended Medicare Safety Net Cap:** $364.95
10806	- patients with ***corrected visual acuity of 0.7 logMAR (6/30) or worse*** in both eyes, being patients for whom a contact lens is prescribed as part of a ***telescopic system*** *(See para A23 of explanatory notes to this Category)* **Fee:** $121.65 **Benefit:** 75% = $91.25 85% = $103.45 **Extended Medicare Safety Net Cap:** $364.95
10807	- patients for whom a wholly or segmentally ***opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia*** caused by: (i) pathological mydriasis; or (ii) aniridia; or (iii) coloboma of the iris; or (iv) pupillary malformation or distortion; or (v) significant ocular deformity or corneal opacity whether congenital, traumatic or surgical in origin *(See para A23 of explanatory notes to this Category)* **Fee:** $121.65 **Benefit:** 75% = $91.25 85% = $103.45 **Extended Medicare Safety Net Cap:** $364.95
10808	- patients who, by reason of physical deformity, are ***unable to wear spectacles*** *(See para A23 of explanatory notes to this Category)* **Fee:** $121.65 **Benefit:** 75% = $91.25 85% = $103.45 **Extended Medicare Safety Net Cap:** $364.95
10809	- patients who have a ***medical or optical condition*** (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10806, 10807 or 10808 applies) requiring the use of a contact lens for correction, where the ***condition is specified*** on the patient's account *(See para A23 of explanatory notes to this Category)* **Fee:** $121.65 **Benefit:** 75% = $91.25 85% = $103.45 **Extended Medicare Safety Net Cap:** $364.95

CONTACT LENSES		CONTACT LENSES
10816	ATTENDANCE FOR THE REFITTING OF CONTACT LENSES with keratometry and testing with trial lenses and the issue of a prescription, where the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structural or functional change in the eye or an allergic response **within 36 months of the fitting of a contact lens to which Items 10801 to 10809 apply** *(See para A24 of explanatory notes to this Category)* **Fee:** $121.65 **Benefit:** 75% = $91.25 85% = $103.45 **Extended Medicare Safety Net Cap:** $364.95	

SERVICES		SERVICES
	GROUP A10 - OPTOMETRICAL SERVICES	
	SUBGROUP 1 – GENERAL	
10905	**REFERRED COMPREHENSIVE INITIAL CONSULTATION** Professional attendance of more than 15 minutes duration, being the first in a course of attention, if the patient has been **referred** by another optometrist who is not associated with the optometrist to whom the patient is referred. *(See para O6 of explanatory notes to this Category)* **Fee:** $66.80 85% = $56.80	
10907	**COMPREHENSIVE INITIAL CONSULTATION BY ANOTHER PRACTITIONER** Professional attendance of more than 15 in minutes duration being the first in a course of attention **if the patient has attended another optometrist** for an attendance to which this item or item 10905, 10910, 10911, 10912, 10913, 10914 or 10915 applies, or to which old item 10900 applied: a) for a patient who is less than 65 years of age – within the previous 36 months; or b) for a patient who is at least 65 years of age – within the previous 12 months. *(See para O6 of explanatory notes to this Category)* **Fee:** $33.45 85% = $28.45	
10910	**COMPREHENSIVE INITIAL CONSULTATION – PATIENT IS LESS THAN 65 YEARS OF AGE** Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if: a) the patient is less than 65 years of age; and b) the patient has not, within the previous 36 months, received a service to which: (i) this item or item 10905, 10907, 10912, 10913, 10914 or 10915 applies; or (ii) old item 10900 applied. *(See para O6 of explanatory notes to this Category)* Fee: $66.80 85%=$56.80	
10911	**COMPREHENSIVE INITIAL CONSULTATION – PATIENT IS AT LEAST 65 YEARS OF AGE** Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if: a) the patient is at least 65 years of age; and b) the patient has not, within the previous 12 months, received a service to which: (i) this item or item 10905, 10907, 10910, 10912, 10913, 10914 or 10915 applies; or (ii) old item 10900 applied. *(See para O6 of explanatory notes to this Category)* Fee: $66.80 85%=$56.80	
10912	**OTHER COMPREHENSIVE CONSULTATIONS** Professional attendance of more than 15 minutes duration, being the first in a course of attention, if the patient has suffered a **significant change of visual function** requiring comprehensive reassessment: a) for a patient who is less than 65 years of age – within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10913, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied; or b) for a patient who is at least 65 years of age – within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10913. 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied. *(See para O6 of explanatory notes to this Category)* **Fee:** $66.80 85% = $56.80	
10913	Professional attendance of more than 15 minutes duration, being the first in a course of attention, if the patient has **new signs or symptoms**, unrelated to the earlier course of attention, requiring comprehensive reassessment: a) for a patient who is less than 65 years of age – within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10912, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied; or b) for a patient who is at least 65 years of age – within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10912, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied. *(See para O6 of explanatory notes to this Category)* **Fee:** $66.80 85% = $56.80	

10914	Professional attendance of more than 15 minutes duration, being the first in a course of attention, if the patient has a **progressive disorder** (excluding presbyopia) requiring comprehensive reassessment: a) for a patient who is less than 65 years of age – within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10912, 10913 or 10915 at the same practice applies; or (ii) old item 10900 applied; or b) for a patient who is at least 65 years of age – within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10912, 10913 or 10915 applies; or (ii) old item 10900 applied. *(See para O6 of explanatory notes to this Category)* **Fee:** $66.80 85% = $56.80
10915	Professional attendance of more than 15 minutes duration, being the first in a course of attention involving the examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus requiring comprehensive reassessment. *(See para O6 of explanatory notes to this Category)* **Fee:** $66.80 85% = $56.80
10916	**BRIEF INITIAL CONSULTATION** Professional attendance, being the first in a course of attention, of not more than 15 minutes duration, not being a service associated with a service to which item 10931, 10932, 10933, 10940, 10941, 10942 or 10943 applies. *(See para O6 of explanatory notes to this Category)* **Fee:** $33.45 85% = $28.45
10918	**SUBSEQUENT CONSULTATION** Professional attendance being the second or subsequent in a course of attention not related to the prescription and fitting of contact lenses, not being a service associated with a service to which item 10940 or 10941 applies. *(See para O6 of explanatory notes to this Category)* **Fee:** $33.45 85% = $28.45
10921	**CONTACT LENSES FOR SPECIFIED CLASSES OF PATIENTS - BULK ITEMS FOR ALL SUBSEQUENT CONSULTATIONS** All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or b) old item 10900 applied. Payable once in a period of 36 months for – patients with **myopia of 5.0 dioptres or greater** (spherical equivalent) in one eye. **Fee:** $165.80 85% = $140.95
10922	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or b) old item 10900 applied Payable once in a period of 36 months for - patients with **manifest hyperopia of 5.0 dioptres or greater** (spherical equivalent) in one eye. **Fee:** $165.80 85% = $140.95
10923	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or b) old item 10900 applied Payable once in a period of 36 months for - patients with **astigmatism of 3.0 dioptres or greater** in one eye. **Fee:** $165.80 85% = $140.95
10924	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or b) old item 10900 applied Payable once in a period of 36 months for - patients with **irregular astigmatism** in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens. **Fee:** $209.20 85% = $177.85

10925	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or b) old item 10900 applied Payable once in a period of 36 months for - patients with **anisometropia of 3.0 dioptres or greater** (difference between spherical equivalents). **Fee:** $165.80 85% = $140.95
10926	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or b) old item 10900 applied Payable once in a period of 36 months for - patients with corrected **visual acuity of 0.7 logMAR (6/30) or worse** in both eyes, being patients for whom a contact lens is prescribed as part of a **telescopic system.** **Fee:** $165.80 85% = $140.95
10927	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or b) old item 10900 applied Payable once in a period of 36 months for - patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by: **(i) pathological mydriasis; or** **(ii) aniridia; or** **(iii) coloboma of the iris; or** **(iv) pupillary malformation or distortion; or** **(v) significant ocular deformity or corneal opacity** whether congenital, traumatic or surgical in origin. **Fee:** $209.20 85% = $177.85
10928	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or b) old item 10900 applied Payable once in a period of 36 months for - patients who, by reason of **physical deformity**, are unable to wear spectacles. **Fee:** $165.80 85% = $140.95
10929	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or b) old item 10900 applied Payable once in a period of 36 months for - patients who have a **medical or optical condition** (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10926, 10927 or 10928 applies) requiring the use of a contact lens for correction, where the **condition is specified** on the patient's account. *Note: Benefits may not be claimed under item 10929 where the patient wants the contact lenses for appearance, sporting, work or psychological reasons - see paragraph O6 of explanatory notes to this category.* **Fee:** $209.20 85% = $177.85
10930	All professional attendances regarded as a single service in a single course of attention involving the prescription and fitting of contact lenses where the patient meets the requirements of an item in the range 10921-10929 and requires a **change in contact lens material or basic lens parameters**, other than a simple power change, because of a **structural or functional change in the eye or an allergic response** within 36 months of the fitting of a contact lens covered by item 10921 to 10929. **Fee:** $165.80 85% = $140.95

SERVICES		SERVICES
	DOMICILIARY VISITS An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10932, 10933, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on **one patient** at a single location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: - this item; and - the applicable item *(See para O6 of explanatory notes to this Category)*	
10931	**Fee:** $23.30 85% = $19.85	
	An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10931, 10933, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on **two patients** at the same location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: - this item; and - the applicable item *(See para O6 of explanatory notes to this Category)*	
10932	**Fee:** $11.60 85% = $9.90	
	An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10931, 10932, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on **three patients** at the same location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: - this item; and - the applicable item *(See para O6 of explanatory notes to this Category)*	
10933	**Fee:** $7.70 85% = $6.55	
	COMPUTERISED PERIMETRY Full quantitative computerised perimetry (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by an optometrist, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, bilateral - to a maximum of two examinations (including examinations to which item 10941 applies) in any twelve month period, not being a service associated with a service to which item 10916, 10918, 10931, 10932 or 10933 applies. *(See para O6 of explanatory notes to this Category)*	
10940	**Fee:** $63.75 85% = $54.20	

SERVICES		SERVICES
10941	Full quantitative computerised perimetry (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by an optometrist, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, unilateral - to a maximum of two examinations (including examinations to which item 10940 applies) in any twelve month period, not being a service associated with a service to which item 10916, 10918, 10931, 10932 or 10933 applies. *(See para O6 of explanatory notes to this Category)* **Fee:** $38.45 85% = $32.70	
10942	**LOW VISION ASSESSMENT** Testing of residual vision to provide optimum visual performance involving one or more of spectacle correction, determination of contrast sensitivity, determination of glare sensitivity and prescription of magnification aids in a patient who has best corrected visual acuity of 6/15 or N.12 or worse in the better eye, or horizontal visual field of less than 120 degrees within 10 degrees above and below the horizontal midline, not being a service associated with a service to which item 10916 or 10921 to 10930 applies, payable twice in a twelve month period. *(See para O6 of explanatory notes to this Category)* **Fee:** $33.45 85% = $28.45	
10943	**CHILDREN'S VISION ASSESSMENT** Additional testing to confirm diagnosis of, or establish a treatment regime for, a significant binocular or accommodative dysfunction, including assessment of one or more of accommodation, ocular motility, vergences, or fusional reserves and/or cycloplegic refraction, in a patient aged three to fourteen years, not to be used for the assessment of learning difficulties or learning disabilities, not being a service associated with a service to which item 10916 or 10921 to 10930 applies, payable once only in a twelve month period *(See para O6 of explanatory notes to this Category)* **Fee:** $33.45 85% = $28.45	
10944	**REMOVAL OF EMBEDDED CORNEAL FOREIGN BODY** CORNEA, complete removal of embedded foreign body from – not more than once on the same day by the same practitioner (excluding aftercare) The item is not to be billed on the same occasion as MBS items 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915, 10916 or 10918. Where the embedded foreign body has not been completely removed, benefits are only payable under item 10916 *(See para O6 of explanatory notes to this Category)* **Fee:** $72.15 85% = $61.35	

SERVICES		SERVICES
	GROUP A10 - OPTOMETRICAL SERVICES	
	SUBGROUP 2 – TELEHEALTH ATTENDANCE	
10945	A professional attendance of less than 15 minutes (whether or not continuous) by a participating optometrist that requires the provision of clinical support to a patient who: a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and b) is not an admitted patient; and c) either: (i) is located within a telehealth eligible area and, at the time of the attendance, is at least 15 kilometres by road from the specialist mentioned in paragraph (a); or (ii) is a patient of an Aboriginal Medical Service, or an Aboriginal Community Controlled Health Service, for which a direction under subsection 19(2) of the Act applies *(See para O12 of explanatory notes to this Category)* **Fee:** $33.45 85% = $28.45	
10946	A professional attendance of at least 15 minutes (whether or not continuous) by a participating optometrist that requires the provision of clinical support to a patient who: a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and b) is not an admitted patient; and c) either: (i) is located within a telehealth eligible area and, at the time of the attendance, is at least 15 kilometres by road from the specialist mentioned in paragraph (a); or (ii) is a patient of an Aboriginal Medical Service, or an Aboriginal Community Controlled Health Service, for which a direction under subsection 19(2) of the Act applies *(See para O12 of explanatory notes to this Category)* **Fee:** $66.80 85% = $56.80	
10947	A professional attendance (not being a service to which any other item applies) of less than 15 minutes (whether or not continuous) by a participating optometrist that requires the provision of clinical support to a patient who: a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and b) at the time of the attendance, is located at a residential aged care facility (whether or not at consulting rooms situated within the facility); and c) is a care recipient in the facility; and d) is not a resident of a self-contained unit; for an attendance on one occasion—each patient *(See para O12 of explanatory notes to this Category)* **Fee:** $33.45 85% = $28.45	
10948	A professional attendance (not being a service to which any other item applies) of at least 15 minutes (whether or not continuous) by a participating optometrist that requires the provision of clinical support to a patient who: a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and b) at the time of the attendance, is located at a residential aged care facility (whether or not at consulting rooms situated within the facility); and c) is a care recipient in the facility; and d) is not a resident of a self-contained unit; for an attendance on one occasion—each patient *(See para O12 of explanatory notes to this Category)* **Fee:** $66.80 85% = $56.80	

INDEX

A

Acupuncture, by a medical practitioner 173,193,195
at a place other than a hospital 197,199
Attendance, acupuncture 173,193,195
acupuncture 173,193,195 197,199
care planning 721,723,729 731
case conference - consultant psychiatrist 855,857,858 861,864,866
case conference, consultant physician 820,822,823 825,826,828,830,832,834,835,837,838
Case Conference, Consultant Psychiatrist 855,857,858 861,864,866
consultant occupational physician 385-388
consultant physician (not psychiatry) 110,116,119 122,128,131
consultant physician treatment and management plan 132,133
consultant psychiatrist 300,302,304 306,308,310,312,314,316,318-320,322,324,326,328 330,332,334,336,338,342,344,346,348,350,352
consultant public health medicine 410-417
contact lenses 10801-10809,10816
emergency physician 501,503,507 511,515,519,520,530,532,534,536
family group therapy 170-172
focussed psychological strategies 2721,2723,2725 2727
general practitioner 3,4,20 23,24,35-37,43,44,47,51,2501,2503,2504,2506,2507 2509,2517,2518,2521,2522,2525,2526,2546,2547,2552 2553,2558,2559
geriatrician comprehensive assessment and management plan 141,143,145 147
incentive items - PIP - general practitioner 2501,2503,2504 2506,2507,2509,2517,2518,2521,2522,2525,2526,2546 2547,2552,2553,2558,2559
incentive items - PIP - other non-preferred 2600,2603,2606 2610,2613,2616,2620,2622,2624,2631,2633,2635,2664 2666,2668,2673,2675,2677
other non-specialist 52-54,57-60,65 92,93,95,96
prolonged, lifesaving treatment 160-164
public health physicians 410-417
specialist 104-108
telepsychiatry 353,355-359,361 364,366,367,369,370
Autism, pervasive developmental disorder, consultant physicians 135,289

C

Care planning 721,723,729 731
Case conferencing
geriatrician or rehabilitation physician 880
Contact lenses, attendances 10801-10809,10816

F

Family group psychotherapy 342,344,346
group therapy 170-172
for aboriginal and Torres Strait Islander people 715

G

Group psychotherapy 342
psychotherapy, family 342,344,346
therapy, family 170-172

H

Health assessments
Care planning 721,723,729 731
Health assessments
Case conferencing by geriatrician/rehabilitation physician 880

P

Pervasive developmental disorder, autism, consultant physicians 135,289
Prolonged professional attendance, lifesaving 160-164
Public health physicians - attendances 410-417

DIAGNOSTIC PROCEDURES AND INVESTIGATIONS CATEGORY 2

SUMMARY OF CHANGES FROM 1/1/2016

The 1/1/2016 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

There are no changes to this Category for 1 January 2016.

D.1.1. ELECTROENCEPHALOGRAPHY (EEG), PROLONGED RECORDING - (ITEM 11003)

Item 11003 covers an extended EEG recording of at least 3 hours duration, other than ambulatory or video recording, including Multiple Sleep Latency Testing (MSLT).

D.1.2. ELECTROENCEPHALOGRAPHY (EEG), AMBULATORY OR VIDEO - (ITEMS 11004 AND 11005)

Items 11004 and 11005 cover prolonged ambulatory or video EEG, recording of at least 3 hours duration for:

- Diagnosing the basis of episodic neurological dysfunction;
- Characterising the nature of a patient's epileptic seizures;
- Localising seizures in patients with uncontrolled epilepsy, with a view to surgery; or
- Assessing treatment response where subclinical seizures are suspected.

D.1.3. NEUROMUSCULAR DIAGNOSIS - (ITEM 11012)

Based on advice from the Australian Association of Neurologists, Medicare benefits are not payable under Item 11012 for quantitative sensory nerve testing using "Neurometer CPT" diagnostic devices. The advice indicated that the device was still in the evaluation and research stage and did not have widespread clinical application.

D.1.4. INVESTIGATION OF CENTRAL NERVOUS SYSTEM EVOKED RESPONSES - (ITEMS 11024 AND 11027)

In the context of these items a study refers to one or more averaged samples of electrical activity recorded from one or more sites in the central nervous system in response to the same stimulus.

Second or subsequent studies refer to either stimulating the point of stimulation (e.g. right eye or left median nerve) with a different stimulus or stimulating another point of stimulation (e.g. left eye or right median nerve).

NOTE: Items 11024 and 11027 are not intended to cover bio-feedback techniques.

D.1.5. ELECTRORETINOGRAPHY - (ITEMS 11204, 11205, 11210 AND 11211)

Current professional guidelines and standards for electroretinography, electroculography and pattern retinography are produced by the International Society for Clinical Electrophysiology of Vision (ISCEV).

D.1.6. COMPUTERISED PERIMETRY PRINTED RESULTS - (ITEMS 11221 TO 11225)

Computerised perimetry performed by optometrists is covered by MBS items 10940 and 10941. Items 11221 - 11225 should not be used to repeat perimetry unless clinically necessary - such as where the results of the perimetry have been provided by the optometrist referring the patient to an ophthalmologist.

D.1.7. COMPUTERISED PERIMETRY - (ITEMS 11222 AND 11225)

Item 11222 for bilateral procedures cannot be claimed for patients who are totally blind in one eye. In this instance, item 11225 for unilateral procedures should be claimed, where appropriate.

Claims for benefits in respect of Items 11222 and 11225 should be accompanied by clinical details confirming the presence of one of the conditions identified in the item.

Claims for benefits for these services should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for approval should be in a sealed envelope marked 'Medical-in Confidence' addressed to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

D.1.8. ORBITAL CONTENTS - (ITEMS 11240, 11241, 11242 AND 11243)

Item 11240 and 11241 may only be utilised once per patient per practitioner. Where an additional service is necessary items 11242 and 11243 should be utilised.

Partial coherence interferometry may also be referred to as optical (or ocular) coherence biometry/tomography or laser Doppler interferometry.

D.1.9. BRAIN STEM EVOKED RESPONSE AUDIOMETRY - (ITEM 11300)

Item 11300 can be claimed for the programming of a cochlear speech processor.

D.1.10. ELECTROCOCHLEOGRAPHY - (ITEM 11304)

Item 11304 refers to electrocochleography with insertion of electrodes through the tympanic membrane.

D.1.11. NON-DETERMINATE AUDIOMETRY - (ITEM 11306)

This refers to screening audiometry covering those services, one or more, referred to in Items 11309-11321 when not performed under the conditions set out in paragraph D1.13.

D.1.12. AUDIOLOGY SERVICES - (ITEMS 11309 TO 11321)

A medical service specified in Items 11309 to 11321 shall be taken to be a medical service for the purposes of payment of benefits if, and only if, it is rendered:

(a) in conditions that allow the establishment of determinate thresholds;
(b) in a sound attenuated environment with background noise conditions that comply with Australian Standard AS/NZS 1269.3-2005; and
(c) using calibrated equipment that complies with Australian Standard AS IEC 60645.1-22002, AS IEC 60645.2-2002 and AS IEC 60645.3-2002.

D.1.13. OTO-ACOUSTIC EMISSION AUDIOMETRY - (ITEM 11332)

Medicare benefits are not payable under Item 11332 for routine screening of infants. The equipment used to provide this service must be capable of displaying the recorded emission and not just a pass/fail indicator.

D.1.14. RESPIRATORY FUNCTION TESTS - (ITEM 11503)

The investigations listed hereunder would attract benefits under Item 11503. This list has been prepared in consultation with the Thoracic Society of Australia and New Zealand.

(a) Carbon monoxide diffusing capacity by any method
(b) Absolute lung volumes by any method
(c) Assessment of arterial carbon dioxide tension or cardiac output - re breathing method
(d) Assessment of pulmonary distensibility involving measurement of lung volumes and oesophageal pressure
(e) Measurement of airway or pulmonary resistance by any method
(f) Measurement of respiratory muscle strength involving the measurement of trans-diaphragmatic or oesophageal pressures
(g) Assessment of phrenic nerve function involving percutaneous stimulation and measurement of the compound action potential of the diaphragm
(h) Measurement of the resistance of the anterior nares or pharynx
(i) Inhalation provocation testing, including pre-provocation spirometry, the construction of a dose response curve, using histamine, cholinergic agents, non-isotonic fluids or powder and post-bronchodilator spirometry
(j) Exercise testing using incremental workloads with monitoring of ventilatory and cardiac responses at rest, during exercise and recovery on premises equipped with a mechanical ventilator and defibrillator
(k) Tests of distribution of ventilation involving inhalation of inert gases
(l) Measurement of gas exchange involving simultaneous collection of arterial blood and expired air with measurements of the partial pressures of oxygen and carbon dioxide in gas and blood
(m) Multiple inert gas elimination techniques for measuring ventilation perfusion ratios in the lung
(n) Continuous monitoring of pulmonary function other than spirometry, tidal breathing and minute ventilation, of at least 6 hours duration
(o) Ventilatory and/or occlusion pressure responses to progressive hypercapnia and progressive hypoxia
(p) Monitoring pulmonary arterial pressure at rest or during exercise
(q) Measurement of the strength of inspiratory and expiratory muscles at multiple lung volumes
(r) Measurement of the respiratory muscle endurance/fatigability by any technique
(s) Measurement of respiratory muscle strength before and after intravenous injection of placebo and anticholinesterase drugs
(t) Simulated altitude test involving exposure to hypoxic gas mixtures and measurement of ventilation, heart rate and oxygen saturation at rest and/or during exercise and observation of the effect of supplemental oxygen
(u) Inhalation provocation testing to specific sensitising agents

(v) Spirometry performed before and after simple exercise testing undertaken as a provocation test for the investigation of asthma, in premises capable of performing complex lung function tests and equipped with a mechanical ventilator and defibrillator

D.1.15. CAPSULE ENDOSCOPY - (ITEM 11820 AND 11823)

Capsule endoscopy is primarily used to view the small bowel, which cannot be viewed by upper gastrointestinal endoscopy and colonoscopy.

Conjoint committee
The Conjoint Committee comprises representatives from the Gastroenterological Society of Australia (GESA), the Royal Australasian College of Physicians (RACP) and the Royal Australasian College of Surgeons (RACS). For the purposes of Items 11820 and 11823, specialists or consultant physicians performing this procedure must have endoscopic training recognised by The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy, and the Department of Human Services notified of that recognition.

D.1.16. EPICUTANEOUS PATCH TESTING - (ITEMS 12012, 12015 AND 12018)

A standard epicutaneous patch test battery refers to the European Standard Series or the International Contact Research Group Standard Series.

D.1.17. ADMINISTRATION OF THYROTROPIN ALFA-RCH FOR THE DETECTION OF RECURRENT WELL-DIFFERENTIATED THYROID CANCER - (ITEM 12201)

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

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

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

- an assessment that the patient meets the criteria prescribed by the item;
  the supply of thyrotropin alfa-rch;
- ensuring that thyrotropin alfa-rch is injected (either by the administering practitioner or by another practitioner) in two doses at 24 hour intervals, with the second dose being administered 72 hours prior to whole body study with radioactive iodine and serum thyroglobulin test; and
- arranging the whole body radioactive iodine study and the serum thyroglobulin test.

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

D.1.18. INVESTIGATIONS FOR SLEEP APNOEA - (ITEMS 12203, 12207, 12210, 12213, 12215, 12217 AND 12250)

Claims for benefits in respect of items 12207, 12215 and 12217 should be accompanied by clinical details confirming the presence of the conditions set out above. Claims for benefits for these services should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for approval should be addressed in a sealed envelope marked "Medical-in-Confidence" to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

In relation to item 12250 for home-based sleep studies, the investigation cannot be provided on the same occasion as a service described in any of items 11000 to 11005, 11503, 11700 to 11709, 11713 and 12203.

Where the date of service for item 12250 is the same as the date of service of any items 11000 to 11005, 11503, 11700 to 11709, 11713 and 12203, for a benefit to be payable, there must be written notation on the account, identifying that the service under any of items 11000 to 11005, 11503, 11700 to 11709, 11713 and 12203 was not provided on the same occasion as item 12250 and was not for a home-based sleep study.

The correct date to specify on the account for item 12250 is the day the home-based sleep study was completed (as opposed to the day it was initiated).

D.1.19. BONE DENSITOMETRY - (ITEMS 12306 TO 12323)

Item 12321 is intended to allow for bone mineral density measurement following a significant change in therapy - e.g. a change in the class of drugs - rather than for a change in the dosage regimen.

Item 12323 enables the payment of a Medicare benefit for a bone densitometry service performed on a patient aged 70 years or over. The Government has decided to expand access to Medicare subsidised bone mineral density testing to coincide with the expanded eligibility for the osteoporosis medication 'alendronate' under the Pharmaceutical Benefits Scheme.

An examination under any of these items covers the measurement of 2 or more sites, interpretation and provision of a report; all performed by a specialist or consultant physician in the practice of his or her specialty. Two or more sites must include the measurement of bone density of the lumbar spine and proximal femur. If technical difficulties preclude measurement at these sites, other sites can be used for the purpose of measurements. The measurement of bone mineral density at either forearms or both heels or in combination is excluded for the purpose of Medicare benefit.

Referrals
Bone densitometry services are available on the basis of referral by a medical practitioner to a specialist or consultant physician. However, providers of bone densitometry to whom a patient is referred for management may determine that a bone densitometry service is required in line with the provisions of Items 12306, 12309, 12312, 12315, 12318, 12321 and 12323.

For Items 12306 and 12309 the referral should specify the indication for the test, namely:
(a) 1 or more fractures occurring after minimal trauma; or
(b) monitoring of low bone mineral density proven by previous bone densitometry.

For Item 12312 the referral should specify the indication for the test, namely:
(a) prolonged glucocorticoid therapy;
(b) conditions associated with excess glucocorticoid secretion;
(c) male hypogonadism; or
(d) female hypogonadism lasting more than 6 months before the age of 45.

For Item 12315 the referral should specify the indication for the test, namely:
(a) primary hyperparathyroidism;
(b) chronic liver disease;
(c) chronic renal disease;
(d) proven malabsorptive disorders;
(e) rheumatoid arthritis; or
(f) conditions associated with thyroxine excess.

For Item 12318 the referral should specify the indication for the test, namely:
(a) prolonged glucocorticoid therapy;
(b) conditions associated with excess glucocorticoid secretion;
(c) male hypogonadism;
(d) female hypogonadism lasting more than 6 months before the age of 45;
(e) primary hyperparathyroidism;
(f) chronic liver disease;
(g) chronic renal disease;
(h) proven malabsorptive disorders;
(i) rheumatoid arthritis; or

(j) conditions associated with thyroxine excess.

Definitions
Low bone mineral density is present when the bone (organ) mineral density falls more than 1.5 standard deviations below the age matched mean or more than 2.5 standard deviations below the young normal mean at the same site and in the same gender.

For Items 12312 and 12318
(a) 'Prolonged glucocorticoid therapy' is defined as the commencement of a dosage of inhaled glucocorticoid equivalent to or greater than 800 micrograms beclomethasone dipropionate or budesonide per day; or
(b) a supraphysiological glucocorticoid dosage equivalent to or greater than 7.5 mg prednisolone in an adult taken orally per day;
for a period anticipated to last for at least 4 months.
Glucocorticoid therapy must be contemporaneous with the current scan. Patients no longer on steroids would not qualify for benefits.

For Items 12312 and 12318
(a) Male hypogonadism is defined as serum testosterone levels below the age matched normal range.
(b) Female hypogonadism is defined as serum oestrogen levels below the age matched normal range.

For Items 12315 and 12318
A malabsorptive disorder is defined as one or more of the following:
(a) malabsorption of fat, defined as faecal fat estimated at greater than 18 gm per 72 hours on a normal fat diet; or
(b) bowel disease with presumptive vitamin D malabsorption as indicated by a sub-normal circulating 25-hydroxyvitamin D level; or
(c) histologically proven Coeliac disease.

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.

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

Higher rates of benefits are also provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons).

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.

GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

SUBGROUP 1 - NEUROLOGY

11000	ELECTROENCEPHALOGRAPHY, not being a service: (a) associated with a service to which item 11003, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices (Anaes.) **Fee:** $123.10	**Benefit:** 75% = $92.35	85% = $104.65
11003	ELECTROENCEPHALOGRAPHY, prolonged recording of at least 3 hours duration, not being a service: (a) associated with a service to which item 11000, 11004, 11005, 11006 or 11009 applies; and (b) involving quantitative topographic mapping using neurometrics or similar devices *(See para D1.1 of explanatory notes to this Category)* **Fee:** $325.70	**Benefit:** 75% = $244.30	85% = $276.85
11004	ELECTROENCEPHALOGRAPHY, ambulatory or video, prolonged recording of at least 3 hours duration up to 24 hours duration, recording on the first day, not being a service: (a) associated with a service to which item 11000, 11003, 11005, 11006 or 11009 applies; and (b) involving quantitative topographic mapping using neurometrics or similar devices *(See para D1.2 of explanatory notes to this Category)* **Fee:** $325.70	**Benefit:** 75% = $244.30	85% = $276.85
11005	ELECTROENCEPHALOGRAPHY, ambulatory or video, prolonged recording of at least 3 hours duration up to 24 hours duration, recording on each day subsequent to the first day, not being a service: (a) associated with a service to which item 11000, 11003, 11004, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices *(See para D1.2 of explanatory notes to this Category)* **Fee:** $325.70	**Benefit:** 75% = $244.30	85% = $276.85
11006	ELECTROENCEPHALOGRAPHY, temporosphenoidal, not being a service involving quantitative topographic mapping using neurometrics or similar devices **Fee:** $167.00	**Benefit:** 75% = $125.25	85% = $141.95
11009	ELECTROCORTICOGRAPHY **Fee:** $227.75	**Benefit:** 75% = $170.85	85% = $193.60
11012	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 1 nerve OR ELECTROMYOGRAPHY of 1 or more muscles using concentric needle electrodes OR both these examinations (not being a service associated with a service to which item 11015 or 11018 applies) *(See para D1.3 of explanatory notes to this Category)* **Fee:** $112.00	**Benefit:** 75% = $84.00	85% = $95.20
11015	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 2 or 3 nerves with or without electromyography (not being a service associated with a service to which item 11012 or 11018 applies) **Fee:** $149.90	**Benefit:** 75% = $112.45	85% = $127.45
11018	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 4 or more nerves with or without electromyography OR recordings from single fibres of nerves and muscles OR both of these examinations (not being a service associated with a service to which item 11012 or 11015 applies) **Fee:** $223.95	**Benefit:** 75% = $168.00	85% = $190.40
11021	NEUROMUSCULAR ELECTRODIAGNOSIS repetitive stimulation for study of neuromuscular conduction OR electromyography with quantitative computerised analysis OR both of these examinations **Fee:** $149.90	**Benefit:** 75% = $112.45	85% = $127.45
11024	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or multifocal multichannel objective perimetry - 1 or 2 studies *(See para D1.4 of explanatory notes to this Category)* **Fee:** $113.85	**Benefit:** 75% = $85.40	85% = $96.80
11027	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or multifocal multichannel objective perimetry - 3 or more studies *(See para D1.4 of explanatory notes to this Category)* **Fee:** $168.90	**Benefit:** 75% = $126.70	85% = $143.60

	SUBGROUP 2 - OPHTHALMOLOGY
11200	PROVOCATIVE TEST OR TESTS FOR OPEN ANGLE GLAUCOMA, including water drinking **Fee:** $40.80 **Benefit:** 75% = $30.60 85% = $34.70
11204	ELECTRORETINOGRAPHY of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards *(See para D1.5 of explanatory notes to this Category)* **Fee:** $108.25 **Benefit:** 75% = $81.20 85% = $92.05
11205	ELECTROOCULOGRAPHY of one or both eyes performed according to current professional guidelines or standards *(See para D1.5 of explanatory notes to this Category)* **Fee:** $108.25 **Benefit:** 75% = $81.20 85% = $92.05
11210	PATTERN ELECTRORETINOGRAPHY of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards *(See para D1.5 of explanatory notes to this Category)* **Fee:** $108.25 **Benefit:** 75% = $81.20 85% = $92.05
11211	DARK ADAPTOMETRY of one or both eyes with a quantitative (log cd/m2) estimation of threshold in log lumens at 45 minutes of dark adaptations *(See para D1.5 of explanatory notes to this Category)* **Fee:** $108.25 **Benefit:** 75% = $81.20 85% = $92.05
11215	RETINAL PHOTOGRAPHY, multiple exposures of 1 eye with intravenous dye injection **Fee:** $123.00 **Benefit:** 75% = $92.25 85% = $104.55
11218	RETINAL PHOTOGRAPHY, multiple exposures of both eyes with intravenous dye injection **Fee:** $151.95 **Benefit:** 75% = $114.00 85% = $129.20
11221	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, bilateral - ***to a maximum of 2 examinations*** (including examinations to which item 11224 applies) ***in any 12 month period*** *(See para D1.6 of explanatory notes to this Category)* **Fee:** $67.75 **Benefit:** 75% = $50.85 85% = $57.60
11222	FULL QUANTITATIVE COMPUTERISED PERIMETRY (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, with assessment and report, bilateral, ***where it can be demonstrated that a further examination is indicated in the same 12 month period to which Item 11221 applies due to presence of one of the following conditions:-*** . established glaucoma (where surgery may be required within a six month period) where there has been definite progression of damage over a 12 month period; . established neurological disease which may be progressive and where a visual field is necessary for the management of the patient; or . monitoring for ocular disease or disease of the visual pathways which may be caused by systemic drug toxicity, where there may also be other disease such as glaucoma or neurological disease **- *each additional examination*** *(See para D1.6 and D1.7 of explanatory notes to this Category)* **Fee:** $67.75 **Benefit:** 75% = $50.85 85% = $57.60
11224	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, unilateral - ***to a maximum of 2 examinations*** (including examinations to which item 11221 applies) ***in any 12 month period*** *(See para D1.6 of explanatory notes to this Category)* **Fee:** $40.85 **Benefit:** 75% = $30.65 85% = $34.75

11225	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, with assessment and report, unilateral, ***where it can be demonstrated that a further examination is indicated in the same 12 month period to which item 11224 applies due to presence of one of the following conditions:-*** . established glaucoma (where surgery may be required within a 6 month period) where there has been definite progression of damage over a 12 month period; . established neurological disease which may be progressive and where a visual field is necessary for the management of the patient; or . monitoring for ocular disease or disease of the visual pathways which may be caused by systemic drug toxicity, where there may also be other disease such as glaucoma or neurological disease ***- each additional examination*** *(See para D1.6 and D1.7 of explanatory notes to this Category)* **Fee:** $40.85 **Benefit:** 75% = $30.65 85% = $34.75
11235	EXAMINATION OF THE EYE BY IMPRESSION CYTOLOGY OF CORNEA for the investigation of ocular surface dysplasia, including the collection of cells, processing and all cytological examinations and preparation of report **Fee:** $122.75 **Benefit:** 75% = $92.10 85% = $104.35
11237	OCULAR CONTENTS, simultaneous ultrasonic echography by both unidimensional and bidimensional techniques, for the diagnosis, monitoring or measurement of choroidal and ciliary body melanomas, retinoblastoma or suspicious naevi or simulating lesions, one eye, not being a service associated with a service to which items in Group I1 apply **Fee:** $81.45 **Benefit:** 75% = $61.10 85% = $69.25
11240	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of one eye prior to lens surgery on that eye, not being a service associated with a service to which items in Group I1 apply *(See para D1.8 of explanatory notes to this Category)* **Fee:** $81.45 **Benefit:** 75% = $61.10 85% = $69.25
11241	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for bilateral eye measurement prior to lens surgery on both eyes, not being a service associated with a service to which items in Group I1 apply *(See para D1.8 of explanatory notes to this Category)* **Fee:** $103.65 **Benefit:** 75% = $77.75 85% = $88.15
11242	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of an eye previously measured and on which lens surgery has been performed, and where further lens surgery is contemplated in that eye, not being a service associated with a service to which items in Group I1 apply *(See para D1.8 of explanatory notes to this Category)* **Fee:** $80.10 **Benefit:** 75% = $60.10 85% = $68.10
11243	ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of a second eye where surgery for the first eye has resulted in more than 1 dioptre of error or where more than 3 years have elapsed since the surgery for the first eye, not being a service associated with a service to which items in Group I1 apply *(See para D1.8 of explanatory notes to this Category)* **Fee:** $80.10 **Benefit:** 75% = $60.10 85% = $68.10
11244	**Orbital contents,** diagnostic B-scan of, by a specialist practising in his or her speciality of ophthalmology, not being a service associated with a service to which an item in Group I1 of the diagnostic imaging services table applies. **Fee:** $77.00 **Benefit:** 75% = $57.75 85% = $65.45
	SUBGROUP 3 - OTOLARYNGOLOGY
11300	BRAIN stem evoked response audiometry (Anaes.) *(See para D1.9 of explanatory notes to this Category)* **Fee:** $192.45 **Benefit:** 75% = $144.35 85% = $163.60
11303	ELECTROCOCHLEOGRAPHY, extratympanic method, 1 or both ears **Fee:** $192.45 **Benefit:** 75% = $144.35 85% = $163.60
11304	ELECTROCOCHLEOGRAPHY, transtympanic membrane insertion technique, 1 or both ears *(See para D1.10 of explanatory notes to this Category)* **Fee:** $316.95 **Benefit:** 75% = $237.75 85% = $269.45
11306	Nondeterminate AUDIOMETRY *(See para D1.11 of explanatory notes to this Category)* **Fee:** $21.90 **Benefit:** 75% = $16.45 85% = $18.65

11309	AUDIOGRAM, air conduction *(See para D1.12 of explanatory notes to this Category)* **Fee:** $26.30 **Benefit:** 75% = $19.75 85% = $22.40
11312	AUDIOGRAM, air and bone conduction or air conduction and speech discrimination *(See para D1.12 of explanatory notes to this Category)* **Fee:** $37.15 **Benefit:** 75% = $27.90 85% = $31.60
11315	AUDIOGRAM, air and bone conduction and speech *(See para D1.12 of explanatory notes to this Category)* **Fee:** $49.20 **Benefit:** 75% = $36.90 85% = $41.85
11318	AUDIOGRAM, air and bone conduction and speech, with other Cochlear tests *(See para D1.12 of explanatory notes to this Category)* **Fee:** $60.75 **Benefit:** 75% = $45.60 85% = $51.65
11321	GLYCEROL INDUCED COCHLEAR FUNCTION CHANGES assessed by a minimum of 4 air conduction and speech discrimination tests (Klockoff's tests) *(See para D1.12 of explanatory notes to this Category)* **Fee:** $115.35 **Benefit:** 75% = $86.55 85% = $98.05
11324	IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner - not being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies **Fee:** $32.85 **Benefit:** 75% = $24.65 85% = $27.95
11327	IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner - being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies **Fee:** $19.75 **Benefit:** 75% = $14.85 85% = $16.80
11330	IMPEDANCE AUDIOGRAM where the patient is not referred by a medical practitioner - 1 examination in any 4 week period **Fee:** $7.90 **Benefit:** 75% = $5.95 85% = $6.75
11332	OTO-ACOUSTIC EMISSION AUDIOMETRY for the detection of permanent congenital hearing impairment, performed by or on behalf of a specialist or consultant physician, on an infant or child who is at risk due to one or more of the following factors:- (i) admission to a neonatal intensive care unit; or (ii) family history of hearing impairment; or (iii) intra-uterine or perinatal infection (either suspected or confirmed); or (iv) birthweight less than 1.5kg; or (v) craniofacial deformity: or (vi) birth asphyxia; or (vii) chromosomal abnormality, including Down's Syndrome; or (viii) exchange transfusion; and where:- - the patient is referred by another medical practitioner; and - middle ear pathology has been excluded by specialist opinion *(See para D1.13 of explanatory notes to this Category)* **Fee:** $58.55 **Benefit:** 75% = $43.95 85% = $49.80
11333	CALORIC TEST OF LABYRINTH OR LABYRINTHS **Fee:** $44.60 **Benefit:** 75% = $33.45 85% = $37.95
11336	SIMULTANEOUS BITHERMAL CALORIC TEST OF LABYRINTHS **Fee:** $44.60 **Benefit:** 75% = $33.45 85% = $37.95
11339	ELECTRONYSTAGMOGRAPHY **Fee:** $44.60 **Benefit:** 75% = $33.45 85% = $37.95
	SUBGROUP 4 - RESPIRATORY
11500	BRONCHOSPIROMETRY, including gas analysis **Fee:** $167.00 **Benefit:** 75% = $125.25 85% = $141.95

	Measurement of the: (a) mechanical or gas exchange function of the respiratory system; or (b) respiratory muscle function; or (c) ventilatory control mechanisms. Various measurement parameters may be used including any of the following: (a) pressures; (b) volumes; (c) flow; (d) gas concentrations in inspired or expired air; (e) alveolar gas or blood; (f) electrical activity of muscles. The tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital. Each occasion at which 1 or more such tests are performed, not being a service associated with a service to which item 22018 applies. *(See para D1.14 of explanatory notes to this Category)*
11503	**Fee:** $138.65 **Benefit:** 75% = $104.00 85% = $117.90
	MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing performed before and after inhalation of bronchodilator - each occasion at which 1 or more such tests are performed
11506	**Fee:** $20.55 **Benefit:** 75% = $15.45 85% = $17.50
	MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex respiratory function tests (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) - each occasion at which 1 or more such tests are performed
11509	**Fee:** $35.65 **Benefit:** 75% = $26.75 85% = $30.35
	CONTINUOUS MEASUREMENT OF THE RELATIONSHIP BETWEEN FLOW AND VOLUME DURING EXPIRATION OR INSPIRATION involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex lung function tests (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) - each occasion at which 1 or more such tests are performed
11512	**Fee:** $61.75 **Benefit:** 75% = $46.35 85% = $52.50
	SUBGROUP 5 - VASCULAR
	BLOOD PRESSURE MONITORING (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - once only for each type of pressure on any calendar day up to a maximum of 4 pressures (not being a service to which item 13876 applies and where not performed in association with the administration of general anaesthesia) *(See para T1.10 and T1.11 of explanatory notes to this Category)*
11600	**Fee:** $69.30 **Benefit:** 75% = $52.00 85% = $58.95
	Investigation of venous reflux or obstruction in one or more limbs at rest by CW Doppler or pulsed Doppler involving examination at multiple sites along each limb using intermittent limb compression or Valsava manoeuvres, or both, to detect prograde and retrograde flow, other than a service associated with a service to which item 32500 or 32501 applies - hard copy trace and written report, the report component of which must be performed by a medical practitioner, maximum of two examinations in a 12 month period, not to be used in conjunction with sclerotherapy.
11602	**Fee:** $57.75 **Benefit:** 75% = $43.35 85% = $49.10
	Investigation of chronic venous disease in the upper and lower extremities, one or more limbs, by plethysmography (excluding photoplethysmography) - examination, hard copy trace and written report, not being a service associated with a service to which item 32500 or 32501 applies.
11604	**Fee:** $75.70 **Benefit:** 75% = $56.80 85% = $64.35
	Investigation of complex chronic lower limb reflux or obstruction, in one or more limbs, by infrared photoplethysmography, during and following exercise to determine surgical intervention or the conservative management of deep venous thrombotic disease, hard copy trace, calculation of 90% recovery time and written report, not being a service associated with a service to which item 32500 or 32501 applies.
11605	**Fee:** $75.70 **Benefit:** 75% = $56.80 85% = $64.35
	MEASUREMENT OF ANKLE: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of lower extremity arterial disease, examination, hard copy trace and report.
11610	**Fee:** $63.75 **Benefit:** 75% = $47.85 85% = $54.20

11611	MEASUREMENT OF WRIST: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS, measurement of radial and ulnar (or finger) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of the wrist (or finger) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of upper extremity arterial disease, examination, hard copy trace and report. **Fee:** $63.75 **Benefit:** 75% = $47.85 85% = $54.20
11612	EXERCISE STUDY FOR THE EVALUATION OF LOWER EXTREMITY ARTERIAL DISEASE, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure indices for the evaluation of lower extremity arterial disease at rest and following exercise using a treadmill or bicycle ergometer or other such equipment where the exercise workload is quantifiably documented, examination and report. **Fee:** $112.40 **Benefit:** 75% = $84.30 85% = $95.55
11614	TRANSCRANIAL DOPPLER, examination of the intracranial arterial circulation using CW Doppler or pulsed Doppler with hard copy recording of waveforms, examination and report, not associated with a service to which item 55280 applies. **Fee:** $75.70 **Benefit:** 75% = $56.80 85% = $64.35
11615	MEASUREMENT OF DIGITAL TEMPERATURE, 1 or more digits, (unilateral or bilateral) and report, with hard copy recording of temperature before and for 10 minutes or more after cold stress testing. **Fee:** $75.90 **Benefit:** 75% = $56.95 85% = $64.55
11627	PULMONARY ARTERY pressure monitoring during open heart surgery, in a person under 12 years of age **Fee:** $228.65 **Benefit:** 75% = $171.50 85% = $194.40
	SUBGROUP 6 - CARDIOVASCULAR
11700	TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing and report **Fee:** $31.25 **Benefit:** 75% = $23.45 85% = $26.60 **Extended Medicare Safety Net Cap:** $25.00
11701	TWELVE-LEAD ELECTROCARDIOGRAPHY, report only where the tracing has been forwarded to another medical practitioner, not in association with a consultation on the same occasion **Fee:** $15.55 **Benefit:** 75% = $11.70 85% = $13.25
11702	TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing only **Fee:** $15.55 **Benefit:** 75% = $11.70 85% = $13.25
11708	**Continuous ECG recording** of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), **not in association with ambulatory blood pressure monitoring**, involving microprocessor based analysis equipment, interpretation and report of recordings by a specialist physician or consultant physician. Not being a service to which item 11709 applies. The changing of a tape or batteries does not constitute a separate service. Where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode is regarded as a separate service. **Fee:** $127.90 **Benefit:** 75% = $95.95 85% = $108.75
11709	**Continuous ECG recording** (Holter) of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), **not in association with ambulatory blood pressure monitoring**, utilising a system capable of superimposition and full disclosure printout of at least 12 hours of recorded ECG data, microprocessor based scanning analysis, with interpretation and report by a specialist physician or consultant physician. The changing of a tape or batteries does not constitute a separate service. Where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode is regarded as a separate service. **Fee:** $167.45 **Benefit:** 75% = $125.60 85% = $142.35
11710	AMBULATORY ECG MONITORING, patient activated, single or multiple event recording, utilising a looping memory recording device which is connected continuously to the patient for 12 hours or more and is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period **Fee:** $51.90 **Benefit:** 75% = $38.95 85% = $44.15
11711	AMBULATORY ECG MONITORING for 12 hours or more, patient activated, single or multiple event recording, utilising a memory recording device which is capable of recording for at least 30 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period **Fee:** $28.30 **Benefit:** 75% = $21.25 85% = $24.10

11712	MULTI CHANNEL ECG MONITORING AND RECORDING during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts) or pharmacological stress, involving the continuous attendance of a medical practitioner for not less than 20 minutes, with resting ECG, and with or without continuous blood pressure monitoring and the recording of other parameters, on premises equipped with mechanical respirator and defibrillator **Fee:** $152.15 **Benefit:** 75% = $114.15 85% = $129.35
11713	SIGNAL AVERAGED ECG RECORDING involving not more than 300 beats, using at least 3 leads with data acquisition at not less than 1000Hz of at least 100 QRS complexes, including analysis, interpretation and report of recording by a specialist physician or consultant physician **Fee:** $69.75 **Benefit:** 75% = $52.35 85% = $59.30
11715	BLOOD DYE DILUTION INDICATOR TEST **Fee:** $120.75 **Benefit:** 75% = $90.60 85% = $102.65
11718	IMPLANTED PACEMAKER TESTING involving electrocardiography, measurement of rate, width and amplitude of stimulus, including reprogramming when required, not being a service associated with a service to which item 11700, 11719, 11720, 11721, 11725 or 11726 applies **Fee:** $34.75 **Benefit:** 75% = $26.10 85% = $29.55
11719	IMPLANTED PACEMAKER (including cardiac resynchronisation pacemaker) REMOTE MONITORING involving reviews (without patient attendance) or arrhythmias, lead and device parameters, if at least one remote review is provided in a 12 month period. Payable only once in any 12 month period **Fee:** $66.85 **Benefit:** 75% = $50.15 85% = $56.85
11720	IMPLANTED PACEMAKER TESTING, with patient attendance, following detection of abnormality by remote monitoring involving electrocardiography, measurement of rate, width and amplitude of stimulus including reprogramming when required, not being a service associated with a service to which item 11718 or 11721 applies. **Fee:** $66.85 **Benefit:** 75% = $50.15 85% = $56.85
11721	IMPLANTED PACEMAKER TESTING of atrioventricular (AV) sequential, rate responsive, or antitachycardia pacemakers, including reprogramming when required, not being a service associated with a service to which Item 11700, 11718 11719, 11720, 11725 or 11726 applies **Fee:** $69.75 **Benefit:** 75% = $52.35 85% = $59.30
11722	IMPLANTED ECG LOOP RECORDING, for investigation of recurrent unexplained syncope, including re-programming of device, retrieval of stored data, analysis, interpretation and report, not in association with item 38285 **Fee:** $34.75 **Benefit:** 75% = $26.10 85% = $29.55
11724	UP-RIGHT TILT TABLE TESTING for the investigation of syncope of suspected cardiothoracic origin, including blood pressure monitoring, continuous ECG monitoring and the recording of the parameters, and involving an established intravenous line and the continuous attendance of a specialist or consultant physician - on premises equipped with a mechanical respirator and defibrillator **Fee:** $168.90 **Benefit:** 75% = $126.70 85% = $143.60
11725	IMPLANTED DEFIBRILLATOR (including cardiac resynchronisation defibrillator) REMOTE MONITORING involving reviews (without patient attendance) of arrhythmias, lead and device parameters, if at least 2 remote reviews are provided in a 12 month period. Payable only once in any 12 month period **Fee:** $189.50 **Benefit:** 75% = $142.15 85% = $161.10
11726	IMPLANTED DEFIBRILLATOR TESTING with patient attendance following detection of abnormality by remote monitoring involving electrocardiography, measurement of rate, width and amplitude of stimulus, not being a service associated with a service to which item 11727 applies. **Fee:** $94.75 **Benefit:** 75% = $71.10 85% = $80.55
11727	IMPLANTED DEFIBRILLATOR TESTING involving electrocardiography, assessment of pacing and sensing thresholds for pacing and defibrillation electrodes, download and interpretation of stored events and electrograms, including programming when required, not being a service associated with a service to which item 11700, 11718, 11719, 11720, 11721, 11725 or 11726 applies **Fee:** $94.75 **Benefit:** 75% = $71.10 85% = $80.55
	SUBGROUP 7 - GASTROENTEROLOGY & COLORECTAL
11800	OESOPHAGEAL MOTILITY TEST, manometric **Fee:** $174.45 **Benefit:** 75% = $130.85 85% = $148.30

11801	CLINICAL ASSESSMENT OF GASTRO-OESOPHAGEAL REFLUX DISEASE that involves 48 hour catheter-free wireless ambulatory oesophageal pH monitoring including administration of the device and associated endoscopy procedure for placement, analysis and interpretation of the data and all attendances for providing the service, if (a) a cathetter-based ambulatory oesophageal pH-mnitoring: (i) has been attempted on the patient but failed due to clinical complications, or (ii) is not clinically appropriate for the patient due to anatomical reasons (nasopharyngeal anatomy) preventing the use of catheter-based pH monitoring; and (b) the services is performed by a specialist or consultant physician with endoscopic training that is recognised by The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy. Not in association with another item in Category 2, sub-group 7 (Anaes.) **Fee:** $263.00 **Benefit:** 75% = $197.25 85% = $223.55
11810	CLINICAL ASSESSMENT of GASTRO-OESOPHAGEAL REFLUX DISEASE involving 24 hour pH monitoring, including analysis, interpretation and report and including any associated consultation **Fee:** $174.45 **Benefit:** 75% = $130.85 85% = $148.30
11820	Capsule endoscopy to investigate an episode of obscure gastrointestinal bleeding, using a capsule endoscopy device (including administration of the capsule, associated endoscopy procedure if required for placement, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the patient to whom the service is provided: (i) has recurrent or persistent bleeding; and (ii) is anaemic or has active bleeding; and (b) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding; and (c) the service has not been provided to the same patient on more than 2 occasions in the preceding 12 months; and (d) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by The Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy; and (e) the service is not associated with balloon enteroscopy. (f) the service has not been provided to the same patient: (i) more than once in an episode of bleeding, being bleeding occurring within 6 months of the prerequisite upper gastrointestinal endoscopy and colonoscopy (any bleeding after that time is considered to be a new episode); or (ii) on more than 2 occasions in any 12 month period *(See para D1.15 of explanatory notes to this Category)* **Fee:** $2,039.20 **Benefit:** 75% = $1,529.40 85% = $1,959.70
11823	Capsule endoscopy to conduct small bowel surveillance of a patient diagnosed with Peutz-Jeghers Syndrome, using a capsule endoscopy device approved by the Therapeutic Goods Administration (including administration of the capsule, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (b) the item is performed only once in any 2 year period; and (c) the service is not associated with balloon enteroscopy. *(See para D1.15 of explanatory notes to this Category)* **Fee:** $2,039.20 **Benefit:** 75% = $1,529.40 85% = $1,959.70
11830	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex **Fee:** $186.80 **Benefit:** 75% = $140.10 85% = $158.80
11833	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency **Fee:** $249.75 **Benefit:** 75% = $187.35 85% = $212.30
	SUBGROUP 8 - GENITO/URINARY PHYSIOLOGICAL INVESTIGATIONS
11900	URINE FLOW STUDY including peak urine flow measurement, not being a service associated with a service to which item 11919 applies **Fee:** $27.55 **Benefit:** 75% = $20.70 85% = $23.45
11903	CYSTOMETROGRAPHY, not being a service associated with a service to which any of items 11012-11027, 11912, 11915, 11919, 11921 and 36800 or any item in Group I3 applies **Fee:** $111.10 **Benefit:** 75% = $83.35 85% = $94.45

11906	URETHRAL PRESSURE PROFILOMETRY, not being a service associated with a service to which any of items 11012-11027, 11909, 11919, 11921 and 36800 or any item in Group I3 applies **Fee:** $111.10 **Benefit:** 75% = $83.35 85% = $94.45
11909	URETHRAL PRESSURE PROFILOMETRY WITH simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which item 11906, 11915, 11919, 36800 or any item in Group I3 applies **Fee:** $165.15 **Benefit:** 75% = $123.90 85% = $140.40
11912	CYSTOMETROGRAPHY with simultaneous measurement of rectal pressure, not being a service associated with a service to which any of items 11012-11027, 11903, 11915, 11919, 11921 and 36800 or any item in Group I3 applies (Anaes.) **Fee:** $165.15 **Benefit:** 75% = $123.90 85% = $140.40
11915	CYSTOMETROGRAPHY with simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which any of items 11012-11027, 11903, 11909, 11912, 11919, 11921 and 36800 or any item in Group I3 applies (Anaes.) **Fee:** $165.15 **Benefit:** 75% = $123.90 85% = $140.40
11917	CYSTOMETROGRAPHY IN CONJUNCTION WITH ULTRASOUND OF 1 OR MORE COMPONENTS OF THE URINARY TRACT, with measurement of any 1 or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all imaging associated with cystometrography, not being a service associated with a service to which items 11012-11027, 11900-11915, 11919, 11921 and 36800 apply. (Anaes.) **Fee:** $428.35 **Benefit:** 75% = $321.30 85% = $364.10
11919	CYSTOMETROGRAPHY IN CONJUNCTION WITH CONTRAST MICTURATING CYSTOURETHROGRAPHY, with measurement of any 1 or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all imaging associated with cystometrography, not being a service associated with a service to which items 11012-11027, 11900-11917, 11921 and 36800 apply (Anaes.) **Fee:** $428.35 **Benefit:** 75% = $321.30 85% = $364.10
11921	BLADDER WASHOUT TEST for localisation of urinary infection not including bacterial counts for organisms in specimens **Fee:** $75.05 **Benefit:** 75% = $56.30 85% = $63.80
	SUBGROUP 9 - ALLERGY TESTING
12000	SKIN SENSITIVITY TESTING for allergens, USING 1 TO 20 ALLERGENS, not being a service associated with a service to which item 12012, 12015, 12018 or 12021 applies **Fee:** $38.95 **Benefit:** 75% = $29.25 85% = $33.15
12003	SKIN SENSITIVITY TESTING for allergens, USING MORE THAN 20 ALLERGENS, not being a service associated with a service to which item 12012, 12015, 12018 or 12021 applies **Fee:** $58.85 **Benefit:** 75% = $44.15 85% = $50.05
12012	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis using less than the number of allergens included in a standard patch test battery *(See para D1.16 of explanatory notes to this Category)* **Fee:** $20.80 **Benefit:** 75% = $15.60 85% = $17.70
12015	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis using all of the allergens in a standard patch test battery *(See para D1.16 of explanatory notes to this Category)* **Fee:** $62.45 **Benefit:** 75% = $46.85 85% = $53.10
12018	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis using all of the allergens in a standard patch test battery and additional allergens to a total of up to and including 50 allergens *(See para D1.16 of explanatory notes to this Category)* **Fee:** $80.35 **Benefit:** 75% = $60.30 85% = $68.30
12021	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis, performed by or on behalf of a specialist in the practice of his or her specialty, using more than 50 allergens **Fee:** $117.85 **Benefit:** 75% = $88.40 85% = $100.20
	SUBGROUP 10 - OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
12200	COLLECTION OF SPECIMEN OF SWEAT by iontophoresis **Fee:** $37.20 **Benefit:** 75% = $27.90 85% = $31.65

	Administration, by a specialist or consultant physician in the practice of his or her specialty, of thyrotropin alfa-rch (recombinant human thyroid-stimulating hormone), and arranging services to which both items 61426 and 66650 apply, for the detection of recurrent well-differentiated thyroid cancer in a patient who: (a) has had a total thyroidectomy and one ablative dose of radioactive iodine; and (b) is maintained on thyroid hormone therapy; and (c) is at risk of recurrence; and (d) on at least one previous whole body scan or serum thyroglobulin test when withdrawn from thyroid hormone therapy did not have evidence of well differentiated thyroid cancer; and (i) withdrawal from thyroid hormone therapy resulted in severe psychiatric disturbances when hypothyroid; or (ii) withdrawal is medically contraindicated because the patient has: - unstable coronary artery disease; or - hypopituitarism ; or - a high risk of relapse or exacerbation of a previous severe psychiatric illness payable once only in any twelve month period. *(See para D1.17 of explanatory notes to this Category)*
12201	**Fee:** $2,392.90 **Benefit:** 75% = $1,794.70 85% = $2,313.40
	OVERNIGHT INVESTIGATION FOR SLEEP APNOEA FOR A PERIOD OF AT LEAST 8 HOURS DURATION, FOR AN ADULT AGED 18 YEARS AND OVER WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG, EOG, submental EMG, anterior tibial EMG, respiratory movement, airflow, oxygen saturation and ECG are performed; b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report ; and f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient - payable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period. *(See para D1.18 of explanatory notes to this Category)*
12203	**Fee:** $588.00 **Benefit:** 75% = $441.00 85% = $508.50
	OVERNIGHT INVESTIGATION FOR SLEEP APNOEA FOR A PERIOD OF AT LEAST 8 HOURS DURATION, FOR AN ADULT AGED 18 YEARS AND OVER WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG, EOG, submental EMG, anterior tibial EMG, respiratory movement, airflow, oxygen saturation and ECG are performed; b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient ***where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12203 applies*** for the adjustment and/or testing of the effectiveness of a *positive pressure ventilatory support device* (other than nasal continuous positive airway pressure) in sleep, in a *patient with severe cardio-respiratory failure,* and where previous studies have demonstrated failure of continuous positive airway pressure or oxygen - **each additional investigation** *(See para D1.18 of explanatory notes to this Category)*
12207	**Fee:** $588.00 **Benefit:** 75% = $441.00 85% = $508.50

	OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR A CHILD AGED 0 - 12 YEARS, WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum) airflow detection, measurement of CO2 either end-tidal or transcutaneous, oxygen saturation and ECG are performed; b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; f) the interpretation and report to be provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. payable only in relation to the first 3 occasions the investigation is performed in a 12 month period. *(See para D1.18 of explanatory notes to this Category)*
12210	**Fee:** $701.85 **Benefit:** 75% = $526.40 85% = $622.35
	OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR A CHILD AGED BETWEEN 12 AND 18 YEARS, WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum) airflow detection, measurement of CO2 either end-tidal or transcutaneous, oxygen saturation and ECG are performed; b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; f) the interpretation and report to be provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. payable only in relation to the first 3 occasions the investigation is performed in a 12 month period. *(See para D1.18 of explanatory notes to this Category)*
12213	**Fee:** $632.30 **Benefit:** 75% = $474.25 85% = $552.80
	OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR CHILDREN AGED 0 - 12 YEARS, WHERE: a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum) airflow detection, measurement of CO2 either end-tidal or transcutaneous, oxygen saturation and ECG are performed; b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; f) the interpretation and report to be provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12210 applies, for therapy with Continuous Positive Airway Pressure (CPAP), bilevel pressure support and/or ventilation is instigated or in the presence of recurring hypoxia and supplemental oxygen is required - each additional investigation. *(See para D1.18 of explanatory notes to this Category)*
12215	**Fee:** $701.85 **Benefit:** 75% = $526.40 85% = $622.35

OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR CHILDREN AGED BETWEEN 12 AND 18 YEARS, WHERE:

a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum) airflow detection, measurement of CO2 either end-tidal or transcutaneous, oxygen saturation and ECG are performed;
b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner;
c) the patient is referred by a medical practitioner;
d) the necessity for the investigation is determined by a qualified sleep medicine practitioner prior to the investigation;
e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report;
f) the interpretation and report to be provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient.

where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12213 applies, for therapy with Continuous Positive Airway Pressure (CPAP), bilevel pressure support and/or ventilation is instigated or in the presence of recurring hypoxia and supplemental oxygen is required - each additional investigation.
(See para D1.18 of explanatory notes to this Category)

12217 **Fee:** $632.30 **Benefit:** 75% = $474.25 85% = $552.80

Overnight investigation for sleep apnoea for a period of at least 8 hours duration for a patient aged 18 years or more, if all of the following requirements are met:

(a) the patient has, before the overnight investigation, been referred to a qualified adult sleep medicine practitioner by a medical practitioner whose clinical opinion is that there is a high probability that the patient has obstructive sleep apnoea; and

(b) the investigation takes place after the qualified adult sleep medicine practitioner has:
(i) confirmed the necessity for the investigation; and
(ii) communicated this confirmation to the referring medical practitioner; and

(c) during a period of sleep, the investigation involves recording a minimum of seven physiological parameters which must include:
(i) continuous electro-encephalogram (EEG); and
(ii) continuous electro-cardiogram (ECG; and
(iii) airflow; and
(iv) thoraco-abdominal movement; and
(v) oxygen saturation; and
(vi) 2 or more of the following:
(A) electro-oculogram (EOG);
(B) chin electro-myogram (EMG);
(C) body position; and

(d) in the report on of the investigation, the qualified adult sleep medicine practitioner uses the data specified in paragraph (c) to:
(i) analyse sleep stage, arousals and respiratory events; and
(ii) assess clinically significant alteration in heart rate; and

(e) the qualified adult sleep medicine practitioner:
(i) before the investigation takes place, establishes quality assurance procedures for data acquisition; and
(ii) personally analyses the data and writes the report on the results of the investigation;

(f) the investigation is not provided to the patient on the same occasion as a service mentioned in any of items 11000 to 11005, 11503, 11700 to 11709, 11713 and 12203 is provided to the patient

Payable only once in a 12 month period
(See para D1.18 of explanatory notes to this Category)

12250 **Fee:** $335.30 **Benefit:** 75% = $251.50 85% = $285.05

DIAGNOSTIC		OTHER
12306	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry**, for: . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma; or . for the monitoring of low bone mineral density proven by bone densitometry at least 12 months previously. Measurement of 2 or more sites - **1 service only in a period of 24 months** - including interpretation and report; not being a service associated with a service to which item 12309, 12312, 12315, 12318 or 12321 applies (Ministerial Determination) *(See para D1.19 of explanatory notes to this Category)* **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05	
12309	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using quantitative computerised tomography**, for: . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma; or . for the monitoring of low bone mineral density proven by bone densitometry at least 12 months previously. Measurement of 2 or more sites - **1 service only in a period of 24 months** - including interpretation and report; not being a service associated with a service to which item 12306, 12312, 12315, 12318 or 12321 applies (Ministerial Determination) *(See para D1.19 of explanatory notes to this Category)* **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05	
12312	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry**, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions: . prolonged glucocorticoid therapy; . conditions associated with excess glucocorticoid secretion; . male hypogonadism; or . female hypogonadism lasting more than 6 months before the age of 45. Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - **1 service only in a period of 12 consecutive months** - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12315, 12318 or 12321 applies (Ministerial Determination) *(See para D1.19 of explanatory notes to this Category)* **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05	
12315	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry**, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions: . primary hyperparathyroidism; . chronic liver disease; . chronic renal disease; . proven malabsorptive disorders; . rheumatoid arthritis; or . conditions associated with thyroxine excess. Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - **1 service only in a period of 24 consecutive months** - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12318 or 12321 applies (Ministerial Determination) *(See para D1.19 of explanatory notes to this Category)* **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05	
12318	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using quantitative computerised tomography**, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions: . prolonged glucocorticoid therapy; . conditions associated with excess glucocorticoid secretion; . male hypogonadism; . female hypogonadism lasting more than 6 months before the age of 45; . primary hyperparathyroidism; . chronic liver disease; . chronic renal disease; . proven malabsorptive disorders; . rheumatoid arthritis; or . conditions associated with thyroxine excess. Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - **1 service only in a period of 24 consecutive months** - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315 or 12321 applies (Ministerial Determination) *(See para D1.19 of explanatory notes to this Category)* **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05	

DIAGNOSTIC		OTHER
12321	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry**, for the **measurement** of bone density 12 months following a significant change in therapy for: . established low bone mineral density; or . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma. Measurement of 2 or more sites - **1 service only in a period of 12 consecutive months** - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315 or 12318 applies (Ministerial Determination). *(See para D1.19 of explanatory notes to this Category)* **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05	
12323	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry** or **quantitative computerised tomography**, for the measurement of bone mineral density, for a person aged 70 years or over. Measurement of 2 or more sites - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315, 12318 or 12321 applies (Ministerial Determination). *(See para D1.19 of explanatory notes to this Category)* **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05	

	GROUP D2 - NUCLEAR MEDICINE (NON-IMAGING)		
12500	BLOOD VOLUME ESTIMATION **Fee:** $216.65	**Benefit:** 75% = $162.50	85% = $184.20
12503	ERYTHROCYTE RADIOACTIVE UPTAKE SURVIVAL TIME TEST OR IRON KINETIC TEST **Fee:** $424.75	**Benefit:** 75% = $318.60	85% = $361.05
12506	GASTROINTESTINAL BLOOD LOSS ESTIMATION involving examination of stool specimens **Fee:** $303.30	**Benefit:** 75% = $227.50	85% = $257.85
12509	GASTROINTESTINAL PROTEIN LOSS **Fee:** $216.65	**Benefit:** 75% = $162.50	85% = $184.20
12512	RADIOACTIVE B12 ABSORPTION TEST 1 isotope **Fee:** $105.05	**Benefit:** 75% = $78.80	85% = $89.30
12515	RADIOACTIVE B12 ABSORPTION TEST 2 isotopes **Fee:** $229.85	**Benefit:** 75% = $172.40	85% = $195.40
12518	THYROID UPTAKE (using probe) **Fee:** $105.05	**Benefit:** 75% = $78.80	85% = $89.30
12521	PERCHLORATE DISCHARGE STUDY **Fee:** $126.65	**Benefit:** 75% = $95.00	85% = $107.70
12524	RENAL FUNCTION TEST (without imaging procedure) **Fee:** $158.35	**Benefit:** 75% = $118.80	85% = $134.60
12527	RENAL FUNCTION TEST (with imaging and at least 2 blood samples) **Fee:** $84.95	**Benefit:** 75% = $63.75	85% = $72.25
12530	WHOLE BODY COUNT not being a service associated with a service to which another item applies **Fee:** $126.65	**Benefit:** 75% = $95.00	85% = $107.70
12533	CARBON-LABELLED UREA BREATH TEST using oral C-13 or C-14 urea, performed by a specialist or consultant physician, including the measurement of exhaled $^{13}CO_2$ or $^{14}CO_2$, for either:- (a) the confirmation of *Helicobacter pylori* colonisation, OR (b) the monitoring of the success of eradication of *Helicobacter pylori*. not being a service to which 66900 applies **Fee:** $84.65	**Benefit:** 75% = $63.50	85% = $72.00

INDEX

A

Allergens, epicutaneous patch testing 12012,12015,12018 12021
  skin sensitivity testing 12000,12003
Anal canal, laser therapy (restriction)
  manometry, pelvic floor abnormalities 11830
Anorectal carcinoma, excision of
  sensation, measurement of 11830
Audiogram 11309,11312,11315 11318
  impedance 11324,11327,11330
Audiometry, brain stem evoked response 11300
  non-determinate 11306
  oto-acoustic emission audiometry 11332

B

Bladder, aspiration of, by needle
  washout test of 11921
Blood, administration of
  dye - dilution indicator test 11715
  pressure monitoring, indwelling catheter 11600
  volume estimation, nuclear 12500
Bone, cysts, injection into or aspiration of
  densitometry 12306,12309,12312 12315,12318,12321
Brain stem evoked response audiometry 11300
Bronchospirometry 11500

C

C-13 or C-14 urea breath test 12533
Caloric test of labyrinth(s) 11333,11336
Capsule endoscopy for Peutz-Jeghers syndrome 11823
Capsule endoscopy, for obscure gastrointestinal
    bleeding 11820
Carbon dioxide laser resurfacing, face or neck
  dioxide output, estimation of 11503
  labelled urea breath test 12533
Central cannulation for cardiopulmonary bypass
  nervous system evoked responses 11024,11027
Cochlear implant, insertion with mastoidectomy
  tests 11318,11321
Computerised perimetry 11221,11222,11224 11225
Cystometrography 11903
  with other procedures 11912,11915,11917 11919

D

Dark Adaptometry 11211
device for delivery of therapeutic agents
  loop recorder for investigation of syncope 11722
  pace maker testing 11718,11721
Diffusing capacity 11503
Digital nail, toe, removal of
  temperature, measurement of 11615
Doppler recordings 11602,11610-11612,11614

E

E.C.G. 11700-11702,11708-11713
E.E.G. 11000,11003-11006
E.M.G. 11012,11021,11833
E.N.G. 11339
Electrocardiography 11700-11702,11708-11713
Electrocochleography 11303,11304
Electrocorticography 11009
Electrodiagnosis, neuromuscular 11012,11015,11018 11021
Electroencephalography (E.E.G) 11000,11003-11006
Electromyography (E.M.G.) 11012,11021,11833
Electroneurography of facial nerve 11015
Electronystagmography (E.N.G.) 11339
Electrooculography 11205
Electroretinography 11204,11205,11210
Endoscopy with balloon dilatation gastric stricture
  capsule, for obscure gastrointestinal bleeding 11820
Epicutaneous patch testing 12012,12015,12018 12021
Ergometry, with electrocardiography 11712
Erythrocyte radioactive uptake survival time 12503
  screening test, volume Cr51 12500
Evoked response audiometry, brain stem 11300
  responses, central nervous system 11024,11027
Eye, capsulotomy, laser
  investigation of ocular surface dysplasia 11235

F

Flow volume loops 11512

G

Gastro-oesophageal balloon intubation
  reflux, clinical assessment of 11810
Gastrointestinal blood loss estimation 12506
  capsule endoscopy, investigation of obscure bleeding 11820
  protein loss 12509
Glaucoma, filtering and allied operations for
  provocative tests for 11200

I

Implantable Cardioverter Defibrillator
  Implantable Cardioverter Defibrillator testing 11727
Iontophoresis, collection of specimen of sweat by 12200
Iron kinetic test 12503

K

Klockoff's test, assessment of cochlear function changes 11321

L

Labyrinths, caloric test of 11333,11336
Laser: ablation of prostate, endoscopic
  Doppler interferometry of eyes 11240-11243
Lung compliance, estimation of 11503
  volumes 11503

M

Manometric oesophageal motility test 11800
Motility test, manometric, of oesophagus 11800
Muscle, activity sampling (electromyography) 11012,11015,11018

N

Nerve block, regional or field
  conduction studies 11012,11015,11018

Neuromuscular electrodiagnosis 11012,11015,11018 11021

O

Ocular muscle, torn, repair of 11240-11243
coherence biometry/tomography 11240-11243
surface dysplasia, investigation 11235
Oesophageal atresia, neonatal, operations for 11800
motility test, manometric 11800
Optical coherence biometry/tomography 11240-11243
Orbital cavity, bone or cartilage graft to 11240-11243
contents, partial coherence interferometry of 11240-11243
contents, ultrasonic echography of 11240-11243
Oto-acoustic emission audiometry 11332
Oxygen consumption, estimation of 11503

P

Pacemaker electrode, permanent, insertion, sub-xyphoid 11718,11721
implanted, testing of 11718,11721
Partial coherence interferometry of eyes 11240-11243
Patch angioplasty for vein stenosis 12012,12015,12018 12021
testing, epicutaneous 12012,12015,12018 12021
Pelvic abscess, drainage via rectum or vagina 11830,11833
floor abnormalities, diagnosis of 11830,11833
Perchlorate discharge study 12521
Perimetry, quantitative 11221,11222,11224 11225
quantitative, computerised 11221,11222,11224 11225
Peripheral arterial atherectomy 11604,11605,11610-11612
vessels, examination of 11604,11605,11610-11612
Plethysmography 11604,11605,11610-11612
Profilometry, urethral pressure 11906,11909
Provocative test for glaucoma 11200
Pudendal and spinal nerve motor latency, measurement 11833
Pulmonary artery, banding of 11627
artery pressure monitoring, open heart 11627

R

Radioactive B12 absorption test 12512,12515
Rectosphincteric reflex, measurement of 11830
Renal artery, aberrant, operation for 12524,12527
function test 12524,12527
Respiratory function, estimation of 11503,11506,11509 11512
Retinal photography 11215,11218

S

Schilling test 12512,12515
Skin, biopsy of 12000,12003
sensitivity testing for allergens 12000,12003
Sleep apnoea, overnight investigation for 12203,12207
Overnight paediatric investigation 12210,12213,12215 12217
Small bowel, capsule endoscopy, investigation of 11820
obscure bleeding 11820
Specimen of sweat, collection of, by iontophoresis 12200
Speech discrimination tests 11321
Sphincter, anal, direct repair of 11833
muscle and pelvic floor abnormalities, diagnosis of 11833
Spinal and pudendal nerve motor latency, measurement 11833
Spirometry 11506,11509
Sweat, collection of specimen of, by iontophoresis 12200

T

Temperature, digital, measurement of 11615
Temporosphenoidal electroencephalography 11006
Thyroid uptake 12518
Thyrotropin alfa-rch, administration of 12201
Tilt table testing for investigation of syncope 11724
Transcranial doppler 11614

U

Upright tilt table testing for syncope 11724
Urea breath test 12533
Urethral abscess, drainage of 11906,11909
pressure profilometry 11906,11909
Urinary conduit or reservoir, endoscopic examination 11921
infection, bladder washout test 11921
Urine flow study 11900

W

Whole body count 12530

THERAPEUTIC PROCEDURES
CATEGORY 3

SUMMARY OF CHANGES FROM 1/1/2016

The 1/1/2016 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

There are no changes to this Category for 1 January 2016.

T.1.1. HYPERBARIC OXYGEN THERAPY - (ITEMS 13015, 13020, 13025 AND 13030)

Hyperbaric Oxygen Therapy not covered by these items would attract benefits on an attendance basis. For the purposes of these items, a comprehensive hyperbaric medicine facility means a separate hospital area that, on a 24 hour basis:

(a) is equipped and staffed so that it is capable of providing to a patient:

(i) hyperbaric oxygen therapy at a treatment pressure of at least 2.8 atmospheric pressure absolute (180 kilopascal gauge pressure); and

(ii) mechanical ventilation and invasive cardiovascular monitoring within a monoplace or multiplace chamber for the duration of the hyperbaric treatment; and

(b) is under the direction of at least 1 medical practitioner who is rostered, and immediately available, to the facility during the facility's ordinary working hours if the practitioner:

(i) is a specialist with training in diving and hyperbaric medicine; or

(ii) holds a Diploma of Diving and Hyperbaric Medicine of the South Pacific Underwater Medicine Society; and

(c) is staffed by:

(i) at least 1 medical practitioner with training in diving and hyperbaric medicine who is present in the facility and immediately available at all times when patients are being treated at the facility; and

(ii) at least 1 registered nurse with specific training in hyperbaric patient care to the published standards of the Hyperbaric Technicians and Nurses Association, who is present during hyperbaric oxygen therapy; and

(d) has admission and discharge policies in operation.

T.1.2. HAEMODIALYSIS - (ITEMS 13100 AND 13103)

Item 13100 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in the patient who is not stabilised where the total attendance time by the supervising medical specialist exceeds 45 minutes.

Item 13103 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in a stabilised patient, or in the case of an unstabilised patient, where the total attendance time by the supervising medical specialist does not exceed 45 minutes.

T.1.3. CONSULTANT PHYSICIAN SUPERVISION OF HOME DIALYSIS - (ITEM 13104)

Item 13104 covers the planning and management of dialysis and the supervision of a patient on home dialysis by a consultant physician in the practice of his or her specialty of renal medicine. Planning and management would cover the consultant physician participating in patient management discussions coordinated by renal centres. Supervision of the patient at home can be undertaken by telephone or other electronic medium, and includes:

- Regular ordering, performance and interpretation of appropriate biochemical and haematological studies (generally monthly);
- Feed-back of results to the home patient and his or her treating general physician;
- Adjustments to medications and dialysis therapies based upon these results;
- Co-ordination of regular investigations required to keep patient on active transplantation lists, where relevant;
- Referral to, and communication with, other specialists involved in the care of the patient; and
- Being available to advise the patient or the patient's agent.

A record of the services provided should be made in the patient's clinical notes.

The schedule fee equates to one hour of time spent undertaking these activities. It is expected that the item will be claimed once per month, to a maximum of 12 claims per year. The patient should be informed that he or she will incur a charge for which a Medicare rebate will be payable.

This item includes dialysis conducted in a residential aged care facility. In remote areas, where a patient's home is an unsuitable environment for home dialysis due to a lack of space, or the absence of telecommunication, electricity and water utilities, the item includes dialysis in a community facility such as the local primary health care clinic.

T.1.4. ASSISTED REPRODUCTIVE TECHNOLOGY ART SERVICES - (ITEMS 13200 TO 13221)

Medicare benefits are not payable in respect of ANY other item in the Medicare Benefits Schedule (including Pathology and Diagnostic Imaging) in lieu of or in connection with items 13200 – 13221. Specifically, Medicare benefits are not payable for these items in association with items 104, 105, 14203, 14206, 35637, pathology tests or diagnostic imaging.

A treatment cycle that is a series of treatments for the purposes of ART services is defined as beginning either on the day on which treatment by superovulatory drugs is commenced or on the first day of the patient's menstrual cycle, and ending either; not more than 30 days later, or if a service mentioned in item 13212, 13215 or 13321 is provided in connection with the series of treatments–on the day after the day on which the last of those services is provided.

The date of service in respect of treatment covered by Items 13200, 13201, 13203, 13206, 13209 and 13218 is **DEEMED** to be the **FIRST DAY** of the treatment cycle.

Items 13200, 13201, 13202 and 13203 are linked to the supply of hormones under the Section 100 (National Health Act) arrangements. Providers must notify the Department of Human Services of Medicare card numbers of patients using hormones under this program, and hormones are only supplied for patients claiming one of these four items.

Medicare benefits are not payable for assisted reproductive services rendered in conjunction with surrogacy arrangements where surrogacy is defined as 'an arrangement whereby a woman agrees to become pregnant and to bear a child for another person or persons to whom she will transfer guardianship and custodial rights at or shortly after birth'.

NOTE: Items 14203 and 14206 are not payable for artificial insemination.

T.1.5. INTRACYTOPLASMIC SPERM INJECTION - (ITEM 13251)

Item 13251 provides for intracytoplasmic sperm injection for male factor infertility under the following circumstances:
- where fertilisation with standard IVF is highly unlikely to be successful; or
- where in a previous cycle of IVF, the fertilisation rate has failed due to low or no fertilisation.

Item 13251 excludes a service to which item 13218 applies. Sperm retrieval procedures associated with intracytoplasmic sperm injection are covered under items 37605 and 37606.

Items 13251, 37605, 37606 do not include services provided in relation to artificial insemination using the husband's or donated sperm.

T.1.6. PERIPHERALLY INSERTED CENTRAL CATHETERS

Peripherally inserted central catheters (PICC) are an alternative to standard percutaneous central venous catheter placement or surgically placed intravenous catheters where long-term venous access is required for ongoing patient therapy.

Medicare benefits for PICC can be claimed under central vein catheterisation items 13318, 13319, 13815 and 22020.

These items are for central vein catheterisation (where the tip of the catheter is positioned in a central vein) and cannot be used for venous catheters where the tip is positioned in a peripheral vein.

T.1.7. ADMINISTRATION OF BLOOD OR BONE MARROW ALREADY COLLECTED (ITEM 13706)

Item 13706 is payable for the transfusion of blood, or platelets or white blood cells or bone marrow or gamma globulins. This item is not payable when gamma globulin is administered intramuscularly.

T.1.8. COLLECTION OF BLOOD - (ITEM 13709)

Medicare benefits are payable under Item 13709 for collection of blood for autologous transfusions in respect of an impending operation (whether or not the blood is used), or when homologous blood is required in an emergency situation.

Medicare benefits are not payable under Item 13709 for collection of blood for long-term storage for possible future autologous transfusion, or for other forms of directed blood donation.

T.1.9. INTENSIVE CARE UNITS - (ITEMS 13870 TO 13888)

'Intensive Care Unit' means a separate hospital area that:
(a) is equipped and staffed so as to be capable of providing to a patient:
  (i) mechanical ventilation for a period of several days; and
  (ii) invasive cardiovascular monitoring; and
(b) is supported by:
  (i) at least one specialist or consultant physician in the specialty of intensive care who is immediately available and exclusively rostered to the ICU during normal working hours; and
  (ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and

(iii) a registered nurse for at least 18 hours in each day; and

(c) has defined admission and discharge policies.

"**immediately available**" means that the intensivist must be predominantly present in the ICU during normal working hours. Reasonable absences from the ICU would be acceptable to attend conferences, meetings and other commitments which might involve absences of up to 2 hours during the working day.

"**exclusively rostered**" means that the specialist's sole clinical commitment is to intensive care associated activities and is not involved in any other duties that may preclude immediate availability to intensive care if required.

For Neonatal Intensive Care Units an 'Intensive Care Unit' means a separate hospital area that:

(a) is equipped and staffed so as to be capable of providing to a patient, being a newly-born child:
  (i) mechanical ventilation for a period of several days; and
  (ii) invasive cardiovascular monitoring; and

(b) is supported by:
  (i) at least one consultant physician in the specialty of paediatric medicine, appointed to manage the unit, and who is immediately available and exclusively rostered to the ICU during normal working hours; and
  (ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and
  (iii) a registered nurse for at least 18 hours in each day; and

(c) has defined admission and discharge policies.

Medicare benefits are payable under the 'management' items only once per day irrespective of the number of intensivists involved with the patient on that day. However, benefits are also payable for an attendance by another specialist/consultant physician who is not managing the patient but who has been asked to attend the patient. Where appropriate, accounts should be endorsed to the effect that the consultation was not part of the patient's intensive care management in order to identify which consultations should attract benefits in addition to the intensive care items.

In respect of Neonatal Intensive Care Units, as defined above, benefits are payable for admissions of babies who meet the following criteria:-

(i) all babies weighing less than 1000gms;
(ii) all babies with an endotracheal tube, and for the 24 hours following endotracheal tube removal;
(iii) all babies requiring Constant Positive Airway Pressure (CPAP) for acute respiratory instability;
(iv) all babies requiring more than 40% oxygen for more than 4 hours;
(v) all babies requiring an arterial line for blood gas or pressure monitoring; or
(vi) all babies having frequent seizures.

Cases may arise where babies admitted to a Neonatal Intensive Care Unit under the above criteria who, because they no longer satisfy the criteria are ready for discharge, in accordance with accepted discharge policies, but who are physically retained in the Neonatal Intensive Care Unit for other reasons. For benefit purposes such babies must be deemed as being discharged from the Neonatal Intensive Care Unit and not eligible for benefits under items 13870, 13873, 13876, 13881, 13882, 13885 and 13888.

Likewise, Medicare benefits are not payable under items 13870, 13873, 13876, 13881 13882, 13885 and 13888 in respect of babies not meeting the above criteria, but who, for whatever other reasons, are physically located in a Neonatal Intensive Care Unit.

Medicare benefits are payable for admissions to an Intensive Care Unit following surgery only where clear clinical justification for post-operative intensive care exists.

T.1.10. PROCEDURES ASSOCIATED WITH INTENSIVE CARE - (ITEMS 13818, 13842, 13847, 13848 AND 13857)

Item 13818 covers the insertion of a right heart balloon catheter (Swan-Ganz catheter). Benefits are payable under this item only once per day except where a second discrete operation is performed on that day.

Benefits are payable under items 13876 (within an ICU) and 11600 (outside an ICU) once only for each type of pressure, up to a maximum of 4 pressures per patient per calendar day, and irrespective of the number of the practitioners involoved in monitoring the pressures.

If a service covered by Item 13842 is provided outside of an ICU, in association with, for example, an anaesthetic, benefits are payable for Item 13842 in addition to Item 13870 where the services are performed on the same day. Where this occurs, accounts should be endorsed "performed outside of an Intensive Care Unit" against Item 13842.

Items 13847 and 13848
Item 13847 covers management of counterpulsation by intraaortic balloon on the first day and includes initial and subsequent consultations and monitoring of parameters. Insertion of the intraaortic balloon is covered under item 38609 Management on each day subsequent to the first is covered under item 13848.

"management" of counterpulsation of intraaortic balloon means full heamodynamic assessment and management on several occasions during the day.

Item 13857 covers the establishment of airway access and initiation of ventilation on a patient outside intensive care for the purpose of subsequent ventilatory support in intensive care. Benefits are not payable under Item 13857 where airway access and ventilation is initiated in the context of an anaesthetic for surgery even if it is likely that following surgery the patient will be ventilated in an ICU. In such cases the appropriate anaesthetic item/s should be itemised.

Medicare benefits are not payable for sampling by arterial puncture under Item 13839 in addition to Item 13870 (and 13873) on the same day. Benefits are payable under Item 13842 (Intra-arterial cannulation) in addition to Item 13870 (and 13873) when performed on the same day.

T.1.11. MANAGEMENT AND PROCEDURES IN INTENSIVE CARE UNIT - (ITEMS 13870, 13873, 13876)

Medicare benefits are only payable for management and procedures in intensive care covered by items 13870, 13873, 13876, 13882, 13885 and 13888 where the service is provided by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care.

Items 13870 and 13873
Medicare Benefits Schedule fees for Items 13870 and 13873 represent global daily fees covering all attendances by the intensivist in the ICU (and attendances provided by support medical personnel) and all electrocardiographic monitoring, arterial sampling and, bladder catheterisation.performed on the patient on the one day. If a patient is transferred from one ICU to another it would be necessary for an arrangement to be made between the two ICUs regarding the billing of the patient.

Items 13870 and 13873 should be itemised on accounts according to each calendar day and not per 24 hour period. For periods when patients are in an ICU for very short periods (say less than 2 hours) with minimal ICU management during that time, a fee should not be raised.

Item 13876
Item 13876 covers the monitoring of pressures in an ICU. Benefits are paid only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day and irrespective of the number of medical practitioners involved in the monitoring of pressures in an ICU.

Item 11600
Item 11600 covers the monitoring of pressures outside the ICU by practitioners not associated with the ICU. Benefits are paid only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day and irrespective of the number of practitioners involved in monitoring the pressures.

T.1.12. CYTOTOXIC CHEMOTHERAPY ADMINISTRATION - (ITEM 13915)

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

T.1.13. IMPLANTED PUMP OR RESERVOIR/DRUG DELIVERY DEVICE - (ITEMS 13939 AND 13942)

The schedule fee for Items 13939 and 13942 includes a component to cover accessing of the drug delivery device. Accordingly, benefits are not payable under Item 13945 (Long-term implanted drug delivery device, accessing of) in addition to Items 13939 and 13942.

T.1.14. PUVA OR UVB THERAPY - (ITEMS 14050 AND 14053)

A component for any necessary subsequent consultation has been included in the Schedule fee for these items. However, the initial consultation preceding commencement of a course of therapy would attract benefits.

T.1.15. LASER PHOTOCOAGULATION - (ITEMS 14106 TO 14124)

The Australasian College of Dermatologists has advised that the following ranges (applicable to an average 4 year old child and an adult) should be used as a reference to the treatment areas specified in Items 14106 - 14124:

Entire forehead	50 -75 cm^2
Cheek	55 - 85 cm^2
Nose	10 -25 cm^2
Chin	10 - 30 cm^2
Unilateral midline anterior - posterior neck	60 - 220 cm^2
Dorsum of hand	25 - 80 cm^2
Forearm	100 - 250 cm^2
Upper arm	105 - 320 cm^2

T.1.17. FACIAL INJECTIONS OF POLY-L-LACTIC ACID - (ITEMS 14201 AND 14202)

Poly-L-lactic acid is listed within the standard arrangements on the Pharmaceutical Benefits Scheme (PBS) as an Authority Required listing for initial and maintenance treatments, for facial administration only, of severe facial lipoatrophy caused by therapy for HIV infection.

T.1.18. HORMONE AND LIVING TISSUE IMPLANTATION - (ITEMS 14203 AND 14206)

Items 14203 and 14206 are not payable for artificial insemination.

T.1.19. IMPLANTABLE DRUG DELIVERY SYSTEM FOR THE TREATMENT OF SEVERE CHRONIC SPASTICITY - (ITEMS 14227 TO 14242)

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

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

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

T.1.20. IMMUNOMODULATING AGENT - (ITEM 14245)

Item 14245 applies only to a service provided by a medical practitioner who is registered by the Department of Human Services CEO to participate in the arrangements made, under paragraph 100 (1) (b) of the National Health Act 1953, for the purpose of providing an adequate pharmaceutical service for persons requiring treatment with an immunomodulating agent.

These drugs are associated with risk of anaphylaxis which must be treated by a medical practitioner. For this reason a medical practitioner needs to be available at all times during the infusion in case of an emergency.

T.1.21. THERAPEUTIC PROCEDURES MAY BE PROVIDED BY A SPECIALIST TRAINEE (ITEMS 13015 TO 51318)

(1) Items 13015 to 51318 (excluding 13209 (T1) 16400 to 16500 (T4), 16590 to 16591 (T4), 17610 to 17690 (T6) and 18350 to 18373 (T11) apply to a medical service provided by;

(a) A medical practitioner, or;
(b) A specialist trainee under the direct supervision of a medical practitioner.

(2) For paragraph (1) (b), a medical service provided by a specialist trainee is taken to have been provided by the supervising medical practitioner.

(3) In this rule: Specialist trainee means a medical practitioner who is undertaking an Australian Medical Council (AMC) accredited Medical College Training Program. Direct Supervision means personal and continuous attendance for the duration of the service.

T.1.22. TELEHEALTH SPECIALIST SERVICES

These notes provide information on the telehealth MBS video consultation items by specialists, consultant physicians and psychiatrists. A video consultation involves a single specialist, consultant physician or psychiatrist attending a patient, with the possible support of another medical practitioner, a participating optometrist, a participating nurse practitioner, a participating midwife, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker at the patient end of the video conference. The decision as to whether the patient requires clinical support at the patient end of the specialist service is based on whether the support is necessary for the provision of the specialist service. Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

MBS items numbers 99, 112, 149, 288, 389, 2820, 3015, 6016, 13210, 16399 and 17609 allow a range of existing MBS attendance items to be provided via video conferencing. These items have a derived fee which is equal to 50% of the schedule fee for the consultation item claimed (e.g. 50% of the schedule fee for item 104) when billed with one of the associated consultation items (such as 104). A patient rebate of 85% for the derived fee is payable.

Six MBS item numbers (113, 114, 384, 2799, 3003 and 6004) provide for an initial attendance via videoconferencing by a specialist, consultant physician, consultant occupational physician, pain medicine specialist/consultant physician, palliative medicine specialist/consultant physician or neurosurgeon where the service is 10 minutes or less. The items are stand-alone items and do not have a derived fee.

Where an attendance is more than 10 minutes, practitioners should use the existing item numbers consistent with the current arrangements. Normal restrictions which apply for initial consultations will also apply for these items. For example, if a patient has an initial consultation via telehealth, they cannot also claim an initial face-to-face consultation as part of the same course of treatment.

Clinical indications
The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist, consultant physician or psychiatrist.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Restrictions
The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations. In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Billing Requirements
All video consultations provided by specialists, consultant physicians or psychiatrists must be **separately billed**. That is, only the relevant telehealth MBS consultation item and the associated derived item are to be itemised on the account/bill/voucher. Any other service/item billed should be itemised on a separate account/bill/voucher. This will ensure the claim is accurately assessed as being a video consultation and paid accordingly.

Practitioners should not use the notation ‘telehealth’, ‘verbal consent’ or ‘Patient unable to sign’ to overcome administrative difficulties to obtaining a patient signature for bulk billed claims (for further information see mbsonline.gov.au/telehealth).

Eligible Geographical Areas
Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in a residential care service; or at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the *Health Insurance Act 1973* as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/ telehealth eligible areas

Record Keeping
Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Extended Medicare Safety Net (EMSN)
All telehealth consultations (with the exception of the participating optometrist telehealth items) are subject to EMSN caps. The EMSN caps for ART and Obstetric telehealth items 13210 and 16399 were set in reference to the EMSN caps applying to the base ART and Obstetric consultation items.

The EMSN caps for all other telehealth consultation items are equal to 300% of the schedule fee (to a maximum of $500). The maximum EMSN benefit for a telehealth consultation is equal to the sum of the EMSN cap for the base item and the EMSN cap for the telehealth items.

Aftercare Rule
Video consultations are subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple attendances on the same day
In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Referrals
The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements
In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

T.2.1. RADIATION ONCOLOGY - GENERAL

The level of benefits for radiotherapy depends on the number of fields irradiated and the number of times treatment is given.

Treatment by rotational therapy (including rotational therapy using volumetric modulated arc therapy or intensity modulated arc therapy) is considered to be equivalent to the irradiation of three fields (i.e., irradiation of one field plus two additional fields). For example, each attendance for orthovoltage rotational therapy at the rate of 3 or more treatments per week would attract benefit under Item 15100 plus twice Item 15103. Similarly, each attendance for arc therapy of the prostate using a dual photon linear accelerator would attract benefits under 15248 plus twice 15263. Benefits are payable once only per attendance for treatment irrespective of whether one or more arcs are involved.

Benefits for consultations rendered on the same day as treatment and/or planning services are only payable where they are clinically relevant. A clinically relevant service is one that is generally accepted by the relevant profession as being necessary for the appropriate treatment of the patient.

T.2.2. BRACHYTHERAPY OF THE PROSTATE - (ITEM 15338)

One of the requirements of item 15338 is that patients have a Gleason score of less than or equal to 7. However, where the patient has a score of 7, comprising a primary score of 4 and a secondary score of 3 (ie. 4+3=7), it is recommended that low dose rate brachytherapy form part of a combined modality treatment.

Low dose brachytherapy of the prostate should be performed in patients with favourable anatomy allowing adequate access to the prostate without pubic arch interference and who have a life expectancy of at least greater than 10 years.

An 'approved site' for the purposes of this item is one at which radiation oncology services may be performed lawfully under the law of the State or Territory in which the site is located.

T.2.3. PLANNING SERVICES - (ITEMS 15500 TO 15562 AND 15850)

A planning episode involves field setting and dosimetry. One plan only will attract Medicare benefits in a course of treatment. However, benefits are payable for a plan for brachytherapy and a plan for megavoltage or teletherapy treatment, when rendered in the same course of treatment.

- further planning items where planning is undertaken in respect of a different tumour site to that (or those) specified in the original prescription by the radiation oncologist; and
- a plan for brachytherapy and a plan for megavoltage or teletherapy treatment, when rendered in the same course of treatment.

Items 15500 to 15533 (inclusive) are for a planning episode for 2D conformal radiotherapy. Items 15550 to 15562 (inclusive) are for a planning episode for 3D conformal radiotherapy.

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

Item 15850 covers radiation source localisation for high dose brachytherapy treatment. Item 15850 applies to brachytherapy provided to any part of the body.

T.2.4. TREATMENT VERIFICATION - (ITEMS 15700 TO 15705, 15710 AND 15800)

In these items, 'treatment verification' means:
a quality assurance procedure designed to facilitate accurate and reproducible delivery of the radiotherapy/brachytherapy to the prescribed site(s) or region(s) of the body as defined in the treatment prescription and/or associated dose plan(s) and which utilises the capture and assessment of appropriate images using:

(a) x-rays (this includes portal imaging, either megavoltage or kilovoltage, using a linear accelerator)
(b) computed tomography; or
(c) ultrasound, where the ultrasound equipment is capable of producing images in at least three dimensions (unidimensional ultrasound is not covered); together with a record of the assessment(s) and any correction(s) of significant treatment delivery inaccuracies detected.

Item 15700 covers the acquisition of images in one plane and incorporates both single or double exposures. The item may be itemised once only per attendance for treatment, irrespective of the number of treatment sites verified at that attendance.

Item 15705 (multiple projections) applies where images in more that one plane are taken, for example orthogonal views to confirm the isocentre. It can be itemised only where verification is undertaken of treatments involving three or more fields. It can be itemised where single projections are acquired for multiple sites, eg multiple metastases for palliative patients. Item 15705 can be itemized only once per attendance for treatment, irrespective of the number of treatment sites verified at that attendance.

15710 applies to volumetric verification imaging using acquisition by computed tomography. It can be itemised only where verification is undertaken of treatments involving three or more fields and only once per attendance for treatment, irrespective of the number of treatment sites verified at that attendance.

Items 15700, 15705 and 15710:

- may not claimed together for the same attendance at which treatment is rendered
- must only be itemised when the verification procedure has been prescribed in the treatment plan and the image has been reviewed by a radiation oncologist

Item 15800 - Benefits are payable once only per attendance at which treatment is verified.

T.3.1. THERAPEUTIC DOSE OF YTTRIUM 90 - (ITEM 16003)

This item cannot be claimed for selective internal radiation therapy (SIRT).

See items 35404, 35406 and 35408 for SIRT using SIR_Spheres (yttrium-90 microspheres).

T.4.1. ANTENATAL SERVICE PROVIDED BY A NURSE, MIDWIFE OR AN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER - (ITEM 16400)

Item 16400 can only be claimed by a medical practitioner (including a vocationally registered or non-vocationally registered GP, a specialist or a consultant physician) where an antenatal service is provided to a patient by a midwife, nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of the medical practitioner at, or from an eligible practice location in a regional, rural or remote area.

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

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

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

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

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

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

The midwife, nurse or Aboriginal and Torres Strait Islander health practitioner must also comply with any relevant legislative or regulatory requirements regarding the provision of the antenatal service.

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

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

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

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

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

Item 16400 can only be claimed 10 times per pregnancy.

Item 16400 cannot be claimed for an admitted patient of a hospital.

T.4.2. ITEMS FOR INITIAL AND SUBSEQUENT OBSTETRIC ATTENDANCES (ITEMS 16401 AND 16404)

16401 and 16404 replace items 104 and 105 for any specialist obstetric attendance relating to pregnancy. This includes any initial and subsequent attendance with a specialist obstetrician for discussion of pregnancy or pregnancy related conditions or complications, or any postnatal care provided to the patient subsequent to the expiration of normal aftercare period. Item 16500 is still claimed for routine antenatal attendances. These items are subject to Extended Medicare Safety Net caps.

T.4.3. ANTENATAL CARE - (ITEM 16500)

In addition to routine antenatal attendances covered by Item 16500 the following services, where rendered during the antenatal period, attract benefits:-

(a) Items 16501, 16502, 16504, 16505, 16508, 16509 (but not normally before the 24th week of pregnancy), 16511, 16512, 16514 and 16600 to 16636.
(b) The initial consultation at which pregnancy is diagnosed.
(c) The first referred consultation by a specialist obstetrician when called in to advise on the pregnancy.
(d) All other services, excluding those in Category 1 and Group T4 of Category 3 not mentioned above.
(e) Treatment of an intercurrent condition not directly related to the pregnancy.

Item 16504 relates to the treatment of habitual miscarriage by injection of hormones. A case becomes one of habitual miscarriage following two consecutive spontaneous miscarriages or where progesterone deficiency has been proved by hormonal assay of cells obtained from a smear of the lateral vaginal wall.

Item 16514 relates to antenatal cardiotocography in the management of high risk pregnancy. Benefits for this service are not attracted when performed during the course of the labour and delivery.

T.4.4. EXTERNAL CEPHALIC VERSION FOR BREECH PRESENTATION - (ITEM 16501)

Contraindications for this item are as follows:

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

T.4.5. LABOUR AND DELIVERY - (ITEMS 16515, 16518, 16519 AND 16525)

Benefits for management of labour and delivery covered by Items 16515, 16518, 16519 and 16525 includes the following (where indicated):-

- - surgical and/or intravenous infusion induction of labour;
- - forceps or vacuum extraction;
- - evacuation of products of conception by manual removal (not being an independent procedure);
- - episiotomy or repair of tears.

Item 16519 covers delivery by any means including Caesarean section. If, however, a patient is referred, or her care is transferred to another medical practitioner for the specific purpose of delivery by Caesarean section, whether because of an emergency situation or otherwise, then Item 16520 would be the appropriate item.

In some instances the obstetrician may not be able to be present at all stages of confinement. In these circumstances, Medicare benefits are payable under Item 16519 provided that the doctor attends the patient as soon as possible during the confinement and assumes full responsibility for the mother and baby.

Two items in Group T9 provide benefits for assistance by a medical practitioner at a Caesarean section. Item 51306 relates to those instances where the Caesarean section is the only procedure performed, while Item 51309 applies when other operative procedures are performed at the same time.

As a rule, 24 weeks would be the period distinguishing a miscarriage from a premature confinement. However, if a live birth has taken place before 24 weeks and the foetus survives for a reasonable period, benefit would be payable under the appropriate confinement item.

Where, during labour, a medical practitioner hands the patient over to another medical practitioner, benefits are payable under Item 16518 for the referring practitioner's services. The second practitioner's services would attract benefits under Item 16515 (i.e., management of vaginal delivery) or Item 16520 (Caesarean section). If another medical practitioner is called in for the management of the labour and delivery, benefits for the referring practitioner's services should be assessed under Item 16500 for the routine antenatal attendances and on a consultation basis for the postnatal attendances, if performed.

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

T.4.6. CAESAREAN SECTION - (ITEM 16520)

Benefits under this item are attracted only where the patient has been specifically referred to another medical practitioner for the management of the delivery by Caesarean section and the practitioner carrying out the procedure has not rendered any antenatal care. Caesarean sections performed in any other circumstances attract benefits under Item 16519.

T.4.7. COMPLICATED CONFINEMENT - (ITEM 16522)

Conditions that pose a significant risk of maternal death referred to in Item 16522 include:

- severe pre-eclampsia as defined in the Consensus Statement on the Management of Hypertension in Pregnancy, published in the Medical Journal of Australia, Volume 158 on 17 May 1993, and as revised;
- cardiac disease (co-managed with a consultant physician or a specialist physician);
- coagulopathy;
- severe autoimmune disease;
- previous organ transplant; or
- pre-existing renal or hepatic failure.

T.4.8. LABOUR AND DELIVERY WHERE CARE IS TRANSFERRED BY A PARTICIPATING MIDWIFE - (ITEMS 16527 TO 16528)

Where the inter-partum care of a women is transferred to a medical practitioner by a participating midwife for management of birth, item 16527 or 16528 would apply depending on the service provided.

Where care is transferred by a participating midwife prior to the commencement of labour, items 16519 or 16522 would apply.

T.4.9. ITEMS FOR PLANNING AND MANAGEMENT OF A PREGNANCY (ITEM 16590)

Item 16590 is intended to provide for the planning and management of pregnancy that has progressed beyond 20 weeks, where the medical practitioner is intending to undertake the delivery for a privately admitted patient. From 1 January 2010 a new item, 16591, has been introduced to reflect the different responsibilities of GPs and obstetricians who plan to manage the pregnancy, labour and birth, and those who are part of a shared care arrangement. Medical practitioners who do not plan to undertake the delivery of a privately admitted patient should claim item 16591. Both 16590 and 16591 are subject to Extended Medicare Safety Net caps and should only be claimed by a patient once per pregnancy.

T.4.10. POST-PARTUM CARE - (ITEMS 16564 TO 16573)

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

(i) where the medical services rendered are outside those covered by a consultation, e.g., blood transfusion;

(ii) where the condition of the mother and/or baby is such as to require the services of another practitioner (e.g., paediatrician, gynaecologist, etc);

(iii) where the patient is transferred, at arms length, to another medical practitioner for routine post-partum, care (eg mother and/or baby returning from a larger centre to a country town or transferring between hospitals following confinement). In such cases routine postnatal attendances attract benefits on an attendance basis. The transfer of a patient within a group practice would not qualify for benefits under this arrangement except in the case of Items 16515 and 16518. These items cover those occasions when a patient is handed over <u>while in labour</u> from the practitioner who under normal circumstances would have delivered the baby, but because of compelling circumstances decides to transfer the patient to another practitioner for the delivery;

(iv) where during the postnatal period a condition occurs which requires treatment outside the scope of normal postnatal care;

(v) in the management of premature babies (i.e. babies born prior to the end of the 37th week of pregnancy or where the birth weight of the baby is less than 2500 grams) during the period that close supervision is necessary.

Normal postnatal care by a medical practitioner would include:-

(i) uncomplicated care and check of
- lochia
- fundus
- perineum and vulva/episiotomy site
- temperature
- bladder/urination
- bowels

(ii) advice and support for establishment of breast feeding
(iii) psychological assessment and support
(iv) Rhesus status
(v) Rubella status and immunisation
(vi) contraception advice/management

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

Items 16564 to 16573 relate to postnatal complications and should not be itemised in respect of a normal delivery. To qualify for benefits under these items, the patient is required to be transferred to theatre, or be administered general anaesthesia or epidural injection for the performance of the procedure. Utilisation of the items will be closely monitored to ensure appropriate usage.

T.4.11. INTERVENTIONAL TECHNIQUES - (ITEMS 16600 TO 16636)

For Items 16600 to 16636, 35518 and 35674 there is no component in the Schedule fee for the associated ultrasound. Benefits are attracted for the ultrasound under the appropriate items in Group I1 of the Diagnostic Imaging Services Table. If diagnostic ultrasound is performed on a separate occasion to the procedure, benefits would be payable under the appropriate ultrasound item.

Item 51312 provides a benefit for assistance by a medical practitioner at interventional techniques covered by Items 16606, 16609, 16612, 16615, 16627 and 16633.

T.4.12. TELEHEALTH SPECIALIST SERVICES

These notes provide information on the telehealth MBS video consultation items by specialists, consultant physicians and psychiatrists. A video consultation involves a single specialist, consultant physician or psychiatrist attending a patient, with the possible support of another medical practitioner, a participating optometrist, a participating nurse practitioner, a participating midwife, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker at the patient end of the video conference. The decision as to whether the patient requires clinical support at the patient end of the specialist service is based on whether the support is necessary for the provision of the specialist service. Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

MBS items numbers 99, 112, 149, 288, 389, 2820, 3015, 6016, 13210, 16399 and 17609 allow a range of existing MBS attendance items to be provided via video conferencing. These items have a derived fee which is equal to 50% of the schedule fee for the consultation item claimed (e.g. 50% of the schedule fee for item 104) when billed with one of the associated consultation items (such as 104). A patient rebate of 85% for the derived fee is payable.

Six MBS item numbers (113, 114, 384, 2799, 3003 and 6004) provide for an initial attendance via videoconferencing by a specialist, consultant physician, consultant occupational physician, pain medicine specialist/consultant physician, palliative medicine specialist/consultant physician or neurosurgeon where the service is 10 minutes or less. The items are stand alone items and do not have a derived fee.

Where an attendance is more than 10 minutes, practitioners should use the existing item numbers consistent with the current arrangements. Normal restrictions which apply for initial consultations will also apply for these items. For example, if a patient has an initial consultation via telehealth, they cannot also claim an initial face-to-face consultation as part of the same course of treatment.

Clinical indications

The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist, consultant physician or psychiatrist.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Restrictions
The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations. In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Billing Requirements
All video consultations provided by specialists, consultant physicians or psychiatrists must be **separately billed**. That is, only the relevant telehealth MBS consultation item and the associated derived item are to be itemised on the account/bill/voucher. Any other service/item billed should be itemised on a separate account/bill/voucher. This will ensure the claim is accurately assessed as being a video consultation and paid accordingly.

Practitioners should not use the notation 'telehealth', 'verbal consent' or 'Patient unable to sign' to overcome administrative difficulties to obtaining a patient signature for bulk billed claims (for further information see mbsonline.gov.au/telehealth).

Eligible Geographical Areas
Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in a residential care service; or at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the *Health Insurance Act 197,* as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/ telehealth eligible areas

Record Keeping
Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Extended Medicare Safety Net (EMSN)
All telehealth consultations (with the exceptions of the participating optometrist telehealth items) are subject to EMSN caps. The EMSN caps for ART and Obstetric telehealth items 13210 and 16399 were set in reference to the EMSN caps applying to the base ART and Obstetric consultation items.

The EMSN caps for all other telehealth consultation items are equal to 300% of the schedule fee (to a maximum of $500). The maximum EMSN benefit for a telehealth consultation is equal to the sum of the EMSN cap for the base item and the EMSN cap for the telehealth items.

Aftercare Rule
Video consultations are subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple attendances on the same day
In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Referrals
The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements
In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

T.6.1. PRE-ANAESTHESIA CONSULTATIONS BY AN ANAESTHETIST - (ITEMS 17610 TO 17625)

Pre-anaesthesia consultations are covered by items in the range 17610 - 17625.

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

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

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

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

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

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

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

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

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

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

- Major cardiac problems – e.g cardiomyopathy, unstable ischaemic heart disease, heart failure
- Major respiratory disease – e.g COPD, respiratory failure, acute lung conditions eg. infection and asthma,
- Major neurological conditions – CVA, intra/extra cerebral haemorrhage, cerebral palsy and/or major intellectual disability, degenerative conditions of the CNS
- Major metabolic conditions – e.g unstable diabetes, uncontrolled hyperthyroidism, renal failure, liver failure, immune deficiency
- Anaesthetic problems – eg past history of awareness, known or anticipated difficulty with securing the airway, malignant hyperpyrexia, drug allergy,
- Other conditions –
    - patients with history of stroke/TIA's presenting for vascular surgery
    - patients on anti-platelet agents presenting for major surgery requiring management of anticoagulant status
    - patients with poor respiratory/cardiac function presenting for major surgery requiring management of perioperative medications, analgaesia and monitoring

NOTE I:

It is important to note that:

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

NOTE II:

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

T.6.2. REFERRED ANAESTHESIA CONSULTATIONS - (ITEMS 17640 TO 17655)

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

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

(i) Acute pain management

- Postoperative, utilising specialised techniques eg Patient Controlled Analgesia System (PCAS)
- as an independent service eg pain control following fractured ribs requiring nerve blocks
- obstetric pain management

(ii) Perioperative management of patients

- postoperative management of cardiac, respiratory and fluid balance problems following major surgery
- vascular access procedures (other than intra-operative peripheral vascular access procedures)

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

NOTE :

- It should be noted that the consultation time under items 17640 – 17655 only applies to the period of active attendance on the patient and does not include time spent in discussion with other health care practitioners.
- Consultation services covered by pain medicine specialist items in the range 2801-3000 cannot be claimed in conjunction with items 17640 – 17655.

- The requirement of a written patient management plan in items 17645-17655 or the discussion of the management plan with other health care professions, where this occurs, does not relate to and cannot be claimed in conjunction GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans or Case Conference items in Group A15 of the MBS.

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

T.6.3. ANAESTHETIST CONSULTATIONS - OTHER - (ITEMS 17680, 17690)

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

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

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

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

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

T.6.4. TELEHEALTH SPECIALIST SERVICES

These notes provide information on the telehealth MBS video consultation items by specialists, consultant physicians and psychiatrists. A video consultation involves a single specialist, consultant physician or psychiatrist attending a patient, with the possible support of another medical practitioner, a participating optometrist, a participating nurse practitioner, a participating midwife, practice nurse or Aboriginal health worker at the patient end of the video conference. The decision as to whether the patient requires clinical support at the patient end of the specialist service is based on whether the support is necessary for the provision of the specialist service. Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

MBS items numbers 99, 112, 149, 288, 389, 2820, 3015, 6016, 13210, 16399 and 17609 allow a range of existing MBS attendance items to be provided via video conferencing. These items have a derived fee which is equal to 50% of the schedule fee for the consultation item claimed (e.g. 50% of the schedule fee for item 104) when billed with one of the associated consultation items (such as 104). A patient rebate of 85% for the derived fee is payable.

Six MBS item numbers (113, 114, 384, 2799, 3003 and 6004) provide for an initial attendance via videoconferencing by a specialist, consultant physician, consultant occupational physician, pain medicine specialist/consultant physician, palliative medicine specialist/consultant physician or neurosurgeon where the service is 10 minutes or less. The items are stand-alone items and do not have a derived fee.

Where an attendance is more than 10 minutes, practitioners should use the existing item numbers consistent with the current arrangements. Normal restrictions which apply for initial consultations will also apply for these items. For example, if a patient has an initial consultation via telehealth, they cannot also claim an initial face-to-face consultation as part of the same course of treatment.

Clinical indications
The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist, consultant physician or psychiatrist.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Restrictions
The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations. In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Billing Requirements
All video consultations provided by specialists, consultant physicians or psychiatrists must be **separately billed**. That is, only the relevant telehealth MBS consultation item and the associated derived item are to be itemised on the account/bill/voucher. Any other service/item billed should be itemised on a separate account/bill/voucher. This will ensure the claim is accurately assessed as being a video consultation and paid accordingly.

Practitioners should not use the notation 'telehealth', 'verbal consent' or 'Patient unable to sign' to overcome administrative difficulties to obtaining a patient signature for bulk billed claims (for further information see mbsonline.gov.au/telehealth).

Eligible Geographical Areas
Geographic eligibility for telehealth services funded under Medicareare determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in a residential care service; or at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the *Health Insurance Act 1973* as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/ telehealth eligible areas

Record Keeping
Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Extended Medicare Safety Net (EMSN)
All telehealth consultations (with the exceptions of the participating optometrist telehealth items) are subject to EMSN caps. The EMSN caps for ART and Obstetric telehealth items 13210 and 16399 were set in reference to the EMSN caps applying to the base ART and Obstetric consultation items.

The EMSN caps for all other telehealth consultation items are equal to 300% of the schedule fee (to a maximum of $500). The maximum EMSN benefit for a telehealth consultation is equal to the sum of the EMSN cap for the base item and the EMSN cap for the telehealth items.

Aftercare Rule
Video consultations are subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple attendances on the same day
In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Referrals
The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements
In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

T.7.1. REGIONAL OR FIELD NERVE BLOCKS - GENERAL

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

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

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

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

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

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

T.7.2. MAINTENANCE OF REGIONAL OR FIELD NERVE BLOCK - (ITEMS 18222 AND 18225)

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

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

T.7.3. INTRATHECAL OR EPIDURAL INJECTION - (ITEM 18232)

This items covers caudal infusion/injection.

T.7.4. INTRATHECAL OR EPIDURAL INFUSION - (ITEMS 18226 AND 18227)

Items 18226 and 18227 apply where intrathecal or epidural analgesia is required for obstetric patients in the after hours period. For these items, the after hours period is defined as the period from 8pm to 8am on any weekday, or any time on a Saturday, Sunday or a public holiday.

Medicare benefits are only payable under item 18227 where more than 50% of the service is provided in the after hours period, benefits would be payable under item 18219.

T.7.5. REGIONAL OR FIELD NERVE BLOCKS - (ITEMS 18234 TO 18298)

Items in the range 18234 - 18298 are intended to cover the injection of anaesthetic into the nerve or nerve sheath and not for the treatment of carpal tunnel or similar compression syndromes.

Paravertebral nerve block items 18274 and 18276 cover the provision of regional anaesthesia for surgical and related procedures for the management acute pain or of chronic pain related to radiculopathy. Infiltration of the soft tissue of the paravertebral area for the treatment of other pain symptoms does not attract benefit under these items. Additionally, items 18274 and 18276 do not cover facet joint blocks/injections. This procedure is covered under item 39013.

Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used to treat the obturator nerve in patients receiving botulinum toxin injections under item 18354 for a dynamic foot deformity.

T.8.1. SURGICAL OPERATIONS

Many items in Group T8 of the Schedule are qualified by one of the following phrases:

- "as an independent procedure";
- "not being a service associated with a service to which another item in this Group applies"; or
- "not being a service to which another item in this Group applies"

An explanation of each of these phrases is as follows.

As an Independent Procedure

The inclusion of this phrase in the description of an item precludes payment of benefits when:-

(i) a procedure so qualified is associated with another procedure that is performed through the same incision, e.g. nephrostomy (Item 36552) in the course of an open operation on the kidney for another purpose;

(ii) such procedure is combined with another in the same body area, e.g. direct examination of larynx (Item 41846) with another operation on the larynx or trachea;

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

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

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

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

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

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

T.8.2. MULTIPLE OPERATION RULE

The fees for two or more operations, listed in Group T8 (other than Subgroup 12 of that Group), performed on a patient on the one occasion (except as provided in paragraph T8.2.3) are calculated by the following rule:-

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

Note:

(a) Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents.

(b) Where two or more operations performed on the one occasion have Schedule fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.

(c) The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

(d) For these purposes the term "operation" only refers to all items in Group T8 (other than Subgroup 12 of that Group).

This rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient if the medical practitioner who performed the operation did not also perform or assist at the other operation or any of the other operations, or administer the anaesthetic. In such cases the fees specified in the Schedule apply.

Where two medical practitioners operate independently and either performs more than one operation, the method of assessment outlined above would apply in respect of the services performed by each medical practitioner.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

There are a number of items in the Schedule where the description indicates that the item applies only when rendered in association with another procedure. The Schedule fees for such items have therefore been determined on the basis that they would always be subject to the "multiple operation rule".

Where the need arises for the patient to be returned to the operating theatre on the same day as the original procedure for further surgery due to post-operative complications, which would not be considered as normal aftercare - see paragraph T8.2, such procedures would generally not be subject to the "multiple operation rule". Accounts should be endorsed to the effect that they are separate procedures so that a separate benefit may be paid.

Extended Medicare Safety Net Cap

The Extended Medicare Safety Net (EMSN) benefit cap for items subject to the multiple operations rule, where all items in that claim are subject to a cap are calculated from the abated (reduced) schedule fee.

For example, if an item has a Schedule fee of $100 and an EMSN benefit cap equal to 80 per cent of the schedule fee, the calculated EMSN benefit cap would be $80. However, if the schedule fee for the item is reduced by 50 per cent in accordance with the multiple operations rule provisions, and all items in that claim carry a cap, the calculated EMSN benefit cap for the item is $40 (50% of $100*80%).

T.8.3. PROCEDURE PERFORMED WITH LOCAL INFILTRATION OR DIGITAL BLOCK

It is to be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.

T.8.4. AFTERCARE (POST-OPERATIVE TREATMENT)

Definition

Section 3(5) of the Health Insurance Act 1973 states that services included in the Schedule (other than attendances) include all professional attendances necessary for the purposes of post-operative treatment of the patient. For the purposes of this book, post-operative treatment is generally referred to as "aftercare".

Aftercare is deemed to include all post-operative treatment rendered by medical practitioners, and includes all attendances until recovery from the operation, the final check or examination, regardless of whether the attendances are at the hospital, private rooms, or the patient's home. Aftercare need not necessarily be limited to treatment given by the surgeon or to treatment given by any one medical practitioner.

The medical practitioner determines each individual aftercare period depending on the needs of the patient as the amount and duration of aftercare following an operation may vary between patients for the same operation, as well as between different operations.

Private Patients

Medicare will not normally pay for any consultations during an aftercare period as the Schedule fee for most operations, procedures, fractures and dislocations listed in the MBS item includes a component of aftercare.

There are some instances where the aftercare component has been excluded from the MBS item and this is clearly indicated in the item description.

There are also some minor operations that are merely stages in the treatment of a particular condition. As such, attendances subsequent to these services should not be regarded as aftercare but rather as a continuation of the treatment of the original condition and attract benefits. Likewise, there are a number of services which may be performed during the aftercare period for pain relief which would also attract benefits. This includes all items in Groups T6 and T7, and items 39013, 39100, 39115, 39118, 39121, 39127, 39130, 39133, 39136, 39324 and 39327.

Where there may be doubt as to whether an item actually does include the aftercare, the item description includes the words "including aftercare".

If a service is provided during the aftercare phase for a condition not related to the operation, then this can be claimed, provided the account identifies the service as ‘Not normal aftercare’, with a brief explanation of the reason for the additional services.

If a patient was admitted as a private patient in a public hospital, then unless the MBS item does not include aftercare, no Medicare benefits are payable for aftercare. If however, a surgeon delegates aftercare to a patient’s medical practitioner, then a Medicare benefit may be apportioned on the basis of 75% for the operation and 25% for the aftercare. Where the benefit is apportioned between two or more medical practitioners, no more than 100% of the benefit for the procedure will be paid.

Medicare benefits are not payable for surgical procedures performed primarily for cosmetic reasons. However, benefits are payable for certain procedures when performed for specific medical reasons, such as breast reconstruction following mastectomy. Surgical procedures not listed on the MBS do not attract a Medicare benefit.

Where an initial or subsequent consultation relates to the assessment and discussion of options for treatment and, a cosmetic or other non-rebatable service are discussed, this would be considered a rebatable service under Medicare. Where a consultation relates entirely to a cosmetic or other non-Medicare rebatable service (either before or after that service has taken place), then that consultation is not rebatable under Medicare. Any aftercare associated with a cosmetic or non-Medicare rebatable service is also not rebatable under Medicare.

Public Patients

All care directly related to a public in-patient's care should be provided free of charge. Where a patient has received in-patient treatment in a hospital as a public patient (as defined in Section 3(1) of the Health Insurance Act 1973), routine and non-routine aftercare directly related to that episode of admitted care will be provided free of charge as part of the public hospital service, regardless of where it is provided, on behalf of the state or territory as required by the National Healthcare Agreement. In this case no Medicare benefit is payable.

Notwithstanding this, where a public patient independently chooses to consult a private medical practitioner for aftercare, then the clinically relevant service provided during this professional attendance will attract Medicare benefits.

Where a public patient independently chooses to consult a private medical practitioner for aftercare following treatment from a public hospital emergency department, then the clinically relevant service provided during this professional attendance will attract Medicare benefits.

Fractures

Where the aftercare for fractures is delegated to a doctor at a place other than where the initial reduction was carried out, then Medicare benefits may be apportioned on a 50:50 basis rather than on the 75:25 basis for surgical operations.

Where the reduction of a fracture is carried out by hospital staff in the out-patient or emergency department of a public hospital, and the patient is then referred to a private practitioner for aftercare, Medicare benefits are payable for the aftercare on an attendance basis.

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

Treatment of fracture of	After-care Period
Terminal phalanx of finger or thumb	6 weeks
Proximal phalanx of finger or thumb	6 weeks
Middle phalanx of finger	6 weeks
One or more metacarpals not involving base of first carpometacarpal joint	6 weeks
First metacarpal involving carpometacarpal joint (Bennett's fracture)	8 weeks
Carpus (excluding navicular)	6 weeks
Navicular or carpal scaphoid	3 months
Colles'/Smith/Barton’s fracture of wrist	3 months
Distal end of radius or ulna, involving wrist	8 weeks
Radius	8 weeks
Ulna	8 weeks
Both shafts of forearm or humerus	3 months
Clavicle or sternum	4 weeks
Scapula	6 weeks
Pelvis (excluding symphysis pubis) or sacrum	4 months
Symphysis pubis	4 months
Femur	6 months
Fibula or tarsus (excepting os calcis or os talus)	8 weeks
Tibia or patella	4 months
Both shafts of leg, ankle (Potts fracture) with or without dislocation, os calcis (calcaneus) or os talus	4 months
Metatarsals - one or more	6 weeks
Phalanx of toe (other than great toe)	6 weeks
More than one phalanx of toe (other than great toe)	6 weeks
Distal phalanx of great toe	8 weeks
Proximal phalanx of great toe	8 weeks

Nasal bones, requiring reduction	4 weeks
Nasal bones, requiring reduction and involving osteotomies	4 weeks
Maxilla or mandible, unilateral or bilateral, not requiring splinting	6 weeks
Maxilla or mandible, requiring splinting or wiring of teeth	3 months
Maxilla or mandible, circumosseous fixation of	3 months
Maxilla or mandible, external skeletal fixation of	3 months
Zygoma	6 weeks
Spine (excluding sacrum), transverse process or bone other than vertebral body requiring immobilisation in plaster or traction by skull calipers	3 months
Spine (excluding sacrum), vertebral body, without involvement of cord, requiring immobilisation in plaster or traction by skull calipers	6 months
Spine (excluding sacrum), vertebral body, with involvement of cord	6 months

Note: This list is a guide only and each case should be judged on individual merits.

T.8.5. ABANDONED SURGERY - (ITEM 30001)

Item 30001 applies where the procedure has been commenced but is then discontinued for medical reasons or for other reasons which are beyond the surgeon's control (eg equipment failure).
An operative procedure commences when the:

a) patient is in the procedure room or on the bed or operation table where the procedure is to be performed; and
b) patient is anaesthetised or operative site is sufficiently anaesthetised for the procedure to commence; and
c) patient is positioned or the operative site is prepared with antiseptic or draping.

Where an abandoned procedure eligible for a benefit under item 30001 attracts an assistant under the provisions of the items listed in Group T9 (Assistance at Operations), the fee for the surgical assistant is calculated as 50% of the assistance fee that would have applied under the relevant item from Group T9.

Practitioners claiming an assistant fee for abandoned surgery should itemise their accounts with the relevant item from group T9. Such claims should include an account endorsement "assistance at abandoned surgery" or similar and should be accompanied by full clinical details of the circumstances of the operation, including details of the surgery proposed and the reasons for the operation being discontinued.

T.8.6. REPAIR OF WOUND - (ITEMS 30023 TO 30049)

The repair of wound referred to in these items must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. These items do not cover repair of wound at time of surgery.

Item 30023 covers debridement of traumatic, "deep or extensively contaminated" wound. Benefits are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

For the purpose of items 30026 to 30049 the term 'superficial' means affecting skin and subcutaneous tissue including fat and the term 'deeper tissue' means all tissues deep to but not including subcutaneous tissue such as fascia and muscle.

T.8.7. BIOPSY FOR DIAGNOSTIC PURPOSES - (ITEMS 30071 TO 30096)

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

Item 30071 should be used when a biopsy (including shave) of a lesion is required to confirm a diagnosis and would facilitate the appropriate management of that lesion. If the shave biopsy results in a definitive excision of the lesion, only 30071 can be claimed.

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

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

T.8.8. LIPECTOMY - (ITEMS 30165 TO 30177)

Multiple lipectomies, e.g., both buttocks and both thighs attract benefits under Item 30171 once only, i.e. the multiple operation rule does not apply. Medicare benefits are not payable in respect of liposuction, except in the circumstances outlined in Items 45584 and 45585.

Lipectomy items 30165 and 30177 may not be claimed for patients if performed within 12 months after the most recent pregnancy.

Lipectomy items 30165 to 30177 cannot be claimed in association with items 45564, 45565 or 45530. Where the abdomen requires closure with reconstruction of the umbilicus following free tissue transfer (45564, 45565) or breast reconstruction (45530), item 45569 is to be claimed.

T.8.9. TREATMENT OF KERATOSES, WARTS ETC (ITEMS 30185, 30186, 30187, 30189, 30192 AND 36815)

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

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

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

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

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

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

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

Ablative techniques include cryotherapy and chemical removal.

T.8.10. CRYOTHERAPY AND SERIAL CURETTAGE EXCISION - (ITEMS 30196 TO 30203)

In items 30196 and 30197, serial curettage excision, as opposed to simple curettage, refers to the technique where the margin having been defined, the lesion is carefully excised by a skin curette using a series of dissections and cauterisations so that all extensions and infiltrations of the lesion are removed.

For the purposes of Items 30196 to 30203 (inclusive), the requirement for histopathological proof of malignancy is satisfied where multiple lesions are to be removed from the one anatomical region if a single lesion from that region is histologically tested and proven for malignancy.

For the purposes of items 30196 to 30203 (inclusive), an anatomical region is defined as: hand, forearm, upper arm, shoulder, upper trunk or chest (anterior and posterior), lower trunk (anterior or posterior) or abdomen (anterior lower trunk), buttock, genital area/perineum, upper leg, lower leg and foot, neck, face (six sections: left/right lower, left/right mid and left/right upper third) and scalp.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline to substantiate proof of malignancy where required for MBS items which is located on the DHS website.

T.8.11. TELANGIECTASES OR STARBURST VESSELS - (ITEMS 30213 AND 30214)

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

Item 30213 is restricted to a maximum of 6 sessions in a 12 month period. Where additional treatments are indicated in that period, item 30214 should be used.

Claims for benefits under item 30214 should be accompanied by full clinical details, including pre-operative colour photographs, to verify the need for additional services. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered.

The claim and the additional information should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for approval should be addressed in a sealed envelope marked 'Medical-in Confidence' to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

T.8.12. SENTINEL NODE BIOPSY FOR BREAST CANCER - (ITEMS 30299 TO 30303)

The Medical Services Advisory Committee (MSAC) evaluated the available evidence and found that sentinel lymph node biopsy is safe and effective in identifying sentinel lymph nodes, but that the long term outcomes of sentinel lymph node biopsy compared to lymph node clearance are uncertain. As a result, interim Medicare funding is available for these items pending the outcome of clinical trials and further consideration by the MSAC.

For items 30299 and 30300, both lymphoscintigraphy and lymphotropic dye injection must be used, unless the patient has an allergy to the lymphotropic dye.

For the purposes of these items, the axillary lymph node levels referred to are as follows:
- **Level I** - axillary lymph nodes up to the inferior border of pectoralis minor.
- **Level II** -axillary lymph nodes up to the superior border of pectoralis minor.
- **Level III** - axillary lymph nodes extending above the superior border of pectoralis minor.

T.8.13. DISSECTION OF AXILLARY LYMPH NODES - (ITEMS 30335 AND 30336)

For the purposes of Items 30335 and 30336, the definitions of lymph node levels referred to are set out below.

Anatomically, the dissection extends from below upwards as follows:
- **Level I** - dissection of axillary lymph nodes up to the inferior border of pectoralis minor.
- **Level II** – dissection of axillary lymph nodes up to the superior border of pectoralis minor.
- **Level III** - dissection of axillary lymph nodes extending above the superior border of pectoralis minor.

T.8.14. LAPAROTOMY AND OTHER PROCEDURES ON THE ABDOMINAL VISCERA - (ITEMS 30375 AND 30622)

Procedures on the abdominal viscera may be performed by laparotomy or laparoscopically. Both items 30375 and 30622 cover several operations on abdominal viscera. Where more than one of the procedures referrec to in these items are performed during the one operation, each procedure may be itemised according to the multiple operation formula.

T.8.15. DIAGNOSTIC LAPAROSCOPY - (ITEMS 30390 AND 30627)

If a diagnostic laparoscopy procedure is performed at a different time on the same day to another laparoscopic service, the procedures are considered to be un-associated services. The claim for benefits should be annotated to indicate that the two services were performed on separate occasions, otherwise the claims will be considered to be a single service.

T.8.16. MAJOR ABDOMINAL INCISION - (ITEM 30396)

A major abdominal incision is one that gives access through an open wound to all compartments of the abdominal cavity. Item 30396 is intended for open surgical incisions only and not those performed laparoscopically.

T.8.17. GASTROINTESTINAL ENDOSCOPIC PROCEDURES - (ITEMS 30473 TO 30481, 30484 TO 30487, 30490 TO 30494, 30680 TO 32023, 32084 TO 32095, 32103, 32104 AND 32106)

The following are guidelines for appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment.

These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

Cleaning, disinfection and sterilisation procedures

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

i. Infection and Endoscopy (3rd edition), Gastroenterological Society of Australia;
ii. Australian Guidelines for the Prevention and Control of Infection in Healthcare (NHMRC, 2010);
iii. Australian Standard AS 4187-1994 (and Amendments), Standards Association of Australia.

Anaesthetic and resuscitation equipment

Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post-operative and resuscitation facilities should conform to the standards outlined in 'Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures' (PS09), Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons.

Conjoint Committee

For the purposes of Item 32023, the procedure is to be performed by a colorectal surgeon or gastroenterologist with endoscopic training who is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy.

T.8.18. GASTRECTOMY, SUB-TOTAL RADICAL - (ITEM 30523)

The item differs from total radical Gastrectomy (Item 30524) in that a small part of the stomach is left behind. It involves resection of the greater omentum and posterior abdominal wall lymph nodes with or without splenectomy.

T.8.19. ANTI REFLUX OPERATIONS - (ITEMS 30527 TO 30533, 31464 AND 31466)

These items cover various operations for reflux oesophagitis. Where the only procedure performed is the simple closure of a diaphragmatic hiatus benefit would be attracted under Item 30387 (Laparotomy involving operation on abdominal viscera, including pelvic viscera, not being a service to which another item in this Group applies).

T.8.20. RADIOFREQUENCY ABLATION OF MUCOSAL METAPLASIA FOR THE TREATMENT OF BARRETT'S OESOPHAGUS (ITEM 30687)

The diagnosis of high grade dysplasia is recommended to be confirmed by two expert pathologists with experience in upper gastrointestinal pathology.

A multidisciplinary team should review treatment options for patients with high grade dysplasia and would typically include upper gastrointestinal surgeons and/or interventional gastroenterologists.

T.8.21. ENDOSCOPIC OR ENDOBRONCHIAL ULTRASOUND +/- FINE NEEDLE ASPIRATION - (ITEMS 30688 - 30710)

For the purposes of these items the following definitions apply:

Biopsy means the removal of solid tissue by core sampling or forceps
FNA means aspiration of cellular material from solid tissue via a small gauge needle.

The provider should make a record of the findings of the ultrasound imaging in the patient's notes for any service claimed against items 30688 to 30710.

Endoscopic ultrasound is an appropriate investigation for patients in whom there is a strong clinical suspicion of pancreatic neoplasia with negative imaging (such as CT scanning). Scenarios include, but are not restricted to:
- A middle aged or elderly patient with a first attack of otherwise unexplained (eg negative abdominal CT) first episode of acute pancreatitis; or
- A patient with biochemical evidence of a neuroendocrine tumour.

The procedure is not claimable for periodic surveillance of patients at increased risk of pancreatic cancer, such as chronic pancreatitis. However, EUS would be appropriate for a patient with chronic pancreatitis in whom there was a clinical suspicion of pancreatic cancer (eg: a pancreatic mass occurring on a background of chronic pancreatitis).

T.8.22. REMOVAL OF SKIN LESIONS - (ITEMS 30611, 31200 TO 31355)

The excision of warts and seborrheic keratoses attracts benefits on an attendance basis with the exceptions outlined in T8.13 of the explanatory notes to this category. Excision of pre-malignant lesions including solar keratoses where clinically indicated are covered by items 31200 to 31240.

The excision of suspicious pigmented lesions for diagnostic purposes attract benefits under items 31205 to 31240. Only if a further more extensive excision is undertaken should the items covering excision of malignancies be used.

Items 31200 and 31245 *do not require* the specimen to be sent for histological confirmation. Items 31205 to 31240 and 31250 *require* that the specimen be sent for histological examination. Items 31255 to 31335 *require* that a specimen has been sent for histological confirmation of malignancy, and any subsequent specimens are sent for histological examination. Confirmation of malignancy *must* be received before itemisation of accounts for Medicare benefits purposes.

Where histological results are available at the time of issuing accounts, the histological diagnosis will decide the appropriate itemisation. If the histological report shows the lesion to be benign, items 31205 to 31240 should be used. Malignant tumours are covered by items 31255 to 31355.

A practitioner providing the first treatment episode for a primary BCC/SCC must use the appropriate item from the following: 31255; 31260; 31265; 31270; 31275; 31280; 31285; or 31290.

Where residual BCC/SCC remains following an initial excision of a primary lesion and the same practitioner is excising that residual BCC/SCC then the appropriate item must be claimed from the following: 31256; 31261; 31266; 31271; 31276; 31281; 31286 or 31291.

Where residual BCC/SCC remains following an initial excision of a primary lesion and a practitioner other than the practitioner that performed the previous excision is excising that residual BCC/SCC then the appropriate item must be claimed from the following: 31257; 31262; 31267; 31272; 31277; 31282; 31287 or 31292.

Where a BCC/SCC was removed and complete excision of the lesion was confirmed, but a BCC/SCC has recurred at the primary site, then the items providing for recurrent BCC/SCC would usually apply.

A practitioner excising a recurrent BCC/SCC of the head or neck and who is a specialist in the practice of his or her specialty or a practitioner other than the practitioner who provided previous treatment (where the lesion was removed by previous surgery, serial cautery and curettage, radiotherapy or two prolonged freeze/thaw cycles of liquid nitrogen therapy) must use item 31295.

A practitioner excising a recurrent BCC/SCC from an area other than the head or neck or who otherwise does not meet the criteria as described under item 31295 must use the appropriate item from the following 31258; 31263; 31268; 31273; 31278; 31283; 31288 or 31293.

For the purpose of these items, the tumour/lesion size should be determined by the macroscopic measurement of the surface diameter of the tumour/lesion or, for elliptical tumours/lesions, by the average surface diameter. The relevant size of the lesion relates to that measured in situ before excision. Suture of wound following surgical excision also includes closure by tissue adhesive resin, clips or similar.

Definitive surgical excision for items 31300 to 31335 is defined as "surgical removal with an adequate margin and, as a result, no further surgery is indicated at that site of excision.

It will be necessary for practitioners to retain copies of histological reports.

Items 31245 and 31250 do not cover shave excision.

T.8.23. REMOVAL OF SKIN LESION FROM FACE - (ITEMS 31235 TO 31245, 31265 TO 31278, 31310 TO 31320)

For the purposes of these items, the face is defined as that portion of the head anterior to the hairline and above the jawline.

T.8.24. DISSECTION OF LYMPH NODES OF NECK - (ITEMS 30618, 31423 TO 31438)

For the purposes of these items, the lymph node levels referred to are as follows:-

Level I	Submandibular and submental lymph nodes
Level II	Lymph nodes of the upper aspect of the neck including the jugulodigastric node, upper jugular chain nodes and upper spinal accessory nodes
Level III	Lymph nodes deep to the middle third of the sternomastoid muscle consisting of mid jugular chain nodes, the lower most of which is the jugulo-omohyoid node, lying at the level where the omohyoid muscle crosses the internal jugular vein
Level IV	Lower jugular chain nodes, including those nodes overlying the scalenus anterior muscle
Level V	Posterior triangle nodes, which are usually distributed along the spinal accessory nerve in the posterior triangle

Comprehensive dissection involves all 5 neck levels while ***selective*** dissection involves the removal of only certain lymph node groups, for example:-

Item 31426 (removal of 3 lymph node levels) - e.g. supraomohyoid neck dissection (levels I-III) or lateral neck dissection (levels II-IV).

Item 31429 (removal of 4 lymph node levels) - e.g. posterolateral neck dissection (levels II-V) or anterolateral neck dissection (levels I-IV)

Other combinations of node levels may be removed according to clinical circumstances.

T.8.25. EXCISION OF BREAST LESIONS, ABNORMALITIES OR TUMOURS - MALIGNANT OR BENIGN - (ITEMS 31500 TO 31515)

Therapeutic biopsy or excision of breast lesions, abnormalities or tumours under Items: 31500, 31503, 31506, 31509, 31512, 31515 either singularly or in combination should not be claimed when using the Advanced Breast Biopsy Instrumentation (ABBI) procedure, or any other large core breast biopsy device.

T.8.27. FINE NEEDLE ASPIRATION OF BREAST LESION - (ITEM 31533)

An impalpable lesion includes those lesions that clinically require definition by ultrasound or mammography for accurate or safe sampling, eg. lesions in association with breast prostheses or in areas of breast thickening.

T.8.28. DIAGNOSTIC BIOPSY OF BREAST USING ADVANCED BREAST BIOPSY INSTRUMENTATION - (ITEMS 31539 AND 31545)

For the purposes of Items 31539 and 31545, surgeons performing this procedure should have evidence of appropriate training via a course approved by the Breast Section of the Royal Australasian College of Surgeons, have experience in the procedure, and the Department of Human Services notified of their eligibility to perform this procedure.

The ABBI procedure is contraindicated and should not be performed on the following subset of patients:
- Patients with mass, asymmetry or clustered microcalcifications that cannot be targeted using digital imaging equipment;
- Patients unable to lie prone and still for 30 to 60 minutes;
- Breasts less than 20mm in thickness when compressed;
- Women on anticoagulants;
- Lesions that are too close to the chest wall to allow cannula access;
- Patients weighing more than 135kg;
- Women with prosthetic breast implants.

T.8.29. PREOPERATIVE LOCALISATION OF BREAST LESION PRIOR TO THE USE OF ADVANCED BREAST BIOPSY INSTRUMENTATION - (ITEM 31542)

For the purposes of item 31542, radiologists eligible to perform the procedure must have been identified by the Royal Australian and New Zealand College of Radiologists as having sufficient training and experience in this procedure, and the Department of Human Services notified of their eligibility to perform this procedure.

T.8.30. BARIATRIC PROCEDURES - (ITEMS 31569 TO 31581, ANAESTHESIA ITEM 20791)

Items 31569 to 31581 and item 20791 provide for surgical treatment of clinically severe obesity and the accompanying anaesthesia service (or similar). The term clinically severe obesity generally refers to a patient with a Body Mass Index (BMI) of 40kg/m^2 or more, or a patient with a BMI of 35kg/m^2 or more with other major medical co-morbidities (such as diabetes, cardiovascular disease, cancer). The BMI values in different population groups may vary due, in part, to different body proportions which affect the percentage of body fat and body fat distribution. Consequently, different ethnic groups may experience major health risks at a BMI that is below the 35-40 kg/m^2 provided for in the definition. The decision to undertake obesity surgery remains a matter for the clinical judgment of the surgeon.

If crural repair taking 45 minutes or less is performed in association with the bariatric procedure, additional hernia repair items cannot be claimed for the same service.

T.8.31. REVERSAL OF A BARIATRIC PROCEDURE - (ITEM 31584)

If a revisional procedure requires the reversal of the existing bariatric procedure, item 31584 can be claimed with items 31569 to 31581 for the new procedure. For example item 31584 could be claimed for reversal of gastric band and 31572 for conversion to gastric bypass or 31575 for conversion to sleeve gastrectomy.

T.8.32. PER ANAL EXCISION OF RECTAL TUMOUR USING RECTOSCOPY - (ITEMS 32103, 32104 AND 32106)

Surgeons performing these procedures should be colorectal surgeons and have undergone appropriate training which is recognised by the Colorectal Surgical Society of Australasia.

Items 32103, 32104 and 32106 cannot be claimed in conjunction with each other or with anterior resection items 32024 or 32025 for the same patient, on the same day, by any practitioner.

T.8.33. VARICOSE VEINS - (ITEMS 32500 TO 32517)

Claims for benefits under item 32501should be accompanied by full clinical details, including pre-operative colour photographs, to verify the need for additional services.

Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for approval should be addressed in a sealed envelope marked 'Medical-in Confidence' to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

In relation to endovenous laser therapy (ELT) and/or radiofrequency diathermy/ablation, Rule 2.44.14 of the *Health Insurance (General Medical Services Table) Regulations* (GMST) means the following:

- ELT and/or radiofrequency diathermy/ablation are not payable if they are billed under any varicose vein items (32500 to 32517) or vascular item 35321.
- If ELT and/or radiofrequency diathermy/ablation are provided on the same occasion as these MBS items, the ELT and radiofrequency diathermy/ablation services must be itemised separately on the invoice, showing the full fees for each service separately to the fees billed against the MBS items.
- We strongly recommend that a practitioner who intends to bill ELT and/or radiofrequency diathermy/ablation on the same occasion as providing MBS services contact Department of Human Services' provider information line on 132 150 to confirm the Department of Human Services' requirements for correct itemisation of MBS and non-MBS services on a single invoice.
- The Department of Human Services monitors billing practices associated with MBS items and any billing which stands out as being out of line with most practitioners may warrant the attention of the Department of Human Services.
- In light of the policy clarification of GMST Rule 2.44.14, with effect from 1 May 2009, the Department of Human Services will be able to track any apparent cost-shifting (of ELT and/or radiofrequency diathermy/ablation) to the MBS items detailed in GMST Rule 2.44.14 or to other MBS items.

T.8.34. ENDOVENOUS LASER THERAPY (ITEMS 32520 AND 32522) AND RADIOFREQUENCY ABLATION (ITEMS 32523 AND 32526)

It is recommended that the medical practitioner performing endovenous laser therapy (ELT) or radiofrequency ablation (RFA) has successfully completed a substantial course of study and training in the management of venous disease, which has been endorsed by their relevant professional organisation.
Medicare-funded ELT and RFA can only be performed in cases where it is documented by duplex ultrasound that the great or small saphenous vein (and major tributaries of saphenous veins as necessary) demonstrates reflux of 0.5 seconds or longer.

T.8.35. UTERINE ARTERY EMBOLISATION - (ITEM 35410)

This item was introduced on an interim basis in November 2006 following a recommendation of the Medical Services Advisory Committee (MSAC), pending the outcome of clinical trials and further consideration by the MSAC. The requirement for specialist referral by a gynaecologist for uterine artery embolisation was a MSAC recommendation. Providers should retain the instrument of specialist referral for each patient from the date of the procedure, as this may be subject to audit by the Department of Human Services.

T.8.36. ENDOVASCULAR COILING OF INTRACRANIAL ANEURYSMS - (ITEM 35412)

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

T.8.37. ARTERIAL AND VENOUS PATCHES - (ITEMS 33545 TO 33551 AND 34815)

Vascular surgery items have been constructed on the basis that arteriotomy and venotomy wounds are closed by simple suture without the use of a patch.

Where a patch angioplasty is used to enlarge a narrowed vein, artery or arteriovenous fistula, the correct item would be 34815 or 34518. If the vein is harvested for the patch through a separate incision, Item 33551 would also apply, in accordance with the multiple operation rule.

If a patch graft is involved in conjunction with an operative procedure included in Items 33500 - 33542, 33803, 33806, 33815, 33833 or 34142, the patch graft would attract benefits under Item 33545 or 33548 in addition to the item for the primary operation (under the multiple operation rule). Where vein is harvested for the patch through a separate incision Item 33551 would also apply.

T.8.38. CAROTID DISEASE - (ITEM 32700, 32703, 32760, 33500, 33545, 33548, 33551, 33554, 35303, 35307)

Interventional procedures for the management of carotid disease should be performed in accordance with the NHMRC endorsed *Clinical Guidelines for Stroke Management 2010*.

Carotid Percutaneous Transluminal Angioplasty with Stenting (CPTAS), under item 35307 is only funded under the MBS for patients who meet the criteria for carotid endarterectomy but are unfit for open surgery.

T.8.39. PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION - (ITEM 35317)

Item 35317 is restricted to the regional delivery of thrombolytic, vasoactive or chemotherapeutic oncologic agents in association with a radiological service. This item in not intended for infusions with systemic affect.

T.8.40. PERIPHERAL ARTERIAL OR VENOUS EMBOLISATION - (ITEM 35321)

As set out in Rule 2.44.14 in the *Health Insurance (General Medical Services Table) Regulations,* item 35321 does not apply to the service described in that item if the service is provided at the same time as, or in connection with, endovenous laser treatment for varicose veins.

T.8.41. SELECTIVE INTERNAL RADIATION THERAPY (SIRT) USING SIR-SPHERES - (ITEMS 35404, 35406 AND 35408)

These items were introduced into the Schedule on an interim basis in May 2006 following a recommendation of the Medical Services Advisory Committee (MSAC) pending the outcome of clinical trials and further consideration by the MSAC. SIRT should not be performed in an outpatient or day patient setting to ensure patient and radiation safety requirements are met.

T.8.42. PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY - (ITEMS 38309, 38312, 38315 AND 38318)

A coronary artery lesion is considered to be complex when the lesion is a chronic total occlusion, located at an ostial site, angulated, tortuous or greater than 1cm in length. Percutaneous transluminal coronary rotational atherectomy is suitable for revascularisation of complex and heavily calcified coronary artery stenoses in patients for whom coronary artery bypass graft surgery is contraindicated.

Each of the items 38309, 38312, 38315 and 38318 describes an episode of service. As such, only one item in this range can be claimed in a single episode.

T.8.43. COLPOSCOPIC EXAMINATION - (ITEM 35614)

It should be noted that colposcopic examination (screening) of a person during the course of a consultation does not attract Medicare benefits under Item 35614 except in the following circumstances:

(a) where the patient has had an abnormal cervical smear;
(b) where there is a history of ingestion of oestrogen by the patient's mother during their pregnancy; or
(c) where the patient has been referred by another medical practitioner because of suspicious signs of genital cancer.

T.8.44. HYSTEROSCOPY - (ITEM 35626)

Hysteroscopy undertaken in the office/consulting rooms can be claimed under this item where the conditions set out in the description of the item are met.

T.8.45. CURETTAGE OF UTERUS UNDER GA OR MAJOR NERVE BLOCK - (ITEMS 35639 AND 35640)

Uterine scraping or biopsy using small curettes (e.g. Sharman's or Zeppelin's) and requiring minimal dilatation of the cervix, not necessitating a general anaesthesia, does not attract benefits under these items but would be paid under Item 35620 where malignancy is suspected, or otherwise on an attendance basis.

T.8.46. NEOPLASTIC CHANGES OF THE CERVIX - (ITEMS 35644-35648)

The term "previously confirmed intraepithelial neoplastic changes of the cervix" in these items refers to diagnosis made by either cytologic, colposcopic or histologic methods. This may also include persistent human papilloma virus (HPV) changes of the cervix.

T.8.47. STERILISATION OF MINORS - LEGAL REQUIREMENTS - (ITEMS 35657, 35687, 35688, 35691, 37622 AND 37623)

(i) It is unlawful throughout Australia to conduct a sterilisation procedure on a minor which is not a by-product of surgery appropriately carried out to treat malfunction or disease (eg malignancies of the reproductive tract) unless legal authorisation has been obtained.

(ii) Practitioners are liable to be subject to criminal and civil action if such a sterilisation procedure is performed on a minor (a person under 18 years of age) which is not authorised by the Family Court of Australia or another court or tribunal with jurisdiction to give such authorisation.

(iii) Parents/guardians have no legal authority to consent on behalf of minors to such sterilisation procedures. Medicare Benefits are only payable for sterilisation procedures that are clinically relevant professional services as defined in Section 3 (1) of the *Health Insurance Act 1973*.

T.8.48. DEBULKING OF UTERUS - (ITEM 35658)

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

T.8.49. NEPHRECTOMY - (ITEMS 36526 AND 36527)

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

T.8.50. SACRAL NERVE STIMULATION - (ITEMS 36658, 36660, AND 36662)

Items 36658, 36660, and 36662 only apply in the following circumstances:

(a) the patients has received a sacral nerve stimulation implant for the management of refractory urinary incontinence or urge retention;

(b) the patient requires replacement or removal of the pulse generator and/or leads for the neurostimulator device; and

(c) the service referred to in paragraph (a) was rendered to the patient prior to 30 April 1998 and a Medicare benefit was paid for that service under item 30000, 39134, 39139 or 39140.

T.8.51. SACRAL NERVE STIMULATION (ITEMS 36663-36668)

A two-stage process of testing and treatment is required to ensure suitability for Sacral Nerve Stimulation for detrusor overactivity or non obstructive urinary retention where urethral obstruction has been urodynamically excluded. The testing phase involves acute and sub-chronic testing. The first stage includes peripheral nerve evaluation and patients who achieve greater than 50% improvement in urinary incontinence or retention episodes during testing will be eligible to receive permanent SNS treatment.

T.8.52. URETEROSCOPY - (ITEM 36803)

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

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

Item numbers 36806 and 36809 may only be used together when 2 independent ureteroscopic procedures are performed in separate ureters. These separate ureters may be components of a complete or partial duplex system. If both these numbers are used together, the Regulations require qualification of these item numbers by the site, as is necessary with 36803 eg 36806 (Right side) and 36809 (Left side).

T.8.53. SELECTIVE CORONARY ANGIOGRAPHY - (ITEMS 38215 TO 38246)

Each item in the range 38215-38240 describes an episode of service. As such, only one item in this range can be claimed in a single episode.

Item 38243 may be billed once only immediately prior to any coronary interventional procedure, including situations where a second operator performs any coronary interventional procedure after diagnostic angiography by the first operator.

Item 38246 may be billed when the same operator performs diagnostic coronary angiography and then proceeds directly with any coronary interventional procedure during the same occasion of service. Consequently, it may not be billed in conjunction with items 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243. In the event that the same operator performed any coronary interventional procedure immediately after the diagnostic procedure described by item 38231, 38237 or 38240, that item may be billed as an alternative to item 38246.

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

T.8.54. TRANSURETHRAL NEEDLE ABLATION (TUNA) OF THE PROSTATE - (ITEMS 37201 AND 37202)

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

Patients not medically fit for transurethral resection of the prostate (TURP) can be defined as:

(i) Those patients who have a high risk of developing a serious complication from the surgery. Retrograde ejaculation is **not** considered to be a serious complication of TURP.

(ii) Those patients with a co-morbidity which may substantially increase the risk of TURP or the risk of the anaesthetic necessary for TURP.

T.8.55. GOLD FIDUCIAL MARKERS INTO THE PROSTATE - (ITEM 37217)

Item 37217 is for the insertion of gold fiducial markers into the prostate or prostate surgical bed as markers for radiotherapy. The service can not be claimed under item 37218 or any other surgical item.
This item is introduced into the Schedule on an interim basis pending the outcome of an evaluation being undertaken by the Medical Services Advisory Committee (MSAC).
Further information on the review of this service is available from the MSAC Secretariat.

T.8.56. BRACHYTHERAPY OF THE PROSTATE - (ITEM 37220)

One of the requirements of item 37220 is that patients have a Gleason score of less than or equal to 7. However, where the patient has a score of 7, comprising a primary score of 4 and a secondary score of 3 (ie. 4+3=7), it is recommended that low dose rate brachytherapy form part of a combined modality treatment.

Low dose rate brachytherapy of the prostate should be performed in patients, with favourable anatomy allowing adequate access to the prostate without pubic arch interference, and who have a life expectancy of greater than 10 years.

An ‘approved site’ for the purposes of this item is one at which radiation oncology services may be performed lawfully under the law of the State or Territory in which the site is located.

T.8.57. HIGH DOSE RATE BRACHYTHERAPY - (ITEM 37227)

Item 37227 covers the service undertaken by an urologist or radiation oncologist as part of the High Dose Rate Brachytherapy procedure, in association with a radiation oncologist. If the service is undertaken by an urologist, a radiation oncologist must be present in person at the time of the service. The removal of the catheters following completion of the Brachytherapy is also covered under this item.

T.8.58. RADICAL OR DEBULKING OPERATION FOR OVARIAN TUMOUR - (ITEM 35720)

This item refers to the operation for carcinoma of the ovary where the bulk of the tumour and the omentum are removed. Where this procedure is undertaken in association with hysterectomy benefits are payable under both item numbers with the application of the multiple operation formula.

T.8.59. TRANSCUTANEOUS SPERM RETRIEVAL - (ITEM 37605)

Item 37605 covers transcutaneous sperm retrieval for the purposes of intracytoplasmic sperm injection (item 13251) for male factor infertility, in association with assisted reproductive technologies.

Item 37605 provides for the procedure to be performed unilaterally. Where it is clinically necessary to perform the service bilaterally, the multiple operation rule would apply, in accordance with point T8.5 of these Explanatory Notes.

Where the procedure is carried out under local infiltration as the means of anaesthesia, additional benefit is not payable for the anaesthesia component as this is considered to be part of the procedure.

T.8.60. SURGICAL SPERM RETRIEVAL, BY OPEN APPROACH - (ITEM 37606)

Item 37606 covers open sperm retrieval for the purposes of intracytoplasmic sperm injection (item 13251) for male factor infertility, in association with assisted reproductive technologies. Item 37606 provides for the procedure to be performed unilaterally. Where it is clinically necessary to perform the service bilaterally, the multiple operation rule would apply.

Benefits for item 37606 may be claimed in conjunction with a service or services provided under item 37605, where an open approach is clinically necessary following an unsuccessful percutaneous approach. Likewise, such services would be subject to the multiple operation rule.

Benefit is not payable for item 37606 in conjunction with item 37604.

T.8.61. CARDIAC PACEMAKER INSERTION - (ITEMS 38209, 38212, 38350, 38353 AND 38356)

The fees for the insertion of a pacemaker (Items 38350, 38353 and 38356) cover the testing of cardiac conduction or conduction threshold, etc related to the pacemaker and pacemaker function.

Accordingly, additional benefits are not payable for such routine testing under Item 38209 or 38212 (Cardiac electrophysiological studies).

T.8.62. IMPLANTABLE ECG LOOP RECORDER - (ITEM 38285)

The fee for implantation of the loop recorder (item 38285) covers the initial programming and testing of the device for satisfactory rhythm capture. Benefits are payable only once per day.

The term “recurrent” refers to more than one episode of syncope, where events occur at intervals of 1 week or longer. The term “other available cardiac investigations” includes the following:

- a complete history and physical examination that excludes a primary neurological cause of syncope and does not exclude a cardiac cause;
- *electrocardiography (ECG) (items 1170-11702);*
- *echocardiography (items 55113-55115);*
- *continuous ECG recording or ambulatory ECG monitoring (items 11708-11711);*
- *up-right tilt table test (item 11724); and*
- cardiac electrophysiological study, unless there is reasonable medical reason to waive this requirement (item 38209).

T.8.63. TRANSLUMINAL INSERTION OF STENT OR STENTS - (ITEM 38306)

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

T.8.64. PERMANENT CARDIAC SYNCHRONISATION DEVICE (ITEMS 38365, 38368 AND 38654)

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

T.8.65. INTRAVASCULAR EXTRACTION OF PERMANENT PACING LEADS - (ITEM 38358)

For the purposes of Item 38358 specialists or consultant physicians claiming this item must have training recognised by the Lead Extraction Advisory Committee of the Cardiac Society of Australia and New Zealand, and the Department of Human Services notified of that recognition. The procedure should only be undertaken in a hospital capable of providing cardiac surgery.

T.8.66. CARDIAC RESYNCHRONISATION THERAPY - (ITEM 38371)

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

T.8.67. IMPLANTABLE CARDIOVERTER DEFIBRILLATOR - (ITEMS 38384 AND 38387)

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

T.8.68. CARDIAC AND THORACIC SURGICAL ITEMS - (ITEMS 38470 TO 38766)

Items 38470 to 38766 must be performed using open exposure or minimally invasive surgery which excludes percutaneous and transcatheter techniques unless otherwise stated in the item.

T.8.69. CORONARY ARTERY BYPASS - (ITEMS 38497 TO 38504)

The fees for Items 38497 and 38498 include the harvesting of vein graft material. Harvesting of internal mammary artery and/or vein graft material is covered in the fees for Items 38500, 38501, 38503 and 38504. Where harvesting of an artery other than the internal mammary artery is undertaken, benefits are payable under Item 38496 on the multiple operation basis. The procedure of coronary artery bypass grafting using arterial graft is covered by Item 38500, 38501, 38503 or 38504 irrespective of the origin of the arterial graft.

Items 38498, 38501 and 38504 require that either a clinical or medical perfusionist are present in the operating theatre throughout the procedure in case it is necessary to convert to an on-pump procedure and cardiopulmonary bypass is required.

If it is necessary to provide cardiopulmonary bypass items 38498, 38501 and 38504 cannot be claimed. The procedure should be claimed under items 38497, 38500 or 38503 as appropriate in conjunction with the relevant cardiopulmonary bypass procedures.

T.8.70. RE-OPERATION VIA MEDIAN STERNOTOMY - (ITEM 38640)

Medicare benefits are payable for Item 38640 plus the item/s covering the major surgical procedure/s performed at the time of the re-operation, using the multiple operation formula. Benefits are not payable for Item 38640 in association with Item 38656, 38643 or 38647.

T.8.71. SKULL BASE SURGERY - (ITEMS 39640 TO 39662)

The surgical management of lesions involving the skull base (base of anterior, middle and posterior fossae) often requires the skills of several surgeons or a number of surgeons from different surgical specialties working together or in tandem during the operative session. These operations are usually not staged because of the need for definitive closure of the dura, subcutaneous tissues, and skin to avoid serious infections such as osteomyelitis and/or meningitis.

Items 39640 to 39662 cover the removal of the tumour, which would normally be performed by a neurosurgeon. Other items are available to cover procedures performed as a part of skull base surgery by practitioners in other specialities, such as ENT and plastic and reconstructive surgery.

T.8.72. INTRADISCAL INJECTION OF CHYMOPAPAIN - (ITEM 40336)

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

T.8.73. REMOVAL OF VENTILATING TUBE FROM EAR - (ITEM 41500)

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

T.8.74. MEATOPLASTY - (ITEM 41515)

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

T.8.75. RECONSTRUCTION OF AUDITORY CANAL - (ITEM 41524)

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

T.8.76. REMOVAL OF NASAL POLYP OR POLYPI - (ITEMS 41662, 41665 AND 41668)

Where such polyps are removed in association with another intranasal procedure, Medicare benefit is paid under Item 41662. However where the associated procedure is of lesser value than Items 41665/41668, benefit for removal of polypi would be paid under Items 41665/41668.

T.8.77. LARYNX, DIRECT EXAMINATION - (ITEM 41846)

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

T.8.78. MICROLARYNGOSCOPY - (ITEM 41858)

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

T.8.79. IMBEDDED FOREIGN BODY - (ITEM 42644)

For the purpose of item 42644, an imbedded foreign body is one that is sub-epithelial or intra-epithelial and is completely removed using a hypodermic needle, foreign body gouge or similar surgical instrument with magnification provided by a slit lamp biomicroscope, loupe or similar device.

Item 42644 also provides for the removal of rust rings from the cornea, which requires the use of a dental burr, foreign body gouge or similar instrument with magnification by a slit lamp biomicroscope.

Where the imbedded foreign body is not completely removed, benefits are payable under the relevant attendance item.

T.8.80. CORNEAL INCISIONS - (ITEM 42672)

The description of this item refers to two sets of calculations, one performed some time prior to the operation, the other during the course of the operation. Both of these measurements are included in the Schedule fee and benefit for Item 42672.

T.8.81. CATARACT SURGERY (ITEMS 42698 AND 42701)

Items 42698 and 42701 provide for intraocular lens extraction and replacement as a separate procedure to be used in instances when lens removal and replacements are contraindicated at the same operation, such as in patients presenting with proliferative diabetic retinopathy or recurrent uveitis.

T.8.82. POSTERIOR JUXTASCLERAL DEPOT INJECTION - (ITEM 42741)

For the purpose of item 42741, the therapeutic substance must be registered with the Therapeutic Goods Administration (or listed on the Pharmaceutical Benefits Schedule, if so listed) as being suitable for injection for the treatment of predominantly (greater than or equal to 50%) classic, subfoveal choroidal neovascularisation due to age-related macular degeneration, as diagnosed by fluorescein angiography, in a patient with a baseline visual acuity equal to or better than 6/60.

T.8.83. CYCLODESTRUCTIVE PROCEDURES - (ITEMS 42770)

Item 42770 is restricted to a maximum of 2 treatments in a 2 year period.

T.8.84. INSERTION OF DRAINAGE DEVICE FOR GLAUCOMA (ITEM 42752)

Item 42752 provides for the insertion of a drainage device for the treatment of glaucoma patients who are at high risk of failure of trabeculectomy (such as patients who have aggressive neovascular glaucoma or extensive conjunctival scarring); have iridocorneal endothelial syndrome; inflammatory (uveitic) glaucoma; or aphakic glaucoma.

T.8.85. LASER TRABECULOPLASTY - (ITEMS 42782 AND 42783)

Item 42782 is restricted to a maximum of 4 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42783 should be utilised.

Claims for benefits for item 42783 should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for approval should be addressed in a sealed envelope marked 'Medical-in Confidence' to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

T.8.86. LASER IRIDOTOMY - (ITEMS 42785 AND 42786)

Item 42785 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42786 should be utilised.

Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

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The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

T.8.87. LASER CAPSULOTOMY - (ITEMS 42788 AND 42789)

Item 42788 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42789 should be utilised.

Claims for benefits for item 42789 should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for approval should be addressed in a sealed envelope marked 'Medical-in Confidence' to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

T.8.88. LASER VITREOLYSIS OR CORTICOLYSIS OF LENS MATERIAL OR FIBRINOLYSIS - (ITEMS 42791 AND 42792)

Item 42791 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42792 should be utilised.

Claims for benefits for item 42792 should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for approval should be addressed in a sealed envelope marked 'Medical-in Confidence' to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

T.8.89. DIVISION OF SUTURE BY LASER - (ITEM 42794)

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

T.8.91. OPHTHALMIC SUTURES - (ITEM 42845)

This item refers to the occasion when readjustment has to be made to the sutures to vary the angle of deviation of the eye. It does not cover the mere tightening of the loosely tied sutures without repositioning, or adjustment performed prior to the patient leaving the operating theatre.

T.8.92. FULL FACE CHEMICAL PEEL - (ITEMS 45019 AND 45020)

These items relate to full face chemical peel in the circumstances outlined in the item descriptors. Claims for benefits should be accompanied by full clinical details, including pre-operative colour photographs, to confirm that the conditions for payment of benefits have been met. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for approval should be addressed in a sealed envelope marked 'Medical-in Confidence'to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

T.8.93. ABRASIVE THERAPY/RESURFACING - (ITEMS 45021 TO 45026)

For the purposes of the above items, one aesthetic area is any of the following of the whole face (considered to be divided into six segments):- forehead; right cheek; left cheek; nose; upper lip; and chin.

Items 45021 and 45024 cover abrasive therapy only. For the purposes of these items, abrasive therapy requires the removal of the epidermis and into the deeper papillary dermis. Services performed using a laser are not eligible for benefits under these items.

Items 45025 and 45026 do not cover the use of fractional (Fraxel®) laser therapy.

T.8.94. ESCHAROTOMY - (ITEM 45054)

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

T.8.95. LOCAL SKIN FLAP - DEFINITION

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

A local skin flap is an area of skin and subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by its pedicle and is moved into the defect by rotation, advancement or transposition, or a combination of these manoeuvres. A benefit is only payable when the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This later procedure will also attract benefit if closed by graft or flap repair but not when closed by direct suture.

By definition, direct wound closure (e.g. by suture) does not constitute skin flap repair. Similarly, angled, curved or trapdoor incisions which are used for exposure and which are sutured back in the same position relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of a wound prior to suturing is considered a normal part of wound closure and is not considered a skin flap repair.

A "Z" plasty is a particular type of transposition flap repair. Although 2 flaps are created, benefit will be paid on the basis of Items 45200, 45203 or 45206 once only.

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

30023, 30180, 30186, 30269, 31205-31340, 45030, 45033, 45036-45045, 45506, 45512, 45626.

Note: This list is not all-inclusive and there are circumstances where other services might involve flap repair.

The following items are examples of where local flap repair would usually not be payable. If further advice is required, the Department of Human Services should be contacted.

30026-30052, 30099-30114, 30165-30177, 31200, 45520, 45522, 45524, 45563, 45587, 45632-45644, 45659, 45662, 45677-45713.

T.8.96. FREE GRAFTING TO BURNS - (ITEMS 45406 TO 45418)

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

T.8.97. REVISION OF SCAR - (ITEMS 45506 TO 45518)

For the purposes of items 45506 to 45518, revision of scar refers to modification of existing scars (traumatic, surgical or pathological) that is designed to decrease scar width, adapt scar position with regard to skin creases and landmarks, release scars from adhering to underlying structures, improve scar contour in keeping with undamaged skin or restore the shape of facial aperture.

Items 45506 to 45518 are only claimable when performed by a specialist in the practice of his or her specialty or where undertaken in the operating theatre of a hospital.

Only items 45506 and 45512, for the face and neck, can be claimed in association with items providing for graft or flap services.

For excision of scar services which do not meet the requirements of the revision of scar items as defined, the appropriate item in the range 31200 to 31240 should be claimed.

T.8.98. AUGMENTATION MAMMAPLASTY - (ITEMS 45524, 45527 AND 45528)

Medicare benefit is generally not attracted under item 45524 unless the asymmetry in breast size is greater than 10%. Augmentation of a second breast some time after an initial augmentation of one side would not attract benefits. Benefits are not payable for augmentation mammaplasty services performed using fat transfer to the breast.

Item 45528 applies where bilateral mammaplasty is indicated because of malformation of breast tissue, disease or trauma of the breast, (but not as a result of previous cosmetic surgery) other than covered under item 45524 or 45527. Claims for benefits under this item should be accompanied by full clinical details, including pre-operative colour photographs. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not

been altered. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Department of Human Services, in a sealed envelope marked 'Medical-in-Confidence'.

Applications for approval should be addressed to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

T.8.99. BREAST RECONSTRUCTION, MYOCUTANEOUS FLAP - (ITEM 45530)

When a prosthesis is inserted in conjunction with this operation, benefit would be attracted under Item 45527, the multiple operation rule applying. Benefits would also be payable for nipple reconstruction (Item 45545) when performed.

When claiming item 45530 for a rectus abdominis flap; item 45569 should be claimed for closure of the abdomen and reconstruction of the umbilicus, and item 45570 may be claimed if repair of the musculoaponeurotic layer is required. When claiming item 45530 for a latissimus dorsi flap, no item for the closure of the musculoaponeurotic layer should be claimed as it is expected that repair will be by direct suture. In the small number of cases, when a latissimus dorsi flap is used, and repair by means other than direct suture is required, use of item 45203 would be appropriate.

Items 30165, 30168, 30171, 30174 or 30177 (lipectomy items) should not be claimed in association with item 45530 as stated in the *Health Insurance (General Medical Services Table) Regulations.*

T.8.100. BREAST PROSTHESIS, REMOVAL AND REPLACEMENT OF - (ITEMS 45552 TO 45555)

It is generally expected that the replacement prosthesis will be the same size as the prosthesis that is removed. Medicare benefits are not payable for services under items 45552-45555 where the procedure is performed solely to increase breast size.

T.8.101. BREAST PTOSIS - (ITEMS 45556 TO 45559)

For the purposes of item 45556, Medicare benefit is only payable for the correction of breast ptosis when performed unilaterally, to match the position of the contralateral breast. This item is payable only once per patient. Additional benefit is not payable if this procedure is also performed on the contralateral breast.

Items 45557 and 45558 apply where correction of breast ptosis is indicated because the nipple is inferior to the infra-mammary groove.

Claims for benefits for items 45557, 45558 and 45559 should be accompanied by full clinical details including colour photographs including an anterolateral view. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with the Department of Human Services for referral to the Medicare Claims Review Panel, in a sealed envelope marked 'Medical-in Confidence'. These items are payable only once per patient.

Applications for approval should be addressed to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

T.8.102. NIPPLE AND/OR AREOLA RECONSTRUCTION - (ITEMS 45545 AND 45546)

Item 45545 involves the taking of tissue from, for example, the other breast, the ear lobe and the inside of the upper thigh with or without local flap.

Item 45546 covers the non-surgical creation of nipple or areola by intradermal colouration.

T.8.103. LIPOSUCTION - (ITEMS 45584, 45585 AND 45586)

Medicare benefits for liposuction are generally attracted under item 45584, that is for the treatment of post-traumatic pseudolipoma. Such trauma must be significant and result in large haematoma and localised swelling. Only on very rare occasions would benefits be payable for bilateral liposuction.

Where liposuction is indicated for the treatment of Barraquer-Simon's Syndrome (pathological lipodystrophy of hips, buttocks, thighs, and knees or lower legs), lymphoedema or macrodystrophia lipomatosa item 45585 applies.

Claims for benefits under items 45585 and 45586 should be accompanied by full clinical details, including pre-operative colour photographs.

Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare, for referral to the Medicare Claims Review Panel, in a sealed envelope marked 'Medical-in-Confidence'.
Applications for approval should be addressed to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

Practitioners may also apply to the Department of Human Services for Prospective approval for proposed surgery.

T.8.104. MELOPLASTY FOR CORRECTION OF FACIAL ASYMMETRY - (ITEMS 45587 AND 45588)

Benefits are payable under items 45587 and 45588 for face-lift operations performed to correct soft tissue abnormalities of the face due to causes other than the ageing process.

Where bilateral meloplasty is indicated because of congenital malformation for conditions such as drooling from the angles of the mouth and deep pitting of the skin resulting from severe acne scarring, disease or trauma (but not as a result of previous cosmetic surgery), item 45588 applies. Claims for benefits under this item should be accompanied by full clinical details, including pre-operative colour photographs. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with the Department of Human Services for referral to the Medicare Claims Review Panel, in a sealed envelope marked 'Medical-in Confidence'.

Applications for approval should be addressed to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

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

T.8.105. REDUCTION OF EYELIDS - (ITEMS 45617 AND 45620)

Where a reduction is performed for a medical condition of one eyelid, it may be necessary to undertake a similar compensating procedure on the other eyelid to restore symmetry. The latter operation would also attract benefits. Where there is doubt as to whether benefits would be payable, advice should be sought from a medical adviser of the Department of Human Services.

T.8.106. RHINOPLASTY - (ITEMS 45638, 45639)

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

Item 45638 applies where surgery is indicated for correction of nasal obstruction, post-traumatic deformity (but not as a result of previous elective cosmetic surgery), or both.

Item 45639 applies where surgery is indicated for the correction of significant developmental deformity. Developmental deformity includes cleft nose, bifid tip and twisted nose. Claims for benefits under this item should be accompanied by full clinical details and pre-operative photographs, including front, base (ie inferior view) and two laterals of the nose. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not

been altered. The claim and the additional information should be lodged with the Department of Human Services for referral to the Medicare Claims Review Panel, in a sealed envelope marked 'Medical-in Confidence'.

Applications for approval should be addressed to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

T.8.107. CONTOUR RESTORATION - (ITEM 45647)

For the purpose of item 45647, a region in relation to the face is defined as either being upper left or right, mid left or right or lower left or right. Accounts should be annotated with region/s to which the service applies.

T.8.108. VERMILIONECTOMY - (ITEM 45669)

Item 45669 covers treatment of the entire lip.

T.8.109. OSTEOTOMY OF JAW - (ITEMS 45720 TO 45752)

The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, eg iliac crest, would attract additional benefit under Item 47726 or 47729 for the harvesting, plus Item 48239 or 48242 for the grafting.

For the purposes of these items, a reference to maxilla includes the zygoma.

Item 75621 for the provision of fitting of surgical templates may be claimed in association with the appropriate orthognathic surgical items in the range of 45720 to 45754 for prescribed dental patients registered under the Cleft Lip and Cleft Palate Scheme.

T.8.110. GENIOPLASTY - (ITEM 45761)

Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

T.8.111. TUMOUR, CYST, ULCER OR SCAR - (ITEMS 45801 TO 45813)

It is recognised that odontogenic keratocysts, although not neoplastic, often require the same surgical management as benign tumours.

T.8.112. FRACTURE OF MANDIBLE OR MAXILLA - (ITEMS 45975 TO 45996)

There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones.

T.8.113. REDUCTION OF DISLOCATION OR FRACTURE

Closed reduction means treatment of a dislocation or fracture by non-operative reduction, and includes the use of percutaneous fixation or external splintage by cast or splints.

Open reduction means treatment of a dislocation or fracture by either operative exposure including the use of any internal or external fixation; or non-operative (closed reduction) where intra-medullary or external fixation is used.

Where the treatment of a fracture requires reduction on more than one occasion to achieve an adequate alignment, benefits are payable for each separate occasion at which reduction is performed under the appropriate item covering the fracture being treated.

The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts benefits on an attendance basis.

T.8.114. REMOVAL OF MULTIPLE EXOSTOSES (ITEMS 47933 AND 47936)

Items 47933 and 47936 provide for removal of multiple exostoses when undertaken via the same incision.

T.8.115. LUMBAR DISCECTOMY - (ITEM 48636)

Following an MSAC assessment of Intradiscal Electrothermal Annuloplasty (IDETA), it was recommended that public funding not be supported for IDETA at this time therefore medical benefits are not payable for the IDETA procedure. A restriction has been placed on the item 48636 (lumbar discectomy). This item cannot be claimed for IDETA.

T.8.116. DISCECTOMY IN RELATION TO ANTERIOR INTERBODY SPINAL FUSION - (ITEMS 48660 TO 48675)

Benefits are not payable for discectomy items claimed in association with anterior interbody fusion items unless discectomy is required to remove expulsed fragments of disc or is undertaken at a level different from where the fusion is performed.

T.8.117. INTERNAL FIXATION - (ITEMS 48678 TO 48690)

Benefits under these items are only attracted where internal fixation is carried out in association with spinal fusion covered by Items 48642 to 48675. The multiple rule would apply in each instance.

T.8.118. WRIST SURGERY - (ITEMS 49200 TO 49227)

For the purposes of these items, the wrist includes both the radiocarpal joint and the midcarpal joint.

T.8.119. DIAGNOSTIC ARTHROSCOPY AND ARTHROSCOPIC SURGERY OF THE KNEE (ITEMS 49557 AND 49563)

The Medical Services Advisory Committee (MSAC) evaluated the available evidence and did not support public funding for matrix-induced autologous chondrocyte implantation (MACI) or autologous chondrocyte implantation (ACI) for the treatment of chondral defects in the knee and other joints, due to the increased cost compared to existing procedures and the lack of evidence showing short term or long-term improvements in clinical outcomes. Medicare benefits are not payable in association with this technology.

T.8.120. PAEDIATRIC PATIENTS - (ITEMS 50450 TO 50658)

For the purpose of Medicare benefits a paediatric patient is considered to be a patient under the age of eighteen years, except in those instances where an item provides further specifications (i.e. fracture items for paediatric patients which state “with open growth plates”).

T.8.121. TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS - (ITEMS 50500 TO 50588)

Items 50552 and 50560 apply to fractures that may arise during delivery and at an age when anaesthesia poses a significant risk and thus reduction is usually performed in the neonatal unit or nursery.

Item 50576 provides for closed reduction in the skeletally immature patient and will require application of a hip spica cast and related aftercare.

Medicare benefits are payable for services that specify reduction with or without internal fixation by open or percutaneous means, where reduction is carried out on the growth plate or joint surface or both.

T.8.122. NON-RESECTABLE HEPATOCELLULAR CARCINOMA DESTRUCTION OF BY OPEN OR LAPAROSCOPIC RADIOFREQUENCY ABLATION - (ITEM 50952)

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

T.8.123. PARACENTESIS OF ANTERIOR CHAMBER OR VITREOUS CAVITY AND/OR INTRAVITREAL INJECTION - (ITEMS 42738 TO 42740)

Items 42738 and 42739 provide for paracentesis for the injection of therapeutic substances and/or the removal of aqueous or vitreous, when undertaken as an independent procedure. That is, not in conjunction with other intraocular surgery.

Item 42739 should be claimed for patients requiring anaesthetic services for the procedure. Advice from the Royal Australian and New Zealand College of Ophthalmologists is that independent injections require only topical anaesthesia, with or without subconjunctival anaesthesia, except in specific circumstances as outlined below where additional anaesthetic services may be indicated:

- nystagmus or eye movement disorder;
- cognitive impairment precluding safe intravitreal injection without sedation;
- a patient under the age of 18 years;
- a patient unable to tolerate intravitreal injection under local anaesthetic without sedation; or

- endophthalmitis or other inflammation requiring more extensive anaesthesia (eg peribulbar).

Practitioners billing item 42739 must keep clinical notes outlining the basis for the use of anaesthetic.

Item 42740 provides for intravitreal injection of therapeutic substances and/or the removal of vitreous for diagnostic purposes when performed in conjunction with other intraocular surgery including with a service to which Item 42809 (retinal photocoagulation) applies.

T.8.124. BONE GRAFT (ITEMS 48200-48242 AND 48642-48651)

Bone graft substitute materials can be used for the purpose of bone graft for items 48200-48242 and 48642-48651.

T.8.125. VULVOPLASTY AND LABIOPLASTY - (ITEMS 35533 AND 35534)

Item 35533 is intended to cover the surgical repair of female genital mutilation and major congenital anomalies of the uro-gynaecological tract which are not covered by existing MBS items. For example, this item would apply where a patient who has previously received treatment for cloacal extrophy, bladder exstrophy or congenital adrenal hyperplasia requires additional or follow-up treatment.

Item 35534 is intended to cover services for localised gigantism which is causing significant functional impairment.

Medicare benefits are not payable for non-therapeutic cosmetic services.

Claims for benefits for item 35534 should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Evidence should include a detailed clinical history outlining the functional impairment and the medical need for reconstructive surgery of the vulva and/or labia. Photographic evidence may not be required for this item.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for Approval should be addressed to:
The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

T.9.1. ASSISTANCE AT OPERATIONS - (ITEMS 51300 TO 51318)

Items covering operations which are eligible for benefits for surgical assistance have been identified by the inclusion of the word "Assist." in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

The assistance must be rendered by a medical practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to a surgeon no additional benefits are payable. The assistance benefit payable is the same irrespective of the number of practitioners providing surgical assistance.

NOTE: The Benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more medical practitioners.

Assistance at Multiple Operations
Where surgical assistance is provided at two or more operations performed on a patient on the one occasion the multiple operation formula is applied to all the operations to determine the surgeon's fee for Medicare benefits purposes. The multiple-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for surgical assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Item 51300 or 51303).

Multiple Operation Rule - Surgeon	Multiple Operation Rule - Assistant
Item A - $300@100%	Item A (Assist.) - $300@100%
Item B - $250@50%	Item B (No Assist.)
Item C - $200@25%	Item C (Assist.) - $200@50%
Item D - $150@25%	Item D (Assist.) - $150@25%

The derived fee applicable to Item 51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery which attracts an assistance rebate.

Surgeons Operating Independently
Where two surgeons operate independently (ie neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a surgical assistant is engaged by each, or one of the surgeons, benefits for surgical assistance are payable in the same manner as if the surgeons were operating separately.

T.9.2. BENEFITS PAYABLE UNDER ITEM 51300

Medicare benefits are payable under item 51300 for assistance rendered at any operation identified by the word "Assist." for which the fee does not exceed the fee threshold specified in the item descriptor, or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee threshold specified in the item descriptor has not been exceeded.

T.9.3. BENEFITS PAYABLE UNDER ITEM 51303

Medicare benefits are payable under item 51303 for assistance rendered at any operation identified by the word "Assist." for which the fee exceeds the fee threshold specified in the item descriptor or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee exceeds the threshold specified in the item descriptor.

T.9.4. BENEFITS PAYABLE UNDER ITEM 51309

Medicare benefits are payable under item 51309 for assistance rendered at any operation identified by the word “Assist.” or a series or combination of operations identified by the word “Assist.” and assistance at a delivery involving Caesarean section.

Where assistance is provided at a Caesarean section delivery and at a procedure or procedures which have not been identified by the word "Assist.", benefits are payable under item 51306.

T.9.5. ASSISTANCE AT CATARACT AND INTRAOCULAR LENS SURGERY - (ITEM 51318)

The reference to “previous significant surgical complication” covers vitreous loss, rupture of posterior capsule, loss of nuclear material into the vitreous, intraocular haemorrhage, intraocular infection (endophthalmitis), cystoid macular oedema, corneal decompensation or retinal detachment.

T.10.1. RELATIVE VALUE GUIDE FOR ANAESTHETICS - (GROUP T10)

Overview of the RVG
The RVG groups anaesthesia services within anatomical regions. These items are listed in the MBS under Group T10, Subgroups 1-16 Anaesthesia for radiological and other therapeutic and diagnostic services are grouped separately under Subgroup 17. Also included in the RVG format are certain additional monitoring and therapeutic services, such as blood pressure monitoring (item 22012) and central vein catheterisation (item 22020) when performed in association with the administration of anaesthesia. These services are listed at subgroup 19. The RVG also provides for assistance at anaesthesia under certain circumstances. These items are listed at subgroup 26.

Details of the billing requirements for the RVG are available from the Department of Human Services website.

The RVG is based on an anaesthesia unit system reflecting the complexity of the service and the total time taken for the service. Each unit has been assigned a dollar value.

Under the RVG, the Medicare benefit for anaesthesia in connection with a procedure is comprised of up to three components:

The basic units allocated to each anaesthetic procedure, reflecting the complexity of the procedure (an item in the range 20100-21997). For example:

20702	INITIATION AND MANAGEMENT OF ANAESTHESIA for percutaneous liver biospy (4 basic units) Fee: $77.80 Benefit: 75% $58.35 85% $66.15

the time unit allocation reflecting the total time of the anaesthesia (an item in the range 23010-24136), for example;

23033	- 41 MINUTES to 45 MINUTES (3 units) Fee: $58.35 Benefit: 75%= $43.80 85% = $ 49.60

plus, where appropriate

modifying units recognising certain added complexities in anaesthesia (an item/s in the range 25000-25020), for example

25015	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA where the patients age is less than 12 months of age or 70 years or greater (1 unit) Fee: $19.45 Benefit: 75% $14.60 85% $16.55

Each assistant at anaesthesia service in subgroup 26 has also been allocated a number of base units. The total time that the assistant anaesthetist was in active attendance on the patient is then added, along with modifiers, as appropriate, to establish the fee for the assistant service. For example:

25200	ASSISTANCE IN THE ADMINISTRATION OF ANAESTHESIA on a patient in imminent danger of death requiring continuous life saving emergency treatment , to the exclusion of all other patients Derived Fee: An amount of $97.25 (5 basic units) plus an item in the range 23010-24136) plus, where applicable, an item/s in the range 25000 – 25020

As with anaesthesia, where whole body perfusion is performed, the Schedule fee is determined on the base units allocated to the service (item 22060), the total time for the perfusion, and modifying units, as appropriate i.e

(a) the basic units allocated to whole body perfusion under item 22060;

22060	WHOLE BODY PERFUSION, CARDIAC BYPASS, using heart-lung machine or equivalent (20 basic units) Fee: $389.00 Benefit: 75% = $291.75 85% = $330.65

(b) plus, the time unit allocation reflecting the total time of the perfusion (an item in the range 23010 – 24136), for example;

23033	41 MINUTES TO 45 MINUTES (3 basic units) Fee: $58.35 Benefit: 75%= $43.80 85% = $ 49.60

plus, where appropriate

(c) modifying units recognising certain added complexities in perfusion (an item/s in the range 25000 – 25020) for example

25015	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA - where the patient's age is up to one year or 70 years or greater (1 basic units) Fee: $19.45 Benefit: 75% $14.60 85% $16.55

T.10.2. ELIGIBLE SERVICES

Generally, a Medicare benefit is only payable for anaesthesia which is performed in connection with an "eligible" service. Under the Health Insurance Regulations, an "eligible" service is defined as a clinically relevant professional service which is listed in the Schedule and which has been identified as attracting an anaesthetic fee**.**

T.10.3. RVG UNIT VALUES

Basic Units

The RVG basic unit allocation represents the complexity of the anaesthetic procedure relative to the anatomical site and physiological impact of the surgery.

Time Units

The number of time units is calculated from the total time of the anaesthesia service, the assistant at anaesthesia service or

the whole body perfusion service:

- *for anaesthesia*, time is considered to begin when the anaesthetist commences exclusive and continuous care of the patient for anaesthesia. Time ends when the anaesthetist is no longer in professional attendance, that is, when the patient is safely placed under the supervision of other personnel;
- *for assistance at anaesthesia*, time is taken to be the period that the assistant anaesthetist is in active attendance on the patient during anaesthesia; and
- *for perfusion*, perfusion time begins with the commencement of anaesthesia and finishes with the closure of the chest.

For up to and including the first - 2 hours of time, each 15 minutes (or part thereof) constitutes 1 time unit. For time beyond 2 hours, each time unit equates to 10 minutes (or part thereof).

For statistical purposes, the first 2 hours of time after the first 15 minutes is represented in the Medicare Benefits Schedule by item numbers in 5 minute increments. For example:

	ANAESTHESIA, ASSISTANCE AT ANAESTHESIA OR PERFUSION TIME - for anaesthesia in connection with an eligible medical service or a dental service or assistance at anaesthesia in connection with an eligible medical service or for perfusion in connection with an eligible medical service 15 MINUTES OR LESS (1 unit)		
23010	Fee: $19.45	Benefit: 75%= $14.60	Benefit: 85% = $16.55
	16 MINUTES TO 20 MINUTES (2 units)		
23021	Fee: $38.90	Benefit: 75%= $29.20	Benefit: 85% = $33.10
	21MINUTES to 25 MINUTES (2 units)		
23022	Fee: $38.90	Benefit: 75%= $29.20	Benefit: 85% = $33.10
	- 26 MINUTES to 30 MINUTES (2 units)		
23023	Fee: $38.90	Benefit: 75%= $29.20	Benefit: 85% = $33.10
	- 31 MINUTES to 35 MINUTES (3 units)		
23031	Fee: $58.35	Benefit: 75%= $43.80	Benefit: 85% = $49.60
	- 36 MINUTES to 40 MINUTES (3 units)		
23032	Fee: $58.35	Benefit: 75%= $43.80	Benefit: 85% = $49.60
	- 41 MINUTES to 45 MINUTES (3 units)		
23033	Fee: $58.35	Benefit: 75%= $43.80	Benefit: 85% = $49.60

For services lasting between 15 minutes and two hours, the appropriate 5 minute item number should be included on accounts.

Modifying Units (25000 – 25050)

Modifying units have been included in the RVG to recognise added complexities in anaesthesia or perfusion, associated with the patient's age, physical status or the requirement for emergency surgery. These cover the following clinical situations:

- **ASA physical status indicator 3 - A patient with severe systemic disease that significantly limits activity (item 25000)**. This would include: severely limiting heart disease; severe diabetes with vascular complications or moderate to severe degrees of pulmonary insufficiency.

  Some examples of clinical situations to which ASA 3 would apply are:
  - a patient with ischaemic heart disease such that they encounter angina frequently on exertion thus significantly limiting activities;
  - a patient with chronic airflow limitation who gets short of breath such that the patient cannot complete one flight of stairs without pausing;
  - a patient who has suffered a stroke and is left with a residual neurological deficit to the extent that is significantly limits normal activity, such as hemiparesis; or
  - a patient who has renal failure requiring regular dialysis.

- **ASA physical status indicator 4 - A patient with severe systemic disease which is a constant threat to life (item 25005)**. This covers patients with severe systemic disorders that are already life-threatening, not always correctable

by an operation. This would include: patients with heart disease showing marked signs of cardiac failure; persistent angina or advanced degrees of pulmonary, hepatic, renal or endocrine insufficiency.

ASA physical status indicator 4 would be characterised by the following clinical examples:

- a person with coronary disease such that they get angina daily on minimum exertion thus severely curtailing their normal activities;
- a person with end stage emphysema who is breathless on minimum exertion such as brushing their hair or walking less than 20 metres; or
- a person with severe diabetes which affects multiple organ systems where they may have one or more of the following examples:-
  - severe visual impairment or significant peripheral vascular disease such that they may get intermittent claudication on walking less than 20 metres; or
  - severe coronary artery disease such that they suffer from cardiac failure and/or angina whereby they are limited to minimal activity.

- **ASA physical status indicator 5 - a moribund patient who is not expected to survive for 24 hours with or without the operation (item 25010).** This would include: a burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure or massive pulmonary embolus.

The following are some examples that would equate to ASA physical status indicator 5

- a burst abdominal aneurysm with profound shock;
- major cerebral trauma with increasing intracranial pressure; or
- massive pulmonary embolus.

NOTE: It should be noted that the Medicare Benefits Schedule does NOT include modifying units for patients assessed as ASA physical status indicator 2. Some examples of ASA 2 would include:

- a patient with controlled hypertension which has no affect on the patient's normal lifestyle;
- a patient with coronary artery disease that results in angina occurring on substantial exertion but not limiting normal activity; or
- a patient with insulin dependant diabetes which is well controlled and has minimal effect on normal lifestyle."

- **Where the patient is less than 12 months or age or 70 years or greater (item 25015).**
- **For anaesthesia, assistance at anaesthesia or a perfusion service in association with an *emergency procedure (item 25020).**
- **For anaesthesia or assistance at anaesthesia in association with an *after hours emergency procedure (items 25025 and 25030).**
- **For a perfusion service in association with *after hours emergency surgery (item 25050).**

*** NOTE:** It should be noted that the emergency modifier and the after hours emergency modifiers cannot both be claimed in the one anaesthesia assistance at anaesthesia or perfusion episode.

It should also be noted that modifiers are not stand alone services and can only be claimed in association with anaesthesia, assistance at anaesthesia or with a perfusion service covered by item 22060.

Definition of Emergency

For the purposes of both the emergency modifier and the after hours emergency modifiers, emergency is defined as existing where the patient requires immediate treatment without which there would be significant threat to life or body part.

Definition of After Hours

For the purposes of the after hours emergency modifier items, the after hours period is defined as being the period from 8pm to 8am on any weekday or at any time on a Saturday, a Sunday or a public holiday. Benefit for the After Hours Emergency Modifiers is only payable where more than 50% of the time for the emergency anaesthesia, the assistance at emergency anaesthesia or the perfusion service is provided in the after hours period. In situations where less than the 50% of the time for the service falls in the after hours period, the emergency modifier rather than the after hours emergency modifier applies. For information about deriving the fee for the service where the after hours emergency modifier applies.

T.10.4. DERIVING THE SCHEDULE FEE UNDER THE RVG

The Schedule fee for each component of anaesthesia (base items, time items and modifier items) in the RVG Schedule is derived by applying the unit value to the total number of anaesthesia units for each component. For example:

ITEM	*DESCRIPTION*		*SCHEDULE FEE*
RVG	**Anaesthesia Service**	**Units**	**SCHEDULE FEE (Units x $ 19.45)**
20840	Anaesthesia for resection of perforated bowel	6	$116.70
23200	Time – 4 hours 40 minutes	24	$466.80
25000	Modifier - Physical status	1	$19.45
22012	Central Venous Pressure Monitoring	3	$58.35

After Hours Emergency Services

When deriving the fee for the after hours emergency modifier for anaesthesia or assistance at anaesthesia, the 50% loading applies to the anaesthesia or assistance service from Group T10 and to any additional clinically relevant therapeutic or diagnostic service from Group T10, Subgroup 18, provided during the anaesthesia episode. For example:

ITEM	*DESCRIPTION*	**UNITS**	*SCHEDULE FEE (Units x $19.45)*
20840	Anaesthesia for resection of perforated bowel	6	$ 116.70
23190	Time – 4 hours 40 minutes	24	$466.80
25000	Modifier - Physical status	1	$19.45
22012	Central Venous Pressure Monitoring	3	$58.35
	TOTAL UNITS	34	Schedule fee = **$661.30**
25025	Anaesthesia After Hours Emergency Modifier		Schedule Fee $661.30 x 50% **=330.65**

Definition of Radical Surgery for the RVG

Where the term radical appears in an item description, it refers to an extensive surgical procedure, performed for the treatment of malignancy. It usually denotes extensive block dissection not only of the malignant tissue, but also of the surrounding tissue, particularly fat and lymphatic drainage systems. See notes T10.18 and T10.22 which clarify the definitions of the words "extensive" and "radical" used in items 20192 and 20474.

Multiple Anaesthesia Services

Where anaesthesia is provided for services covered by multiple items in the RVG, Medicare benefit is only payable for the RVG item with the highest basic unit value. However, the time component should include the total anaesthesia time taken for all services. For example:

ITEM	**DESCRIPTION**	**UNITS**	**SCHEDULE FEE**
20790	Anaesthesia for Cholecystectomy	8	$155.60
20752	Incisional Hernia	6	(lower value - fee not payable) $116.70
23111	Time – 2hrs 30mins	11	$213.95
25015	Physical Status – Over 70	1	$19.45

Prolonged Anaesthesia

Under the RVG, the previous rules that related to prolonged anaesthesia no longer apply. Where anaesthesia is prolonged beyond that which an anaesthetist would normally encounter for a particular service, the RVG provides for the anaesthetist to claim the total anaesthesia time for the procedure/s.

T.10.5. MINIMUM REQUIREMENTS FOR CLAIMING BENEFITS UNDER ITEMS IN THE RVG (INCLUDING SEDATION)

Medicare benefits for RVG services (including sedation) are only payable where both the staffing and the facility in which the service was rendered meets the following minimum guidelines. These guidelines are based on protocols established by the Australian and New Zealand College of Anaesthetists (ANZCA).

Staffing

- Techniques intended to produce loss of consciousness must not be used unless an anaesthetist is present to care exclusively for the patient;
- Where the patient is a young child, is elderly or has any serious medical condition (such as significant cardio-respiratory disease or danger of airway compromise), an anaesthetist should be present to administer sedation and monitor the patient;

- In all other cases, an appropriately trained medical practitioner, other than the proceduralist, is required to be in exclusive attendance on the patient during the procedure, to administer sedation and to monitor the patient; and
- There must be sufficient equipment (including oxygen, suction and appropriate medication), to enable resuscitation should it become necessary.

Facilities
The procedure must be performed in a location which is adequate in size and staffed and equipped to deal with a cardiopulmonary emergency. This must include:
- An operating table, trolley or chair which can be readily tilted;
- Adequate uncluttered floor space to perform resuscitation, should this become necessary;
- Adequate suction and room lighting;
- A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient;
- A self inflating bag suitable for artificial ventilation together with a range of equipment for advance airway management;
- Appropriate drugs for cardiopulmonary resuscitation;
- A pulse oximeter; and
- Ready access to a defibrillator.

These requirements apply equally to dental anaesthesia or sedation services provided under items in Group T10, Subgroup 20 of the RVG.

T.10.6. ACCOUNT REQUIREMENTS

Before a benefit will be paid for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of details additional to those set out at paragraph 7.1 of the General Explanatory Notes of the Medicare Benefits Schedule are required on the anaesthetist's account:
- **the anaesthetist's account** must show the name/s of the medical practitioner/s who performed the associated operation/s. In addition, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and total time of the anaesthetic.
- **the assistant anaesthetist's account** must show the names/s of the medical practitioners who performed the associated operation/s, as well as the name of the principal anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthetic.
- **the perfusionist's account** must record the start time, end time and total time of the perfusion service where the after hours emergency modifier is claimed.

T.10.7. GENERAL INFORMATION

The Health Insurance Act provides that where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of anaesthesia. The administration of anaesthesia also includes the pre-anaesthesia consultation with the patient in preparation for that administration, except where such consultation entails a separate attendance carried out at a place other than an operating theatre or an anaesthesia induction room. The pre-anaesthesia consultation for a patient should be performed in association with a clinically relevant service.

Except in special circumstances, benefit is not payable for the administration of anaesthesia listed in Subgroups 1-18, unless the anaesthesia is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which anaesthesia is administered.

Fees and benefits for anaesthesia services under the RVG cover all essential components in the administration of the anaesthesia service. Separate benefit may be attracted, however, for complementary services such as central venous pressure and direct arterial pressure monitoring (see note T10.9).
It should be noted that additional benefit is not payable for intravenous infusion or electrocardiographic monitoring, provision for which has been made in the value determined for the anaesthetic units.

The Medicare benefit derived under the RVG for the administration of anaesthesia is the benefit payable for that service irrespective of whether one or more than one medical practitioner administers it. However, benefit is provided under Subgroup 24 for the services of one assistant anaesthetist (who must not be either the surgeon or assistant surgeon (see Note 10.9)

Where a regional nerve block or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block is assessed as an anaesthesia item according to the advice in paragraph T10.4. When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

When a regional nerve block or field nerve block covered by an item in Group T7 of the Schedule is administered by a medical practitioner in the course of a surgical procedure undertaken by him/her, then such a block will attract benefit under the appropriate item in Group T7.

It should be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.

It may happen that the professional service for which the anaesthesia is administered does not itself attract a benefit because it is part of the after-care of an operation. This does not, however, affect the benefit payable for the anaesthesia service. Benefit is payable for anaesthesia administered in connection with such a professional service (or combination of services) even though no benefit is payable for the associated professional service.

The administration of epidural anaesthesia during labour is covered by Item 18216 or 18219 in Group T7 of the Schedule whether administered by the medical practitioner undertaking the confinement or by another medical practitioner. Subsequent "top-ups" are covered by Item 18222 or 18225.

T.10.8. ADDITIONAL SERVICES PERFORMED IN CONNECTION WITH ANAESTHESIA - SUBGROUP 19

Included in the RVG format are a number of additional or complimentary services which may be provided in connection with anaesthesia such as pulmonary artery pressure monitoring (item 22012) and intra-arterial cannulation (item 22025).

These items (with the exception of peri-operative nerve blocks (22030-22050)) and perfusion services (22055-22075) have also been retained in the MBS in the non-RVG format, for use by practitioners who provide these services other than in association with anaesthesia.

Where an anaesthetist provides an additional (clinically relevant) service during anaesthesia that is not one listed in Subgroup 19 (excluding intravenous infusion or electrocardiographic monitoring) the relevant non-RVG item should be claimed.

Items 22012 and 22014
Benefits are payable under items 22012 and 22014 only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day, and irrespective of the number of practitioners involved in monitoring the pressures.

T.10.9. ASSISTANCE IN THE ADMINISTRATION OF ANAESTHESIA

The RVG provides for a separate benefit to be paid for the services of an assistant anaesthetist in connection with an operation or series of operations in specified circumstances, as outlined below. This benefit is payable only in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

Therapeutic and Diagnostic services covered by Subgroup 19 items (such as blood transfusion, pressure monitoring, insertion of CVC, etc) are payable only once per patient per anaesthetic episode. Where these services are provided by the assistant anaesthetist these services are eligible for Medicare benefits only where the same service is not also claimed by the primary anaesthetist

Assistance at anaesthesia in connection with emergency treatment (Item 25200)
Item 25200 provides for assistance at anaesthesia where the patient is in imminent danger of death. Situations where imminent danger of death requiring an assistant anaesthetist might arise include: complex airway problems, anaphylaxis or allergic reactions, malignant hyperpyrexia, neonatal and complicated paediatric anaesthesia, massive blood loss and subsequent resuscitation, intra-operative cardiac arrest, critically ill patients from intensive care units or inability to wean critically ill patients from pulmonary bypass.

Assistance in the administration of elective anaesthesia (Item 25205)

A separate benefit is payable under Item 25205 for the services of an assistant anaesthetist in connection with elective anaesthesia in the circumstances outlined in the item descriptor. This benefit is only payable in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

For the purposes of Item 25205, a ‘complex paediatric case’ involves one or more of the following:-
(i) the need for invasive monitoring (intravascular or transoesophageal); or
(ii) organ transplantation; or
(iii) craniofacial surgery; or
(iv) major tumour resection; or
(v) separation of conjoint twins.

T.10.10. PERFUSION SERVICES - (ITEMS 22055 TO 22075)

Perfusion services covered by items 22055-22075 have been included in the RVG format.

As with anaesthesia, where whole body perfusion is performed, the Schedule fee is determined on the base units allocated to the service (item 22060), the total time for the perfusion, and modifying units, as appropriate, i.e.

(a) the basic units allocated to whole body perfusion under item 22060:

22060	**WHOLE BODY PERFUSION, CARDIAC BYPASS**, where the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies. (20 basic units) *(See para T10.10 of explanatory notes to this Category)*

(b) plus, the time unit allocation reflecting the total time of the perfusion (an item in the range 23010 - 24136), for example:

23033	41 MINUTES TO 45 MINUTES (3 basic units)

plus, where appropriate

(c) modifying units recognising certain added complexities in perfusion (an item/s in the range 25000 - 25020), for example:

25015	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA - where the patient's age is up to one year or 70 years or greater (1 basic unit)

The time component for item 22060 is defined as beginning with the commencement of anaesthesia and finishing with the closure of the chest.

Items 22065 and 22070 may only be used in association with item 22060.

Medicare benefits are not payable for perfusion unless the perfusion is performed by a medical practitioner other than the medical practitioner who renders the associated medical service in Group T8 or the medical practitioner who administers the anaesthesia listed in the RVG in Group T10.

The medical practitioner providing the service must comply with the training requirements in the Australian and New Zealand College of Anaesthetists (ANZCA) *Guidelines for Major Extracorporeal Perfusion* (PS27 2015).

Benefits are not payable if another person primarily and/or continuously operates the HLM.

T.10.11. ANAESTHESIA AS A THERAPEUTIC PROCEDURE - (ITEM 21965)

Claims for benefits for this service should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for approval should be addressed to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

T.10.12. DISCONTINUED PROCEDURE - (ITEM 21990)

Claims for benefits under Item 21990 should be submitted to Medicare for approval of benefits and should include full details of the circumstances, including details of the surgery/procedure which had been proposed and the reason for it being discontinued.

T.10.13. ANAESTHESIA IN CONNECTION WITH A PROCEDURE NOT IDENTIFIED AS ATTRACTING A MEDICARE BENEFIT FOR ANAESTHESIA - (ITEM 21997)

Payment of benefit for Item 21997 is not restricted to the service being performed in connection with a surgical service in Group T8. Item 21997 may be performed with any item in the Medicare Benefits Schedule that has not been identified as attracting a Medicare benefit for anaesthesia (including attendances) in circumstances where anaesthesia is considered clinically necessary.

Claims for benefits for this service should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for approval should be addressed to:

The MCRP Officer
PO Box 9822
SYDNEY NSW 2001

T.10.14. ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE - (ITEMS 22900 AND 22905)

Items 22900 and 22905 cover the administration of anaesthesia in connection with a dental service that is not a service covered by an item in the Medicare Benefits Schedule i.e removal of teeth and restorative dental work. Therefore, the requirement that anaesthesia be performed in association with an 'eligible' service (as defined in point T10.2) does not apply to dental anaesthesia items 22900 and 22905.

T.10.15. ANAESTHESIA IN CONNECTION WITH CLEFT LIP AND CLEFT PALATE REPAIR - (ITEMS 20102 AND 20172)

Anaesthesia associated with cleft lip and cleft palate repair is covered in Subgroup 1 of the RVG Schedule, under items 20102 and 20172.

T.10.16. ANAESTHESIA IN CONNECTION WITH AN ORAL AND MAXILLOFACIAl SERVICE - (CATEGORY 4 OF THE MEDICARE BENEFITS SCHEDULE)

Benefit for anaesthesia provided by a medical practitioner in association with an Oral and Maxillofacial service (Category 4 of the Medicare Benefits Schedule) is derived using the RVG. Benefit for anaesthesia for oral and maxillofacial services should be claimed under the appropriate RVG item from Subgroup 1 or 2.

T.10.17. INTRA-OPERATIVE BLOCKS FOR POST OPERATIVE PAIN - (ITEMS 22031 TO 22050)

Benefits are only payable for intra-operative nerve blocks performed for the management of post-operative pain that are specifically catered for under items 22031 to 22050.

T.10.18. ANAESTHESIA IN CONNECTION WITH EXTENSIVE SURGERY ON FACIAL BONES - (ITEM 20192)

The term 'extensive' in relation to this item is defined as major facial bone surgery or reconstruction including major resection or osteotomies or osteectomies of mandibles and/or maxillae, surgery for prognathism or surgery for Le Fort II or III fractures.

T.10.19. INTRATHECAL OR EPIDURAL INJECTION FOR CONTROL OF POST-OPERATIVE PAIN - INITIAL - (ITEM 22031)

Benefits are payable under item 22031 for the initial intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, for the control of post-operative pain. Benefit is not payable for subsequent intra-operative intrathecal and epidural injection (item 22036) in the same anaesthetic episode. Where subsequent infusion is provided post operatively, to maintain analgesia, benefit would be payable under items 18222 or 18225.

T.10.20. INTRATHECAL OR EPIDURAL INJECTION FOR CONTROL OF POST-OPERATIVE PAIN - SUBSEQUENT - (ITEM 22036)

Benefits are payable under item 22036 for subsequent intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, performed intra-operatively, for postoperative pain management, where the catheter is already in-situ. Benefits are not payable under this item where the initial injection was performed intra-operatively, under item 22031, in the same anaesthetic episode.

T.10.21. Regional or Field Nerve Blocks for Post-operative Pain - (Items 22040 - 22050)

Benefits are payable under Items 22040 to 22050 in addition to the general anaesthesia for the related procedure.

T.10.22. Anaesthesia for Radical Procedures on the Chest Wall - (Item 20474)

Radical procedures on the chest wall referred to in item 20474 would include procedures such as pectus excavatum.

T.10.23. Anaesthesia for Extensive Spine or Spinal Cord Procedures - (Item 20670)

This item covers major spinal surgery involving multiple levels of the spinal cord and spinal fusion where performed. Procedures covered under this item would include the Harrington Rod technique. Surgery on individual spinal levels would be covered under items 20600, 20620 and 20630.

T.10.24. Anaesthesia for Femoral Artery Embolectomy - (Item 21274)

Item 21274 covers anaesthesia for femoral artery embolectomy. Grafts involving intra-abdominal vessels would be covered under item 20880.

T.10.25. Anaesthesia for Cardiac Catheterisation - (Item 21941)

Item 21941 does not include either central vein catheterisation or insertion of right heart balloon catheter. Anaesthesia for these procedures is covered under item 21943.

T.10.26. Anaesthesia for 2 Dimensional Real Time Transoesophageal Echocardiography - (Item 21936)

Benefits are payable for anaesthesia in connection with 2 dimensional real time transoesophageal echocardiography, (including intra-operative echocardiography) which includes doppler techniques, real time colour flow mapping and recording onto video tape or digital medium.

T.10.27. Anaesthesia for Services on the Upper and Lower Abdomen - (Subgroups 6 and7)

Establishing whether an RVG anaesthetic item pertains to the upper or lower abdomen, depends on whether the majority of the associated surgery was performed in the region above or below the umbilicus.

Some examples of upper abdomen would be:
- laparoscopy on upper abdominal viscera;
- laparoscopy with operative focus superior to the umbilical port;
- surgery to the liver, gallbladder and ducts, stomach, pancreas, small bowel to DJ flexure;
- the kidneys in their normal location (as opposed to pelvic kidney); or
- spleen or bowel (where it involves a diaphragmatic hernia or adhesions to gallbladder bed).

Some examples of lower abdomen would be:
- abdominal wall below the umbilicus;
- laparoscopy on lower abdominal viscera;
- laparoscopy with operative focus inferior to the umbilical port;
- surgery on the jejunum, ileum, or colon;
- surgery on the appendix; or
- surgery associated with the female reproductive system.

T.10.28. Anaesthesia for Microvascular Free Tissue Flap Surgery - (Items 20230, 20355, 20475, 20704, 20804, 20905, 21155, 21275, 21455, 21535, 21685, 21785 and 21865)

Benefits are only payable where complete free tissue flap surgery is undertaken involving microsurgical arterial and venous anastomoses. Benefits do not apply for microsurgical rotation flaps or for re-implementation of digits or either the hand or the foot.

T.10.29. Anaesthesia for Endoscopic Ureteric Surgery - Including Laser Procedure - (Item 20911)

Benefits are not payable under item 20911 for diagnostic ureteroscopy.

T.11.1. Botulinum Toxin - (Items 18350 to 18379)

The Therapeutic Goods Administration (TGA) assesses each indication for the therapeutic use of botulinum toxin on an individual basis. There are currently two botulinum toxin agents with TGA registration (Botox and Dysport). Each has undergone a separate evaluation of its safety and efficacy by the TGA as they are neither bioequivalent, nor dose

equivalent. When claiming under an item for the injection of botulinum toxin, only the botulinum toxin agent specified in the item can be used. Benefits are not payable where an agent other than that specified in the item is used.

The TGA assesses each indication for the therapeutic use of botulinum toxin by assessment of clinical evidence for its use in paediatric or adult patients. Where an indication has been assessed for adult use, data has generally been assessed using patients over 12 years of age. Paediatric indications have been assessed using data from patients under 18 years of age. Botulinum toxin should only be administered to patients under the age of 18 where an item is for a paediatric indication, and patients over 12 years of age where the item is for an adult indication, unless otherwise specified.

Items for the administration of botulinum toxin can only be claimed by a medical practitioner who is registered by the Department of Human Services to participate in the arrangements under Section 100 of the *National Health Act 1953* relating to the use and supply of botulinum toxin.

Item 18354 for the treatment of equinus, equinovarus or equinovalgus is limited to a maximum of 4 injections per patient on any day (2 per limb). Accounts should be annotated with the limb which has been treated. Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used, in addition to botulinum toxin injection(s), to treat the obturator nerve in patients with a dynamic foor deformity.

Treatment under item 18375 or 18379 can only continue if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline from the start of week 6 through to the end of week 12 after the first treatment. The term 'continue' means the patient can be retreated under item 18375 or 18379 at some point after the 12 week period (for example; 6 to 12 months after the first treatment). This requirement is in line with the recommended PBS listing for the supply of the medicine for this indication under Section 100(1)(b) of the *National Health Act 1953*.

Botulinum toxin, which is not supplied and administered in accordance with the arrangements under Section 100 of the *National Health Act 1953*, is not free of charge to patients. Where a charge is made for the botulinum toxin administered, it must be separately listed on the account and not billed to Medicare.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline to substantiate that a patient had a pre-existing condition at the time of the service which is located on the DHS website.

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.

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

Higher rates of benefits are also provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons).

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.

GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES

SUBGROUP 1 - HYPERBARIC OXYGEN THERAPY

13015	HYPERBARIC, OXYGEN THERAPY, for treatment of localised non-neurological soft tissue radiation injuries excluding radiation-induced soft tissue lymphoedema of the arm after treatment for breast cancer, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance. *(See para T1.1 of explanatory notes to this Category)* **Fee:** $254.75	**Benefit:** 75% = $191.10	85% = $216.55
13020	HYPERBARIC OXYGEN THERAPY, for treatment of decompression illness, gas gangrene, air or gas embolism; diabetic wounds including diabetic gangrene and diabetic foot ulcers; necrotising soft tissue infections including necrotising fasciitis or Fournier's gangrene; or for the prevention and treatment of osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance *(See para T1.1 of explanatory notes to this Category)* **Fee:** $258.85	**Benefit:** 75% = $194.15	85% = $220.05
13025	HYPERBARIC OXYGEN THERAPY for treatment of decompression illness, air or gas embolism, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber greater than 3 hours, including any associated attendance - per hour (or part of an hour) *(See para T1.1 of explanatory notes to this Category)* **Fee:** $115.70	**Benefit:** 75% = $86.80	85% = $98.35
13030	HYPERBARIC OXYGEN THERAPY performed in a comprehensive hyperbaric medicine facility where the medical practitioner is pressurised in the hyperbaric chamber for the purpose of providing continuous life saving emergency treatment, including any associated attendance - per hour (or part of an hour) *(See para T1.1 of explanatory notes to this Category)* **Fee:** $163.45	**Benefit:** 75% = $122.60	85% = $138.95

SUBGROUP 2 - DIALYSIS

13100	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day *(See para T1.2 of explanatory notes to this Category)* **Fee:** $136.65	**Benefit:** 75% = $102.50	85% = $116.20
13103	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day *(See para T1.2 of explanatory notes to this Category)* **Fee:** $71.20	**Benefit:** 75% = $53.40	85% = $60.55
13104	Planning and management of home dialysis (either haemodialysis or peritoneal dialysis), by a consultant physician in the practice of his or her specialty of renal medicine, for a patient with end-stage renal disease, and supervision of that patient on self-administered dialysis, to a maximum of 12 claims per year *(See para T1.3 of explanatory notes to this Category)* **Fee:** $147.95	**Benefit:** 85% = $125.80	
13106	DECLOTTING OF AN ARTERIOVENOUS SHUNT **Fee:** $121.35	**Benefit:** 75% = $91.05	85% = $103.15
13109	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.) **Fee:** $227.75	**Benefit:** 75% = $170.85	85% = $193.60
13110	TENCKHOFF PERITONEAL DIALYSIS CATHETER, removal of (including catheter cuffs) (Anaes.) **Fee:** $228.50	**Benefit:** 75% = $171.40	85% = $194.25
13112	PERITONEAL DIALYSIS, establishment of, by abdominal puncture and insertion of temporary catheter (including associated consultation) (Anaes.) **Fee:** $136.65	**Benefit:** 75% = $102.50	85% = $116.20

	SUBGROUP 3 - ASSISTED REPRODUCTIVE SERVICES
13200	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13201, 13202, 13203, 13206, 13218 applies – being services rendered during 1 treatment cycle - INITIAL cycle in a single calendar year *(See para T1.4 of explanatory notes to this Category)* **Fee:** $3,110.75 **Benefit:** 75% = $2,333.10 85% = $3,031.25 **Extended Medicare Safety Net Cap:** $1,675.50
13201	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13202, 13203, 13206, 13218 applies – being services rendered during 1 treatment cycle - each cycle SUBSEQUENT to the first in a single calendar year *(See para T1.4 of explanatory notes to this Category)* **Fee:** $2,909.75 **Benefit:** 75% = $2,182.35 85% = $2,830.25 **Extended Medicare Safety Net Cap:** $2,432.15
13202	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE THAT IS CANCELLED BEFORE OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation and including quantitative estimation of hormones, semen preparation, ultrasound examinations, but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which Item 13200, 13201, 13203, 13206, 13218, applies being services rendered during 1 treatment cycle *(See para T1.4 of explanatory notes to this Category)* **Fee:** $465.55 **Benefit:** 75% = $349.20 85% = $395.75 **Extended Medicare Safety Net Cap:** $64.95
13203	OVULATION MONITORING SERVICES, for artificial insemination – including quantitative estimation of hormones and ultrasound examinations, being services rendered during 1 treatment cycle but excluding a service to which Item 13200, 13201, 13202, 13206, 13212, 13215, 13218, applies *(See para T1.4 of explanatory notes to this Category)* **Fee:** $486.75 **Benefit:** 75% = $365.10 85% = $413.75 **Extended Medicare Safety Net Cap:** $108.15
13206	ASSISTED REPRODUCTIVE TECHNOLOGIES TREATMENT CYCLE using either the natural cycle or oral medication only to induce oocyte growth and development, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, frozen embryo transfer or donated embryos or ova or treatment involving the use of injectable drugs to induce superovulation being services rendered during 1 treatment cycle but only if rendered in conjunction with a service to which item 13212 applies *(See para T1.4 of explanatory notes to this Category)* **Fee:** $465.55 **Benefit:** 75% = $349.20 85% = $395.75 **Extended Medicare Safety Net Cap:** $64.95
13209	PLANNING and MANAGEMENT of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies or for artificial insemination payable once only during 1 treatment cycle *(See para T1.4 of explanatory notes to this Category)* **Fee:** $84.70 **Benefit:** 75% = $63.55 85% = $72.00 **Extended Medicare Safety Net Cap:** $10.90
13210	Professional attendance on a patient by a specialist practising in his or her specialty if: (a) the attendance is by video conference; and (b) item 13209 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies *(See para T1.22 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee for item 13209. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** $5.30

13212	Oocyte retrieval for the purpose of assisted reproductive technologies—only if rendered in connection with a service to which item 13200, 13201 or 13206 applies (Anaes.) *(See para T1.4 of explanatory notes to this Category)* **Fee:** $354.45 **Benefit:** 75% = $265.85 85% = $301.30 **Extended Medicare Safety Net Cap:** $70.35
13215	Transfer of embryos or both ova and sperm to the uterus or fallopian tubes, excluding artificial insemination—only if rendered in connection with a service to which item 13200, 13201, 13206 or 13218 applies, being services rendered in one treatment cycle (Anaes.) *(See para T1.4 of explanatory notes to this Category)* **Fee:** $111.10 **Benefit:** 75% = $83.35 85% = $94.45 **Extended Medicare Safety Net Cap:** $48.70
13218	PREPARATION of frozen or donated embryos or donated oocytes for transfer to the uterus or fallopian tubes, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in 1 treatment cycle and excluding a service to which item 13200, 13201, 13202, 13203, 13206, 13212 applies (Anaes.) *(See para T1.4 of explanatory notes to this Category)* **Fee:** $793.55 **Benefit:** 75% = $595.20 85% = $714.05 **Extended Medicare Safety Net Cap:** $702.65
13221	Preparation of semen for the purpose of artificial insemination—only if rendered in connection with a service to which item 13203 applies *(See para T1.4 of explanatory notes to this Category)* **Fee:** $50.80 **Benefit:** 75% = $38.10 85% = $43.20 **Extended Medicare Safety Net Cap:** $21.70
13251	INTRACYTOPLASMIC SPERM INJECTION for the purposes of assisted reproductive technologies, for male factor infertility, excluding a service to which Item 13203 or 13218 applies *(See para T1.5 of explanatory notes to this Category)* **Fee:** $417.95 **Benefit:** 75% = $313.50 85% = $355.30 **Extended Medicare Safety Net Cap:** $108.15
13290	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required **Fee:** $204.25 **Benefit:** 75% = $153.20 85% = $173.65
13292	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under general anaesthetic, in a hospital (Anaes.) **Fee:** $408.70 **Benefit:** 75% = $306.55 85% = $347.40
	SUBGROUP 4 - PAEDIATRIC & NEONATAL
13300	UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate **Fee:** $56.95 **Benefit:** 75% = $42.75 85% = $48.45
13303	UMBILICAL ARTERY CATHETERISATION with or without infusion **Fee:** $84.40 **Benefit:** 75% = $63.30 85% = $71.75
13306	BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor **Fee:** $334.10 **Benefit:** 75% = $250.60 85% = $284.00
13309	BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already collected **Fee:** $284.85 **Benefit:** 75% = $213.65 85% = $242.15
13312	BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS **Fee:** $28.45 **Benefit:** 75% = $21.35 85% = $24.20
13318	CENTRAL VEIN CATHETERISATION - by open exposure in a person under 12 years of age (Anaes.) *(See para T1.6 of explanatory notes to this Category)* **Fee:** $227.45 **Benefit:** 75% = $170.60 85% = $193.35
13319	CENTRAL VEIN CATHETERISATION in a neonate via peripheral vein (Anaes.) **Fee:** $227.45 **Benefit:** 75% = $170.60 85% = $193.35

	SUBGROUP 5 - CARDIOVASCULAR
13400	RESTORATION OF CARDIAC RHYTHM by electrical stimulation (cardioversion), other than in the course of cardiac surgery (Anaes.) **Fee:** $96.80 **Benefit:** 75% = $72.60 85% = $82.30
	SUBGROUP 6 - GASTROENTEROLOGY
13500	GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant IN THE ABSENCE OF GASTROINTESTINAL HAEMORRHAGE **Fee:** $180.30 **Benefit:** 75% = $135.25 85% = $153.30
13503	GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant FOR UPPER GASTROINTESTINAL HAEMORRHAGE **Fee:** $360.70 **Benefit:** 75% = $270.55 85% = $306.60
13506	GASTRO-OESOPHAGEAL balloon intubation, for control of bleeding from gastric oesophageal varices *(See para T8.2 of explanatory notes to this Category)* **Fee:** $184.50 **Benefit:** 75% = $138.40 85% = $156.85
	SUBGROUP 8 - HAEMATOLOGY
13700	HARVESTING OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the purpose of transplantation (Anaes.) **Fee:** $333.25 **Benefit:** 75% = $249.95 85% = $283.30
13703	TRANSFUSION OF BLOOD, including collection from donor **Fee:** $119.50 **Benefit:** 75% = $89.65 85% = $101.60
13706	TRANSFUSION OF BLOOD or bone marrow already collected *(See para T1.7 of explanatory notes to this Category)* **Fee:** $83.35 **Benefit:** 75% = $62.55 85% = $70.85
13709	COLLECTION OF BLOOD for autologous transfusion or when homologous blood is required for immediate transfusion in emergency situation *(See para T1.8 of explanatory notes to this Category)* **Fee:** $48.45 **Benefit:** 75% = $36.35 85% = $41.20
13750	THERAPEUTIC HAEMAPHERESIS for the removal of plasma or cellular (or both) elements of blood, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies, if performed; continuous monitoring of vital signs, fluid balance, blood volume and other parameters with continuous registered nurse attendance under the supervision of a consultant physician, not being a service associated with a service to which item 13755 applies -payable once per day **Fee:** $136.65 **Benefit:** 75% = $102.50 85% = $116.20
13755	DONOR HAEMAPHERESIS for the collection of blood products for transfusion, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuous registered nurse attendance under the supervision of a consultant physician; not being a service associated with a service to which item 13750 applies - payable once per day **Fee:** $136.65 **Benefit:** 75% = $102.50 85% = $116.20
13757	THERAPEUTIC VENESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda **Fee:** $72.95 **Benefit:** 75% = $54.75 85% = $62.05
13760	IN VITRO PROCESSING (and cryopreservation) of bone marrow or peripheral blood for autologous stem cell transplantation as an adjunct to high dose chemotherapy for: . chemosensitive intermediate or high grade non-Hodgkin's lymphoma at high risk of relapse following first line chemotherapy; or . Hodgkin's disease which has relapsed following, or is refractory to, chemotherapy; or . acute myelogenous leukaemia in first remission, where suitable genotypically matched sibling donor is not available for allogeneic bone marrow transplant; or . multiple myeloma in remission (complete or partial) following standard dose chemotherapy; or . small round cell sarcomas; or . primitive neuroectodermal tumour; or . germ cell tumours which have relapsed following, or are refractory to, chemotherapy; . germ cell tumours which have had an incomplete response to first line therapy. - performed under the supervision of a consultant physician - each day. **Fee:** $762.60 **Benefit:** 75% = $571.95 85% = $683.10

	SUBGROUP 9 - PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT
13815	CENTRAL VEIN CATHETERISATION by percutaneous or open exposure not being a service to which item 13318 applies (Anaes.) *(See para T1.6 of explanatory notes to this Category)* **Fee:** $85.25 **Benefit:** 75% = $63.95 85% = $72.50
13818	RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.) *(See para T1.10 of explanatory notes to this Category)* **Fee:** $113.70 **Benefit:** 75% = $85.30 85% = $96.65
13830	INTRACRANIAL PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician - each day **Fee:** $75.35 **Benefit:** 75% = $56.55 85% = $64.05
13839	ARTERIAL PUNCTURE and collection of blood for diagnostic purposes **Fee:** $23.05 **Benefit:** 75% = $17.30 85% = $19.60
13842	INTRAARTERIAL CANNULATION for the purpose of taking multiple arterial blood samples for blood gas analysis *(See para T1.10 of explanatory notes to this Category)* **Fee:** $69.30 **Benefit:** 75% = $52.00 85% = $58.95
13847	COUNTERPULSATION BY INTRAAORTIC BALLOON management on the first day including initial and subsequent consultations and monitoring of parameters (Anaes.) *(See para T1.10 of explanatory notes to this Category)* **Fee:** $156.10 **Benefit:** 75% = $117.10 85% = $132.70
13848	COUNTERPULSATION BY INTRAAORTIC BALLOON management on each day subsequent to the first, including associated consultations and monitoring of parameters *(See para T1.10 of explanatory notes to this Category)* **Fee:** $131.05 **Benefit:** 75% = $98.30 85% = $111.40
13851	CIRCULATORY SUPPORT DEVICE, management of, on first day **Fee:** $493.65 **Benefit:** 75% = $370.25 85% = $419.65
13854	CIRCULATORY SUPPORT DEVICE, management of, on each day subsequent to the first **Fee:** $114.85 **Benefit:** 75% = $86.15 85% = $97.65
13857	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATION (other than in the context of an anaesthetic for surgery), outside an Intensive Care Unit, for the purpose of subsequent ventilatory support in an Intensive Care Unit *(See para T1.10 of explanatory notes to this Category)* **Fee:** $146.40 **Benefit:** 75% = $109.80 85% = $124.45
	SUBGROUP 10 - MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT
13870	***(Note: See para T1.8 of Explanatory Notes to this Category for definition of an Intensive Care Unit)*** MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on the first day (H) *(See para T1.9 and T1.11 of explanatory notes to this Category)* **Fee:** $362.10 **Benefit:** 75% = $271.60
13873	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including all attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on each day subsequent to the first day (H) *(See para T1.9 and T1.11 of explanatory notes to this Category)* **Fee:** $268.60 **Benefit:** 75% = $201.45

13876	CENTRAL VENOUS PRESSURE, pulmonary arterial pressure, systemic arterial pressure or cardiac intracavity pressure, continuous monitoring by indwelling catheter in an intensive care unit and managed by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - once only for each type of pressure on any calendar day (up to a maximum of 4 pressures) (H) *(See para T1.9 and T1.11 of explanatory notes to this Category)* **Fee:** $76.90 **Benefit:** 75% = $57.70
13881	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATION, in an Intensive Care Unit, not in association with any anaesthetic service, by a specialist or consultant physician for the purpose of subsequent ventilatory support (H) *(See para T1.9 and T1.11 of explanatory notes to this Category)* **Fee:** $146.40 **Benefit:** 75% = $109.80
13882	VENTILATORY SUPPORT in an Intensive Care Unit, management of, by invasive means, or by non-invasive means where the only alternative to non-invasive ventilatory support would be invasive ventilatory support, by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care, each day (H) *(See para T1.9 and T1.11 of explanatory notes to this Category)* **Fee:** $115.25 **Benefit:** 75% = $86.45
13885	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on the first day (H) *(See para T1.9 and T1.11 of explanatory notes to this Category)* **Fee:** $153.65 **Benefit:** 75% = $115.25
13888	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on each day subsequent to the first day (H) *(See para T1.9 and T1.11 of explanatory notes to this Category)* **Fee:** $76.90 **Benefit:** 75% = $57.70
	SUBGROUP 11 - CHEMOTHERAPEUTIC PROCEDURES
13915	CYTOTOXIC CHEMOTHERAPY, administration of, either by intravenous push technique (directly into a vein, or a butterfly needle, or the side-arm of an infusion) or by intravenous infusion of not more than 1 hours duration - payable once only on the same day, not being a service associated with photodynamic therapy with verteporfin or for the administration of drugs used immediately prior to, or with microwave (UHF radiowave) cancer therapy alone *(See para T1.12 of explanatory notes to this Category)* **Fee:** $65.05 **Benefit:** 75% = $48.80 85% = $55.30
13918	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day **Fee:** $97.95 **Benefit:** 75% = $73.50 85% = $83.30
13921	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - for the first day of treatment **Fee:** $110.80 **Benefit:** 75% = $83.10 85% = $94.20
13924	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode **Fee:** $65.25 **Benefit:** 75% = $48.95 85% = $55.50
13927	CYTOTOXIC CHEMOTHERAPY, administration of, either by intra-arterial push technique (directly into an artery, a butterfly needle or the side-arm of an infusion) or by intra-arterial infusion of not more than 1 hours duration - payable once only on the same day **Fee:** $84.40 **Benefit:** 75% = $63.30 85% = $71.75
13930	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day **Fee:** $117.80 **Benefit:** 75% = $88.35 85% = $100.15
13933	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment **Fee:** $130.70 **Benefit:** 75% = $98.05 85% = $111.10
13936	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode **Fee:** $85.15 **Benefit:** 75% = $63.90 85% = $72.40

13939	IMPLANTED PUMP OR RESERVOIR, loading of, with a cytotoxic agent or agents, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies *(See para T1.13 of explanatory notes to this Category)* **Fee:** $97.95 **Benefit:** 75% = $73.50 85% = $83.30
13942	AMBULATORY DRUG DELIVERY DEVICE, loading of, with a cytotoxic agent or agents for the infusion of the agent or agents via the intravenous, intra-arterial or spinal routes, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies *(See para T1.13 of explanatory notes to this Category)* **Fee:** $65.25 **Benefit:** 75% = $48.95 85% = $55.50
13945	LONG-TERM IMPLANTED DRUG DELIVERY DEVICE FOR CYTOTOXIC CHEMOTHERAPY, accessing of **Fee:** $52.50 **Benefit:** 75% = $39.40 85% = $44.65
13948	CYTOTOXIC AGENT, instillation of, into a body cavity **Fee:** $65.25 **Benefit:** 75% = $48.95 85% = $55.50
	SUBGROUP 12 - DERMATOLOGY
14050	PUVA THERAPY or UVB THERAPY administered in whole body cabinet, not being a service associated with a service to which item 14053 applies including associated consultations other than an initial consultation *(See para T1.14 of explanatory notes to this Category)* **Fee:** $52.75 **Benefit:** 75% = $39.60 85% = $44.85
14053	PUVA THERAPY or UVB THERAPY administered to localised body areas in hand and foot cabinet not being a service associated with a service to which item 14050 applies including associated consultations other than an initial consultation *(See para T1.14 of explanatory notes to this Category)* **Fee:** $52.75 **Benefit:** 75% = $39.60 85% = $44.85
14100	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of vascular lesions of the head or neck where abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period (Anaes.) **Fee:** $152.50 **Benefit:** 75% = $114.40 85% = $129.65 **Extended Medicare Safety Net Cap:** $122.00
14106	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), where the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment up to 50cm^2 (Anaes.) *(See para T1.15 of explanatory notes to this Category)* **Fee:** $152.50 **Benefit:** 75% = $114.40 85% = $129.65
14109	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 50cm^2 and up to 100cm^2 (Anaes.) *(See para T1.15 of explanatory notes to this Category)* **Fee:** $187.35 **Benefit:** 75% = $140.55 85% = $159.25
14112	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 100cm^2 and up to 150cm^2 (Anaes.) *(See para T1.15 of explanatory notes to this Category)* **Fee:** $221.75 **Benefit:** 75% = $166.35 85% = $188.50
14115	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 150cm^2 and up to 250cm^2 (Anaes.) *(See para T1.15 of explanatory notes to this Category)* **Fee:** $256.50 **Benefit:** 75% = $192.40 85% = $218.05

MISCELLANEOUS				OTHER
	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 250cm^2 (Anaes.) *(See para T1.15 of explanatory notes to this Category)*			
14118	**Fee:** $325.75	**Benefit:** 75% = $244.35	85% = $276.90	
	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of haemangiomas of infancy, including any associated consultation - ***where a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period*** (Anaes.) *(See para T1.15 of explanatory notes to this Category)*			
14124	**Fee:** $152.50	**Benefit:** 75% = $114.40	85% = $129.65	
	SUBGROUP 13 - OTHER THERAPEUTIC PROCEDURES			
	GASTRIC LAVAGE in the treatment of ingested poison			
14200	**Fee:** $59.80	**Benefit:** 75% = $44.85	85% = $50.85	
	POLY-L-LACTIC ACID, one or more injections of, for the initial session only, for the treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953 - once per patient *(See para T1.17 of explanatory notes to this Category)*			
14201	**Fee:** $236.85 **Extended Medicare Safety Net Cap:** $35.55	**Benefit:** 75% = $177.65	85% = $201.35	
	POLY-L-LACTIC ACID, one or more injections of (subsequent sessions), for the continuation of treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953 *(See para T1.17 of explanatory notes to this Category)*			
14202	**Fee:** $119.90 **Extended Medicare Safety Net Cap:** $18.00	**Benefit:** 75% = $89.95	85% = $101.95	
	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.) *(See para T1.18 of explanatory notes to this Category)*			
14203	**Fee:** $51.15	**Benefit:** 75% = $38.40	85% = $43.50	
	HORMONE OR LIVING TISSUE IMPLANTATION by cannula *(See para T1.18 of explanatory notes to this Category)*			
14206	**Fee:** $35.60	**Benefit:** 75% = $26.70	85% = $30.30	
	INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent			
14209	**Fee:** $88.70	**Benefit:** 75% = $66.55	85% = $75.40	
	INTUSSUSCEPTION, management of fluid or gas reduction for (Anaes.)			
14212	**Fee:** $185.30	**Benefit:** 75% = $139.00	85% = $157.55	
	IMPLANTED INFUSION PUMP REFILLING OF reservoir, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of chronic intractable pain			
14218	**Fee:** $97.95	**Benefit:** 75% = $73.50	85% = $83.30	
	LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of, not being a service associated with a service to which item 13945 applies			
14221	**Fee:** $52.50	**Benefit:** 75% = $39.40	85% = $44.65	
	ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.)			
14224	**Fee:** $70.35	**Benefit:** 75% = $52.80	85% = $59.80	
	IMPLANTED INFUSION PUMP, REFILLING of reservoir, with baclofen, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of severe chronic spasticity *(See para T1.19 of explanatory notes to this Category)*			
14227	**Fee:** $97.95	**Benefit:** 75% = $73.50	85% = $83.30	
	Intrathecal or epidural SPINAL CATHETER insertion or replacement of, for connection to a subcutaneous implanted infusion pump, for the management of severe chronic spasticity with baclofen (Anaes.) (Assist.) *(See para T1.19 of explanatory notes to this Category)*			
14230	**Fee:** $298.05	**Benefit:** 75% = $223.55		

MISCELLANEOUS		OTHER
14233	INFUSION PUMP, subcutaneous implantation or replacement of, and connection to intrathecal or epidural catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.) (Assist.) *(See para T1.19 of explanatory notes to this Category)* **Fee:** $361.90 **Benefit:** 75% = $271.45	
14236	INFUSION PUMP, subcutaneous implantation of, AND intrathecal or epidural SPINAL CATHETER insertion, and connection of pump to catheter and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.) (Assist.) *(See para T1.19 of explanatory notes to this Category)* **Fee:** $659.95 **Benefit:** 75% = $495.00	
14239	Removal of subcutaneously IMPLANTED INFUSION PUMP, OR removal or repositioning of intrathecal or epidural SPINAL CATHETER, for the management of severe chronic spasticity (Anaes.) *(See para T1.19 of explanatory notes to this Category)* **Fee:** $159.40 **Benefit:** 75% = $119.55	
14242	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of severe chronic spasticity (Anaes.) *(See para T1.19 of explanatory notes to this Category)* **Fee:** $473.65 **Benefit:** 75% = $355.25	
14245	IMMUNOMODULATING AGENT, administration of, by intravenous infusion for at least 2 hours duration - payable once only on the same day and where the agent is provided under section 100 of the Pharmaceutical Benefits Scheme *(See para T1.20 of explanatory notes to this Category)* **Fee:** $97.95 **Benefit:** 75% = $73.50 85% = $83.30	

	GROUP T2 - RADIATION ONCOLOGY
	SUBGROUP 1 - SUPERFICIAL
15000	*(Benefits for administration of general anaesthetic for radiotherapy are payable under Group T10)* RADIOTHERAPY, SUPERFICIAL (including treatment with xrays, radium rays or other radioactive substances), not being a service to which another item in this Group applies each attendance at which fractionated treatment is given - 1 field **Fee:** $42.55 **Benefit:** 75% = $31.95 85% = $36.20
15003	- 2 or more fields up to a maximum of 5 additional fields **Derived Fee:** The fee for item 15000 plus for each field in excess of 1, an amount of $17.10
15006	RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied - 1 field **Fee:** $94.35 **Benefit:** 75% = $70.80 85% = $80.20
15009	- 2 or more fields up to a maximum of 5 additional fields **Derived Fee:** The fee for item 15006 plus for each field in excess of 1, an amount of $18.55
15012	RADIOTHERAPY, SUPERFICIAL each attendance at which treatment is given to an eye **Fee:** $53.45 **Benefit:** 75% = $40.10 85% = $45.45
	SUBGROUP 2 - ORTHOVOLTAGE
15100	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 3 or more treatments per week - 1 field **Fee:** $47.70 **Benefit:** 75% = $35.80 85% = $40.55
15103	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15100 plus for each field in excess of 1, an amount of $18.80
15106	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 1 field **Fee:** $56.30 **Benefit:** 75% = $42.25 85% = $47.90
15109	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15106 plus for each field in excess of 1, an amount of $22.70
15112	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field **Fee:** $120.25 **Benefit:** 75% = $90.20 85% = $102.25
15115	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15112 plus for each field in excess of 1, an amount of $47.30
	SUBGROUP 3 - MEGAVOLTAGE
15211	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given - 1 field **Fee:** $54.70 **Benefit:** 75% = $41.05 85% = $46.50
15214	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15211 plus for each field in excess of 1, an amount of $31.90
15215	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung) **Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75
15218	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate) **Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75

RADIATION ONCOLOGY	MEGAVOLTAGE
15221	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (breast) **Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75
15224	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15215, 15218 and 15221 **Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75
15227	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site **Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75
15230	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung) **Derived Fee:** The fee for item 15215 plus for each field in excess of 1, an amount of $37.95
15233	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate) **Derived Fee:** The fee for item 15218 plus for each field in excess of 1, an amount of $37.95
15236	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast) **Derived Fee:** The fee for item 15221 plus for each field in excess of 1, an amount of $37.95
15239	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15230, 15233 or 15236 **Derived Fee:** The fee for item 15224 plus for each field in excess of 1, an amount of $37.95
15242	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site **Derived Fee:** The fee for item 15227 plus for each field in excess of 1, an amount of $37.95
15245	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung) **Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75
15248	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate) **Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75
15251	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (breast) **Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75
15254	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15245, 15248 or 15251 **Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75
15257	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site **Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75
15260	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung) **Derived Fee:** The fee for item 15245 plus for each field in excess of 1, an amount of $37.95

15263	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate) **Derived Fee:** The fee for item 15248 plus for each field in excess of 1, an amount of $37.95
15266	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast) **Derived Fee:** The fee for item 15251 plus for each field in excess of 1, an amount of $37.95
15269	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15260, 15263 or 15266 **Derived Fee:** The fee for item 15254 plus for each field in excess of 1, an amount of $37.95
15272	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site **Derived Fee:** The fee for item 15257 plus for each field in excess of 1, an amount of $37.95
	SUBGROUP 4 - BRACHYTHERAPY
15303	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $357.00 **Benefit:** 75% = $267.75 85% = $303.45
15304	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $357.00 **Benefit:** 75% = $267.75 85% = $303.45
15307	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) **Fee:** $676.80 **Benefit:** 75% = $507.60 85% = $597.30
15308	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) **Fee:** $676.80 **Benefit:** 75% = $507.60 85% = $597.30
15311	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $333.20 **Benefit:** 75% = $249.90 85% = $283.25
15312	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $330.80 **Benefit:** 75% = $248.10 85% = $281.20
15315	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) **Fee:** $654.25 **Benefit:** 75% = $490.70 85% = $574.75
15316	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) **Fee:** $654.25 **Benefit:** 75% = $490.70 85% = $574.75
15319	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15
15320	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15
15323	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) **Fee:** $722.00 **Benefit:** 75% = $541.50 85% = $642.50

15324	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) **Fee:** $722.00 **Benefit:** 75% = $541.50 85% = $642.50
15327	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using manual afterloading techniques (Anaes.) **Fee:** $785.45 **Benefit:** 75% = $589.10 85% = $705.95
15328	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using automatic afterloading techniques (Anaes.) **Fee:** $785.45 **Benefit:** 75% = $589.10 85% = $705.95
15331	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using manual afterloading techniques (Anaes.) **Fee:** $745.80 **Benefit:** 75% = $559.35 85% = $666.30
15332	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using automatic afterloading techniques (Anaes.) **Fee:** $745.80 **Benefit:** 75% = $559.35 85% = $666.30
15335	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using manual afterloading techniques (Anaes.) **Fee:** $676.80 **Benefit:** 75% = $507.60 85% = $597.30
15336	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using automatic afterloading techniques (Anaes.) **Fee:** $676.80 **Benefit:** 75% = $507.60 85% = $597.30
15338	PROSTATE, radioactive seed implantation of, radiation oncology component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate), with a Gleason score of less than or equal to 7 and a prostate specific antigen (PSA) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed at an approved site in association with a urologist. *(See para T2.2 of explanatory notes to this Category)* **Fee:** $935.60 **Benefit:** 75% = $701.70 85% = $856.10
15339	REMOVAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural or spinal nerve block (Anaes.) **Fee:** $76.20 **Benefit:** 75% = $57.15 85% = $64.80
15342	CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a half-life of greater than 115 days, to treat intracavity, intraoral or intranasal site **Fee:** $190.30 **Benefit:** 75% = $142.75 85% = $161.80
15345	CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a half-life of less than 115 days including iodine, gold, iridium or tantalum to treat intracavity, intraoral or intranasal sites **Fee:** $507.80 **Benefit:** 75% = $380.85 85% = $431.65
15348	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345 each attendance **Fee:** $58.40 **Benefit:** 75% = $43.80 85% = $49.65
15351	CONSTRUCTION WITH OR WITHOUT INITIAL APPLICATION OF RADIOACTIVE MOULD not exceeding 5 cm. diameter to an external surface **Fee:** $116.60 **Benefit:** 75% = $87.45 85% = $99.15
15354	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface **Fee:** $141.50 **Benefit:** 75% = $106.15 85% = $120.30
15357	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15351 or 15354 each attendance **Fee:** $40.05 **Benefit:** 75% = $30.05 85% = $34.05

	SUBGROUP 5 - COMPUTERISED PLANNING
	RADIOTHERAPY PLANNING
15500	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15509 applies) *(See para T2.3 of explanatory notes to this Category)* **Fee:** $242.65 **Benefit:** 75% = $182.00 85% = $206.30
15503	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15512 applies) *(See para T2.3 of explanatory notes to this Category)* **Fee:** $311.55 **Benefit:** 75% = $233.70 85% = $264.85
15506	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15515 applies) *(See para T2.3 of explanatory notes to this Category)* **Fee:** $465.30 **Benefit:** 75% = $349.00 85% = $395.55
15509	RADIATION FIELD SETTING using a diagnostic xray unit of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15500 applies) *(See para T2.3 of explanatory notes to this Category)* **Fee:** $210.30 **Benefit:** 75% = $157.75 85% = $178.80
15512	RADIATION FIELD SETTING using a diagnostic xray unit of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15503 applies) *(See para T2.3 of explanatory notes to this Category)* **Fee:** $271.10 **Benefit:** 75% = $203.35 85% = $230.45
15513	RADIATION SOURCE LOCALISATION using a simulator or x-ray machine or CT of a single area, where views in more than 1 plane are required, for brachytherapy treatment planning for I125 seed implantation of localised prostate cancer, in association with item 15338 **Fee:** $306.55 **Benefit:** 75% = $229.95 85% = $260.60
15515	RADIATION FIELD SETTING using a diagnostic xray unit of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15506 applies) *(See para T2.3 of explanatory notes to this Category)* **Fee:** $392.50 **Benefit:** 75% = $294.40 85% = $333.65
15518	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks *(See para T2.3 of explanatory notes to this Category)* **Fee:** $77.00 **Benefit:** 75% = $57.75 85% = $65.45
15521	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used *(See para T2.3 of explanatory notes to this Category)* **Fee:** $339.90 **Benefit:** 75% = $254.95 85% = $288.95
15524	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields *(See para T2.3 of explanatory notes to this Category)* **Fee:** $637.35 **Benefit:** 75% = $478.05 85% = $557.85
15527	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks *(See para T2.3 of explanatory notes to this Category)* **Fee:** $78.95 **Benefit:** 75% = $59.25 85% = $67.15
15530	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used *(See para T2.3 of explanatory notes to this Category)* **Fee:** $352.15 **Benefit:** 75% = $264.15 85% = $299.35

	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields, or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields *(See para T2.3 of explanatory notes to this Category)*		
15533	**Fee:** $667.70	**Benefit:** 75% = $500.80	85% = $588.20
	BRACHYTHERAPY PLANNING, computerised radiation dosimetry *(See para T2.3 of explanatory notes to this Category)*		
15536	**Fee:** $266.90	**Benefit:** 75% = $200.20	85% = $226.90
	BRACHYTHERAPY PLANNING, computerised radiation dosimetry for I125 seed implantation of localised prostate cancer, in association with item 15338		
15539	**Fee:** $627.30	**Benefit:** 75% = $470.50	85% = $547.80
	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY without intravenous contrast medium, where: (a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and (b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and (c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and (d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images *(See para T2.3 of explanatory notes to this Category)*		
15550	**Fee:** $658.60	**Benefit:** 75% = $493.95	85% = $579.10
	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY pre and post intravenous contrast medium, where: (a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and (b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and (c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and (d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images *(See para T2.3 of explanatory notes to this Category)*		
15553	**Fee:** $710.55	**Benefit:** 75% = $532.95	85% = $631.05
	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 1 COMPLEXITY where: (a) dosimetry for a single phase three dimensional conformal treatment plan using CT image volume dataset and having a single treatment target volume and organ at risk; and (b) one gross tumour volume or clinical target volume, plus one planning target volume plus at least one relevant organ at risk as defined in the prescription must be rendered as volumes; and (c) the organ at risk must be nominated as a planning dose goal or constraint and the prescription must specify the organ at risk dose goal or constraint; and (d) dose volume histograms must be generated, approved and recorded with the plan; and (e) a CT image volume dataset must be used for the relevant region to be planned and treated; and (f) the CT images must be suitable for the generation of quality digitally reconstructed radiographic images *(See para T2.3 of explanatory notes to this Category)*		
15556	**Fee:** $664.40	**Benefit:** 75% = $498.30	85% = $584.90
	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 2 COMPLEXITY where: (a) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, two planning target volumes and one organ at risk defined in the prescription; or (b) dosimetry for a one phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, one planning target volume and two organ at risk dose goals or constraints defined in the prescription; or (c) image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 1 complexity. All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images *(See para T2.3 of explanatory notes to this Category)*		
15559	**Fee:** $866.55	**Benefit:** 75% = $649.95	85% = $787.05

	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 3 COMPLEXITY - where: (a) dosimetry for a three or more phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, three planning target volumes and one organ at risk defined in the prescription; or (b) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, and (i) two planning target volumes; or (ii) two organ at risk dose goals or constraints defined in the prescription. or (c) dosimetry for a one phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, one planning target volume and three organ at risk dose goals or constraints defined in the prescription; or (d) image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 2 complexity. All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images *(See para T2.3 of explanatory notes to this Category)*
15562	**Fee:** $1,120.75 **Benefit:** 75% = $840.60 85% = $1,041.25
	SUBGROUP 6 - STEREOTACTIC RADIOSURGERY
	STEREOTACTIC RADIOSURGERY, including all radiation oncology consultations, planning, simulation, dosimetry and treatment
15600	**Fee:** $1,702.30 **Benefit:** 75% = $1,276.75 85% = $1,622.80
	SUBGROUP 7 - RADIATION ONCOLOGY TREATMENT VERIFICATION
	RADIATION ONCOLOGY TREATMENT VERIFICATION - single projection (with single or double exposures) – when prescribed and reviewed by a radiation oncologist and not associated with item 15705 or 15710 - each attendance at which treatment is verified (ie maximum one per attendance). *(See para T2.4 of explanatory notes to this Category)*
15700	**Fee:** $45.95 **Benefit:** 75% = $34.50 85% = $39.10
	RADIATION ONCOLOGY TREATMENT VERIFICATION - multiple projection acquisition when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15710 - each attendance at which treatment involving three or more fields is verified (ie maximum one per attendance). *(See para T2.4 of explanatory notes to this Category)*
15705	**Fee:** $76.60 **Benefit:** 75% = $57.45 85% = $65.15
	RADIATION ONCOLOGY TREATMENT VERIFICATION - volumetric acquisition, when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15705 – each attendance at which treatment involving three fields or more is verified (ie maximum one per attendance). (see para T2.5 of explanatory notes to this Category)
15710	**Fee:** $76.60 **Benefit:** 75% = $57.45 85% = $65.15
	SUBGROUP 8 - BRACHYTHERAPY PLANNING AND VERIFICATION
	BRACHYTHERAPY TREATMENT VERIFICATION – maximum of one only for each attendance. *(See para T2.4 of explanatory notes to this Category)*
15800	**Fee:** $96.30 **Benefit:** 75% = $72.25 85% = $81.90
	RADIATION SOURCE LOCALISATION using a simulator, x-ray machine, CT or ultrasound of a single area, where views in more than one plane are required, for brachytherapy treatment planning, not being a service to which Item 15513 applies.
15850	**Fee:** $199.50 **Benefit:** 75% = $149.65 85% = $169.60

	SUBGROUP 10 - TARGETTED INTRAOPERATIVE RADIOTHERAPY
	INTRAOPERATIVE RADIOTHERAPY
15900	BREAST, MALIGNANT TUMOUR, targeted intraoperative radiotherapy, using an Intrabeam® device, delivered at the time of breast-conserving surgery (partial mastectomy or lumpectomy) for a patient who: a) is 45 years of age or more; and b) has a T1 or small T2 (less than or equal to 3cm in diameter) primary tumour; and c) has an histologic Grade 1 or 2 tumour; and d) has an oestrogen-receptor positive tumour; and e) has a node negative malignancy; and f) is suitable for wide local excision of a primary invasive ductal carcinoma that was diagnosed as unifocal on conventional examination and imaging; and g) has no contra-indications to breast irradiation **Fee:** $250.00 **Benefit:** 75% = $187.50

	GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE
16003	INTRACAVITY ADMINISTRATION OF A THERAPEUTIC DOSE OF YTTRIUM 90 not including preliminary paracentesis, not being a service associated with selective internal radiation therapy or to which item 35404, 35406 or 35408 applies (Anaes.) *(See para T3.1 of explanatory notes to this Category)* **Fee:** $650.50 **Benefit:** 75% = $487.90 85% = $571.00
16006	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique **Fee:** $499.85 **Benefit:** 75% = $374.90 85% = $424.90
16009	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique **Fee:** $341.15 **Benefit:** 75% = $255.90 85% = $290.00
16012	INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32 **Fee:** $295.15 **Benefit:** 75% = $221.40 85% = $250.90
16015	ADMINISTRATION OF STRONTIUM 89 for painful bony metastases from carcinoma of the prostate where hormone therapy has failed and either: (i) the disease is poorly controlled by conventional radiotherapy; or (ii) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain **Fee:** $4,085.70 **Benefit:** 75% = $3,064.30 85% = $4,006.20
16018	ADMINISTRATION OF ^{153} SM-LEXIDRONAM for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan) where hormonal therapy and/or chemotherapy have failed and either the disease is poorly controlled by conventional radiotherapy or conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain. **Fee:** $2,442.45 **Benefit:** 75% = $1,831.85 85% = $2,362.95

	GROUP T4 - OBSTETRICS
16399	Professional attendance on a patient by a specialist practising in his or her specialty of obstetrics if: (a) the attendance is by video conference; and (b) item 16401, 16404, 16406, 16500, 16590 or 16591 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies *(See para T4.12 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee for item 16401,16404,16406,16500,16590 or 16591. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** $24.10
16400	**ANTENATAL CARE** Antenatal service provided by a midwife, nurse or an Aboriginal and Torres Strait Islander health practitioner if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; (b) the service is provided at, or from, a practice location in a regional, rural or remote area RRMA 3-7; (c) the service is not performed in conjunction with another antenatal attendance item (same patient, same practitioner on the same day); (d) the service is not provided for an admitted patient of a hospital; and to a maximum of 10 service per pregnancy *(See para T4.1 of explanatory notes to this Category)* **Fee:** $27.25 **Benefit:** 85% = $23.20 **Extended Medicare Safety Net Cap:** $11.05
16401	OBSTETRIC SPECIALIST, REFERRED CONSULTATION - SURGERY OR HOSPITAL Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics, after referral of the patient to him or her - each INITIAL attendance, in a single course of treatment - not being a service to which item 104 applies. **Fee:** $85.55 **Benefit:** 75% = $64.20 85% = $72.75 **Extended Medicare Safety Net Cap:** $54.90
16404	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics after referral of the patient to him or her - each attendance SUBSEQUENT to the first attendance in a single course of treatment. **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55 **Extended Medicare Safety Net Cap:** $32.95
16406	32-36 WEEK OBSTETRIC VISIT Antenatal professional attendance, as part of a single course of treatment, at 32-36 weeks of the patient's pregnancy when the patient is referred by a participating midwife. Payable only once for a pregnancy. **Fee:** $133.95 **Benefit:** 75% = $100.50 85% = $113.90 **Extended Medicare Safety Net Cap:** $108.15
16500	ANTENATAL ATTENDANCE *(See para T4.3 of explanatory notes to this Category)* **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10 **Extended Medicare Safety Net Cap:** $32.95
16501	EXTERNAL CEPHALIC VERSION for breech presentation, after 36 weeks where no contraindication exists, in a Unit with facilities for Caesarean Section, including pre- and post version CTG, with or without tocolysis, not being a service to which items 55718 to 55728 and 55768 to 55774 apply - chargeable whether or not the version is successful and limited to a maximum of 2 ECV's per pregnancy *(See para T4.4 of explanatory notes to this Category)* **Fee:** $140.55 **Benefit:** 75% = $105.45 85% = $119.50 **Extended Medicare Safety Net Cap:** $65.90

16502	POLYHYDRAMNIOS, UNSTABLE LIE, MULTIPLE PREGNANCY, PREGNANCY COMPLICATED BY DIABETES OR ANAEMIA, THREATENED PREMATURE LABOUR treated by bed rest only or oral medication, requiring admission to hospital each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10 **Extended Medicare Safety Net Cap:** $22.00
16504	TREATMENT OF HABITUAL MISCARRIAGE by injection of hormones each injection up to a maximum of 12 injections, where the injection is not administered during a routine antenatal attendance **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10 **Extended Medicare Safety Net Cap:** $22.00
16505	THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10 **Extended Medicare Safety Net Cap:** $22.00
16508	PREGNANCY COMPLICATED BY acute intercurrent infection, intrauterine growth retardation, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10 **Extended Medicare Safety Net Cap:** $22.00
16509	PREECLAMPSIA, ECLAMPSIA OR ANTEPARTUM HAEMORRHAGE, treatment of each attendance that is not a routine antenatal attendance **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10 **Extended Medicare Safety Net Cap:** $22.00
16511	CERVIX, purse string ligation of (Anaes.) **Fee:** $219.95 **Benefit:** 75% = $165.00 85% = $187.00 **Extended Medicare Safety Net Cap:** $109.75
16512	CERVIX, removal of purse string ligature of (Anaes.) **Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00 **Extended Medicare Safety Net Cap:** $32.95
16514	ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement) **Fee:** $36.65 **Benefit:** 75% = $27.50 85% = $31.20 **Extended Medicare Safety Net Cap:** $16.55
	MANAGEMENT OF LABOUR AND DELIVERY
16515	MANAGEMENT OF VAGINAL DELIVERY as an independent procedure where the patient's care has been transferred by another medical practitioner for management of the delivery and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the delivery (Anaes.) *(See para T4.5 of explanatory notes to this Category)* **Fee:** $450.65 **Benefit:** 75% = $338.00 85% = $383.10 **Extended Medicare Safety Net Cap:** $175.60
16518	MANAGEMENT OF LABOUR, incomplete, where the patient's care has been transferred to another medical practitioner for completion of the delivery (Anaes.) *(See para T4.5 of explanatory notes to this Category)* **Fee:** $450.65 **Benefit:** 75% = $338.00 85% = $383.10 **Extended Medicare Safety Net Cap:** $175.60
16519	MANAGEMENT OF LABOUR and delivery by any means (including Caesarean section) including post-partum care for 5 days (Anaes.) *(See para T4.5 of explanatory notes to this Category)* **Fee:** $693.95 **Benefit:** 75% = $520.50 85% = $614.45 **Extended Medicare Safety Net Cap:** $329.15
16520	CAESAREAN SECTION and post-operative care for 7 days where the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.) *(See para T4.6 of explanatory notes to this Category)* **Fee:** $811.05 **Benefit:** 75% = $608.30 85% = $731.55 **Extended Medicare Safety Net Cap:** $329.15

16522	MANAGEMENT OF LABOUR AND DELIVERY, or delivery alone, (including Caesarean section), where in the course of antenatal supervision or intrapartum management 1 or more of the following conditions is present, including postnatal care for 7 days: - multiple pregnancy; - recurrent antepartum haemorrhage from 20 weeks gestation; - grades 2, 3 or 4 placenta praevia; - baby with a birth weight less than or equal to 2500gm; - pre-existing diabetes mellitus dependent on medication, or gestational diabetes requiring at least daily blood glucose monitoring; - trial of vaginal delivery in a patient with uterine scar, or trial of vaginal breech delivery; - pre-existing hypertension requiring antihypertensive medication, or pregnancy induced hypertension of at least 140/90mm Hg associated with at least 1+ proteinuria on urinalysis; - prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress; - fetal distress defined by significant cardiotocograph or scalp pH abnormalities requiring immediate delivery; OR - conditions that pose a significant risk of maternal death. (Anaes.) *(See para T4.7 of explanatory notes to this Category)* **Fee:** $1,629.35 **Benefit:** 75% = $1,222.05 85% = $1,549.85 **Extended Medicare Safety Net Cap:** $438.90
16525	MANAGEMENT OF SECOND TRIMESTER LABOUR, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease, not being a service to which item 35643 applies (Anaes.) *(See para T4.5 of explanatory notes to this Category)* **Fee:** $384.35 **Benefit:** 75% = $288.30 85% = $326.70 **Extended Medicare Safety Net Cap:** $153.70
16527	MANAGEMENT OF VAGINAL DELIVERY, if the patient's care has been transferred by a participating midwife for management of the delivery, including all attendances related to the delivery. Payable once only for a pregnancy. (Anaes.) *(See para T4.8 of explanatory notes to this Category)* **Fee:** $450.65 **Benefit:** 75% = $338.00 85% = $383.10 **Extended Medicare Safety Net Cap:** $175.60
16528	CAESAREAN SECTION and post-operative care for 7 days, if the patient's care has been transferred by a participating midwife for management of the birth. Payable once only for a pregnancy. (Anaes.) *(See para T4.8 of explanatory notes to this Category)* **Fee:** $811.05 **Benefit:** 75% = $608.30 85% = $731.55 **Extended Medicare Safety Net Cap:** $329.15
	POST-PARTUM CARE
16564	EVACUATION OF RETAINED PRODUCTS OF CONCEPTION (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.) *(See para T4.10 of explanatory notes to this Category)* **Fee:** $218.00 **Benefit:** 75% = $163.50 85% = $185.30 **Extended Medicare Safety Net Cap:** $219.45
16567	MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure (Anaes.) *(See para T4.10 of explanatory notes to this Category)* **Fee:** $318.80 **Benefit:** 75% = $239.10 85% = $271.00 **Extended Medicare Safety Net Cap:** $219.45
16570	ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure (Anaes.) *(See para T4.10 of explanatory notes to this Category)* **Fee:** $416.05 **Benefit:** 75% = $312.05 85% = $353.65 **Extended Medicare Safety Net Cap:** $219.45
16571	CERVIX, repair of extensive laceration or lacerations (Anaes.) *(See para T4.10 of explanatory notes to this Category)* **Fee:** $318.80 **Benefit:** 75% = $239.10 85% = $271.00 **Extended Medicare Safety Net Cap:** $219.45
16573	THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.) *(See para T4.10 of explanatory notes to this Category)* **Fee:** $259.80 **Benefit:** 75% = $194.85 85% = $220.85 **Extended Medicare Safety Net Cap:** $219.45

16590	Planning and management of a pregnancy that has progressed beyond 20 weeks provided the fee does not include any amount for the management of the labour and delivery, payable once only for any pregnancy that has progressed beyond 20 weeks where the practitioner intends to undertake the delivery for a privately admitted patient, not being a service to which item 16591 applies. **Fee:** $324.10 **Benefit:** 75% = $243.10 85% = $275.50 **Extended Medicare Safety Net Cap:** $219.45
16591	Planning and management of a pregnancy that has progressed beyond 20 weeks provided the fee does not include any amount for the management of the labour and delivery if the care of the patient will be transferred to another medical practitioner, payable once only for any pregnancy that has progressed beyond 20 weeks, not being a service to which item 16590 applies. **Fee:** $142.65 **Benefit:** 75% = $107.00 85% = $121.30 **Extended Medicare Safety Net Cap:** $109.75
	INTERVENTIONAL TECHNIQUES
16600	AMNIOCENTESIS, diagnostic *(See para T4.11 of explanatory notes to this Category)* **Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00 **Extended Medicare Safety Net Cap:** $32.95
16603	CHORIONIC VILLUS SAMPLING, by any route *(See para T4.11 of explanatory notes to this Category)* **Fee:** $121.85 **Benefit:** 75% = $91.40 85% = $103.60 **Extended Medicare Safety Net Cap:** $65.90
16606	FOETAL BLOOD SAMPLING, using interventional techniques from umbilical cord or foetus, including foetal neuromuscular blockade and amniocentesis (Anaes.) *(See para T4.11 of explanatory notes to this Category)* **Fee:** $243.25 **Benefit:** 75% = $182.45 85% = $206.80 **Extended Medicare Safety Net Cap:** $131.75
16609	FOETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling (Anaes.) *(See para T4.11 of explanatory notes to this Category)* **Fee:** $496.00 **Benefit:** 75% = $372.00 85% = $421.60 **Extended Medicare Safety Net Cap:** $252.40
16612	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - not performed in conjunction with a service described in item 16609 (Anaes.) *(See para T4.11 of explanatory notes to this Category)* **Fee:** $390.25 **Benefit:** 75% = $292.70 85% = $331.75
16615	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes.) *(See para T4.11 of explanatory notes to this Category)* **Fee:** $207.85 **Benefit:** 75% = $155.90 85% = $176.70
16618	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated *(See para T4.11 of explanatory notes to this Category)* **Fee:** $207.85 **Benefit:** 75% = $155.90 85% = $176.70 **Extended Medicare Safety Net Cap:** $104.30
16621	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios *(See para T4.11 of explanatory notes to this Category)* **Fee:** $207.85 **Benefit:** 75% = $155.90 85% = $176.70
16624	FOETAL FLUID FILLED CAVITY, drainage of *(See para T4.11 of explanatory notes to this Category)* **Fee:** $299.10 **Benefit:** 75% = $224.35 85% = $254.25 **Extended Medicare Safety Net Cap:** $142.65
16627	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis *(See para T4.11 of explanatory notes to this Category)* **Fee:** $608.95 **Benefit:** 75% = $456.75 85% = $529.45 **Extended Medicare Safety Net Cap:** $307.25

16633	PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16606, 16609, 16612, 16615 and 16627 *(See para T4.11 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee for the first foetus for any additional foetus tested **Extended Medicare Safety Net Cap:** $230.50
16636	PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16600, 16603, 16618, 16621 and 16624 *(See para T4.11 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee for the first foetus for any additional foetus tested **Extended Medicare Safety Net Cap:** $87.85

GROUP T6 - ANAESTHETICS

SUBGROUP 1 - ANAESTHESIA CONSULTATIONS

Professional attendance on a patient by a specialist practising in his or her specialty of anaesthesia if:
(a) the attendance is by video conference; and
(b) item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655 applies to the attendance; and
(c) the patient is not an admitted patient; and
(d) the patient:
(i) is located both:
(A) within a telehealth eligible area; and
(B) at the time of the attendance—at least 15 kms by road from the specialist; or
(ii) is a care recipient in a residential care service; or
(iii) is a patient of:
(A) an Aboriginal Medical Service; or
(B) an Aboriginal Community Controlled Health Service;
for which a direction made under subsection 19 (2) of the Act applies

(See para T6.4 of explanatory notes to this Category)
Derived Fee: 50% of the fee for item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655. Benefit: 85% of the derived fee
17609 **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500, whichever is the lesser amount

ANAESTHETIST, PRE-ANAESTHESIA CONSULTATION

(Professional attendance by a medical practitioner in the practice of ANAESTHESIA)

– a BRIEF consultation involving a targeted history and limited examination (including the cardio-respiratory system)

- *AND of not more than 15 minutes s duration,* not being a service associated with a service to which items 2801 - 3000 apply

(See para T6.1 of explanatory notes to this Category)
Fee: $43.00 **Benefit:** 75% = $32.25 85% = $36.55
17610 **Extended Medicare Safety Net Cap:** $129.00

- a consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a selective history and an extensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes

- *AND of more than 15 minutes but not more than 30 minutes duration,* not being a service associated with a service to which items 2801 - 3000 applies

(See para T6.1 of explanatory notes to this Category)
Fee: $85.55 **Benefit:** 75% = $64.20 85% = $72.75
17615 **Extended Medicare Safety Net Cap:** $256.65

- a consultation on a patient undergoing advanced surgery or who has complex medical problems involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes

- *AND of more than 30 minutes but not more than 45 minutes duration,* not being a service associated with a service to which items 2801 - 3000 apply

(See para T6.1 of explanatory notes to this Category)
Fee: $118.50 **Benefit:** 75% = $88.90 85% = $100.75
17620 **Extended Medicare Safety Net Cap:** $355.50

- a consultation on a patient undergoing advanced surgery or who has complex medical problems involving an exhaustive history and comprehensive examination of multiple systems , the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity documented in the patient notes

- *AND of more than 45 minutes duration,* not being a service associated with a service to which items 2801 – 3000 apply

(See para T6.1 of explanatory notes to this Category)
Fee: $150.90 **Benefit:** 75% = $113.20 85% = $128.30
17625 **Extended Medicare Safety Net Cap:** $452.70

	ANAESTHETIST, REFERRED CONSULTATION (other than prior to anaesthesia) (Professional attendance by a specialist anaesthetist in the practice of ANAESTHESIA where the patient is referred to him or her) - a BRIEF consultation involving a short history and limited examination - *AND of not more than 15 minutes duration*, not being a service associated with a service to which items 2801 – 3000 apply *(See para T6.2 of explanatory notes to this Category)* **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55 17640 **Extended Medicare Safety Net Cap:** $129.00
	- a consultation involving a selective history and examination of multiple systems and the formulation of a written patient management plan - *AND of more than 15 minutes but not more than 30 minutes duration,* not being a service associated with a service to which items 2801 – 3000 apply. *(See para T6.2 of explanatory notes to this Category)* **Fee:** $85.55 **Benefit:** 75% = $64.20 85% = $72.75 17645 **Extended Medicare Safety Net Cap:** $256.65
	- a consultation involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan - *AND of more than 30 minutes but not more than 45 minutes duration,* not being a service associated with a service to which items 2801 – 3000 apply *(See para T6.2 of explanatory notes to this Category)* **Fee:** $118.50 **Benefit:** 75% = $88.90 85% = $100.75 17650 **Extended Medicare Safety Net Cap:** $355.50
	- a consultation involving an exhaustive history and comprehensive examination of multiple systems and the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity, - *AND of more than 45 minutes duration,* not being a service associated with a service to which items 2801 – 3000 apply. *(See para T6.2 of explanatory notes to this Category)* **Fee:** $150.90 **Benefit:** 75% = $113.20 85% = $128.30 17655 **Extended Medicare Safety Net Cap:** $452.70
	ANAESTHETIST, CONSULTATION, OTHER (Professional attendance by an anaesthetist in the practice of ANAESTHESIA) - a consultation immediately prior to the institution of a major regional blockade in a patient in labour, where no previous anaesthesia consultation has occurred, not being a service associated with a service to which items 2801 – 3000 apply. *(See para T6.3 of explanatory notes to this Category)* **Fee:** $85.55 **Benefit:** 75% = $64.20 85% = $72.75 17680 **Extended Medicare Safety Net Cap:** $256.65
	- Where a pre-anaesthesia consultation covered by an item in the range 17615-17625 is performed in-rooms if: (a) the service is provided to a patient prior to an admitted patient episode of care involving anaesthesia; and (b) the service is not provided to an admitted patient of a hospital; and (c) the service is not provided on the day of admission to hospital for the subsequent episode of care involving anaesthesia services; and (d) the service is of more than 15 minutes duration not being a service associated with a service to which items 2801 – 3000 apply. *(See para T6.3 of explanatory notes to this Category)* **Fee:** $39.55 **Benefit:** 75% = $29.70 85% = $33.65 17690 **Extended Medicare Safety Net Cap:** $118.65

GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS

18213	INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion **Fee:** $88.65 **Benefit:** 75% = $66.50 85% = $75.40
18216	INTRATHECAL OR EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner (Anaes.) **Fee:** $189.90 **Benefit:** 75% = $142.45 85% = $161.45
18219	INTRATHECAL or EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, where continuous attendance by the medical practitioner extends beyond the first hour (Anaes.) **Derived Fee:** The fee for item 18216 plus $19.00 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner.
18222	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is 15 minutes or less *(See para T7.2 of explanatory notes to this Category)* **Fee:** $37.65 **Benefit:** 75% = $28.25 85% = $32.05
18225	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is more than 15 minutes *(See para T7.2 of explanatory notes to this Category)* **Fee:** $50.05 **Benefit:** 75% = $37.55 85% = $42.55
18226	**INTRATHECAL OR EPIDURAL INFUSION** of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner, **for a patient in labour**, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday. *(See para T7.4 of explanatory notes to this Category)* **Fee:** $284.80 **Benefit:** 75% = $213.60 85% = $242.10
18227	**INTRATHECAL OR EPIDURAL INFUSION** of a therapeutic substance, initial injection or commencement of, where continuous attendance by a medical practitioner extends beyond the first hour, **for a patient in labour**, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday. *(See para T7.4 of explanatory notes to this Category)* **Derived Fee:** The fee for item 18226 plus $28.60 for each additional 15 minutes or part there of beyond the first hour of attendance by the medical practitioner.
18228	INTERPLEURAL BLOCK, initial injection or commencement of infusion of a therapeutic substance **Fee:** $62.50 **Benefit:** 75% = $46.90 85% = $53.15
18230	INTRATHECAL or EPIDURAL INJECTION of neurolytic substance (Anaes.) **Fee:** $238.45 **Benefit:** 75% = $178.85 85% = $202.70
18232	INTRATHECAL or EPIDURAL INJECTION of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies (Anaes.) *(See para T7.3 of explanatory notes to this Category)* **Fee:** $189.90 **Benefit:** 75% = $142.45 85% = $161.45
18233	EPIDURAL INJECTION of blood for blood patch (Anaes.) **Fee:** $189.90 **Benefit:** 75% = $142.45 85% = $161.45
18234	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $124.85 **Benefit:** 75% = $93.65 85% = $106.15
18236	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $62.50 **Benefit:** 75% = $46.90 85% = $53.15
18238	FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies *(See para T7.5 of explanatory notes to this Category)* **Fee:** $37.65 **Benefit:** 75% = $28.25 85% = $32.05
18240	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $93.60 **Benefit:** 75% = $70.20 85% = $79.60

18242	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $37.65	**Benefit:** 75% = $28.25	85% = $32.05
18244	VAGUS NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $100.80	**Benefit:** 75% = $75.60	85% = $85.70
18246	GLOSSOPHARYNGEAL NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $100.80	**Benefit:** 75% = $75.60	85% = $85.70
18248	PHRENIC NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $88.65	**Benefit:** 75% = $66.50	85% = $75.40
18250	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $62.50	**Benefit:** 75% = $46.90	85% = $53.15
18252	CERVICAL PLEXUS, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $100.80	**Benefit:** 75% = $75.60	85% = $85.70
18254	BRACHIAL PLEXUS, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $100.80	**Benefit:** 75% = $75.60	85% = $85.70
18256	SUPRASCAPULAR NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $62.50	**Benefit:** 75% = $46.90	85% = $53.15
18258	INTERCOSTAL NERVE (single), injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $62.50	**Benefit:** 75% = $46.90	85% = $53.15
18260	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $88.65	**Benefit:** 75% = $66.50	85% = $75.40
18262	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $62.50	**Benefit:** 75% = $46.90	85% = $53.15
18264	PUDENDAL NERVE and or dorsal nerve, injection of anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $100.80	**Benefit:** 75% = $75.60	85% = $85.70
18266	ULNAR, RADIAL OR MEDIAN NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent, not being associated with a brachial plexus block *(See para T7.5 of explanatory notes to this Category)* **Fee:** $62.50	**Benefit:** 75% = $46.90	85% = $53.15
18268	OBTURATOR NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $88.65	**Benefit:** 75% = $66.50	85% = $75.40
18270	FEMORAL NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $88.65	**Benefit:** 75% = $66.50	85% = $75.40
18272	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $62.50	**Benefit:** 75% = $46.90	85% = $53.15

18274	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $88.65	**Benefit:** 75% = $66.50	85% = $75.40
18276	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $124.85	**Benefit:** 75% = $93.65	85% = $106.15
18278	SCIATIC NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $88.65	**Benefit:** 75% = $66.50	85% = $75.40
18280	SPHENOPALATINE GANGLION, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $124.85	**Benefit:** 75% = $93.65	85% = $106.15
18282	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure *(See para T7.5 of explanatory notes to this Category)* **Fee:** $100.80	**Benefit:** 75% = $75.60	85% = $85.70
18284	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $147.65	**Benefit:** 75% = $110.75	85% = $125.55
18286	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $147.65	**Benefit:** 75% = $110.75	85% = $125.55
18288	COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $147.65	**Benefit:** 75% = $110.75	85% = $125.55
18290	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent, not being a service associated with the injection of botulinum toxin (Anaes.) **Fee:** $249.75	**Benefit:** 75% = $187.35	85% = $212.30
18292	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies or a service associated with the injection of botulinum toxin except those services to which item 18354 applies (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $124.85	**Benefit:** 75% = $93.65	85% = $106.15
18294	COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (Anaes.) **Fee:** $176.00	**Benefit:** 75% = $132.00	85% = $149.60
18296	LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.) **Fee:** $150.55	**Benefit:** 75% = $112.95	85% = $128.00
18298	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.) **Fee:** $176.00	**Benefit:** 75% = $132.00	85% = $149.60

GROUP T11 - BOTULINUM TOXIN INJECTIONS

18350	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of hemifacial spasm in a patient who is at least 12 years of age, including all such injections on any one day *(See para T11.1 of explanatory notes to this Category)* **Fee:** $124.85 **Benefit:** 75% = $93.65 85% = $106.15
18351	Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport), injection of, for the treatment of hemifacial spasm in a patient who is at least 18 years of age, including all such injections on any one day *(See para T11.1 of explanatory notes to this Category)* **Fee:** $124.85 **Benefit:** 75% = $93.65 85% = $106.15
18353	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of cervical dystonia (spasmodic torticollis), including all such injections on any one day *(See para T1.11 of explanatory notes to this Category)* **Fee:** $249.75 **Benefit:** 75% = $187.35 85% = $212.30
18354	Botulinum Toxin Type A Purified Neurotixin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport), injection of, for the treatment of dynamic equinus foot deformity (including equinovarus and equinovalgus) due to spasticity in an ambulant cerebral palsy patient, if: (a) the patient is at least 2 years of age; and (b) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each lower limb), including all injections per set (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $124.85 **Benefit:** 75% = $93.65 85% = $106.15
18360	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of moderate to severe focal spasticity, if: (a) the patient is at least 18 years of age; and (b) the spasticity is associated with a previously diagnosed neurological disorder; and (c) treatment is provided as: (i) second line therapy when standard treatment for the conditions has failed; or (ii) an adjunct to physical therapy; and (d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each limb), including all injections per set; and (e) the treatment is not provided on the same occasion as a service mentioned in item 18365 *(See para T11.1 of explanatory notes to this Category)* **Fee:** $124.85 **Benefit:** 75% = $93.65 85% = $106.15
18361	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of moderate to severe upper limb spasticity due to cerebral palsy if: (a) the patient is at least 2 years of age, and (b) for a patient who is at least 18 years of age - before the patient turned 18, the patient had commenced treatment for the spasticity with botulinum toxin supplied under the pharmaceutical benefits scheme; and (c) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $124.85 **Benefit:** 75% = $93.65 85% = $106.15
18362	Botulinum Toxin type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of severe primary axillary hyperhidrosis, including all injections on any one day, if: (a) the patient is at least 12 years of age; and (b) the patient has been intolerant of, or has not responded to, topical aluminium chloride hexahydrate; and (c) the patient has not had treatment with botulinum toxin within the immediately preceding 4 months; and (d) if the patient has had treatment with botulinum toxin within the previous 12 months - the patient had treatment on no more than 2 separate occasions (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $246.70 **Benefit:** 75% = $185.05 85% = $209.70

BOTULINUM TOXIN INJECTIONS		BOTULINUM TOXIN INJECTIONS
18365	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of moderate to severe spasticity of the upper limb following a stroke, if: (a) the patient is at least 18 years of age; and (b) treatment is provided as: (i) second line therapy when standard treatment for the condition has failed; or (ii) an adjunct to physical therapy; and (c) the patient does not have established severe contracture in the limb that is to be treated; and (d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set; and (e) for a patient who has received treatment on 2 previous separate occasions - the patient has responded to the treatment *(See para T11.1 of explanatory notes to this Category)* **Fee:** $124.85 **Benefit:** 75% = $93.65 85% = $106.15
18366	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of strabismus, including all such injections on any one day and associated electromyography (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $156.40 **Benefit:** 75% = $117.30 85% = $132.95
18368	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day *(See para T11.1 of explanatory notes to this Category)* **Fee:** $267.05 **Benefit:** 75% = $200.30 85% = $227.00
18369	Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $45.05 **Benefit:** 75% = $33.80 85% = $38.30
18370	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 12 years of age, including all such injections on any one day (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $45.05 **Benefit:** 75% = $33.80 85% = $38.30
18372	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of bilateral blepharospasm, in a patient who is at least 12 years of age; including all such injections on any one day (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $124.85 **Benefit:** 75% = $93.65 85% = $106.15
18374	Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of bilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $124.85 **Benefit:** 75% = $93.65 85% = $106.15

18375	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesical injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if: (a) the urinary incontinence is due to neurogenic detrusor overactivity as demonstrated by urodynamic study of a patient with: (i) multiple sclerosis; or (ii) spinal cord injury; or (iii) spina bifida and who is at least 18 years of age; and (b) the patient has urinary incontinence that is inadequately controlled by anti-cholinergic therapy, as manifested by having experienced at least 14 episodes of urinary incontinence per week before commencement of treatment with botulinum toxin type A; and (c) the patient is willing and able to self-catheterise; and (d) the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with; and (e) treatment is not provided on the same occasion as a service described in item 104, 105, 110, 116, 119, 11900 or 11919 For each patient - applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $229.85 **Benefit:** 75% = $172.40
18377	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of chronic migraine, including all injections in 1 day, if: (a) the patient is at least 18 years of age; and (b) the patient has experienced an inadequate response, intolerance or contraindication to at least 3 prophylactic migraine medications before commencement of treatment with botulinum toxin, as manifested by an average of 15 or more headache days per month, with at least 8 days of migraine, over a period of at least 6 months, before commencement of treatment with botulinum toxin; and (c) the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with For each patient—applicable not more than twice except if the patient achieves and maintains at least a 50% reduction in the number of headache days per month from baseline after 2 treatment cycles (each of 12 weeks duration) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $124.85 **Benefit:** 75% = $93.65 85% = $106.15
18379	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesical injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if: (a) the urinary incontinence is due to idiopathic overactive bladder in a patient: and (b) the patient is at least 18 years of age; and (c) the patient has urinary incontinence that is inadequately controlled by at least 2 alternative anti-cholinergic agents, as manifested by having experienced at least 14 episodes of urinary incontinence per week before commencement of treatment with botulinum toxin; and (d) the patient is willing and able to self-catheterise; and (e) treatment is not provided on the same occasion as a service mentioned in item 104, 105, 110, 116, 119, 11900 or 11919 For each patient—applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment (H) (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $229.85 **Benefit:** 75% = $172.40

	GROUP T10 - RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE
	SUBGROUP 1 - HEAD
20100	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin, subcutaneous tissue, muscles, salivary glands or superficial vessels of the head including biopsy, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20102	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for plastic repair of cleft lip (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20104	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for electroconvulsive therapy (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20120	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on external, middle or inner ear, including biopsy, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20124	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for otoscopy (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20140	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on eye, not being a service to which another item in this Group applies (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20142	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lens surgery (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 **Extended Medicare Safety Net Cap:** $95.05
20143	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for retinal surgery (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20144	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for corneal transplant (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
20145	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vitrectomy (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
20146	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for biopsy of conjunctiva (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20147	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for squint repair (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20148	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for ophthalmoscopy (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20160	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nose or accessory sinuses, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20162	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical surgery on the nose and accessory sinuses (7 basic units) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
20164	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for biopsy of soft tissue of the nose and accessory sinuses (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20170	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for intraoral procedures, including biopsy, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20172	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of cleft palate (7 basic units) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85

20174	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision of retropharyngeal tumour (9 basic units) **Fee:** $178.20 **Benefit:** 75% = $133.65 85% = $151.50
20176	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical intraoral surgery (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20190	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on facial bones, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20192	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20210	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for intracranial procedures, not being a service to which another item in this Subgroup applies (15 basic units) **Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45
20212	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for subdural taps (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20214	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for burr holes of the cranium (9 basic units) **Fee:** $178.20 **Benefit:** 75% = $133.65 85% = $151.50
20216	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities (20 basic units) **Fee:** $396.00 **Benefit:** 75% = $297.00 85% = $336.60
20220	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for spinal fluid shunt procedures (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20222	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for ablation of an intracranial nerve (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20225	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for all cranial bone procedures (12 basic units) **Fee:** $237.60 **Benefit:** 75% = $178.20 85% = $202.00
20230	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the head or face (12 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $237.60 **Benefit:** 75% = $178.20 85% = $202.00
	SUBGROUP 2 - NECK
20300	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the neck not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20305	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for incision and drainage of large haematoma, large abscess, cellulitis or similar lesion or epiglottitis causing life threatening airway obstruction (15 basic units) **Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45
20320	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on oesophagus, thyroid, larynx, trachea, lymphatic system, muscles, nerves or other deep tissues of the neck, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20321	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20330	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for laser surgery to the airway (excluding nose and mouth) (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65

20350	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on major vessels of neck, not being a service to which another item in this Subgroup applies (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20352	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for simple ligation of major vessels of neck (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20355	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the neck (12 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $237.60 **Benefit:** 75% = $178.20 85% = $202.00
	SUBGROUP 3 - THORAX
20400	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
20401	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the breast, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20402	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for reconstructive procedures on breast (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20403	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for removal of breast lump or for breast segmentectomy where axillary node dissection is performed (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20404	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for mastectomy (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20405	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for reconstructive procedures on the breast using myocutaneous flaps (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
20406	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical or modified radical procedures on breast with internal mammary node dissection (13 basic units) **Fee:** $257.40 **Benefit:** 75% = $193.05 85% = $218.80
20410	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for electrical conversion of arrhythmias (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20420	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the posterior part of the chest not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20440	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow biopsy of the sternum (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20450	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on clavicle, scapula or sternum, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20452	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical surgery on clavicle, scapula or sternum (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20470	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for partial rib resection, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20472	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for thoracoplasty (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20474	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical procedures on chest wall (13 basic units) *(See para T10.22 of explanatory notes to this Category)* **Fee:** $257.40 **Benefit:** 75% = $193.05 85% = $218.80

20475	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the anterior or posterior thorax (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
	SUBGROUP 4 - INTRATHORACIC
20500	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on the oesophagus (15 basic units) **Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45
20520	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for all closed chest procedures (including rigid oesophagoscopy or bronchoscopy), not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20522	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for needle biopsy of pleura (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20524	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for pneumocentesis (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20526	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for thoracoscopy (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20528	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for mediastinoscopy (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
20540	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for thoracotomy procedures involving lungs, pleura, diaphragm, or mediastinum, not being a service to which another item in this Subgroup applies (13 basic units) **Fee:** $257.40 **Benefit:** 75% = $193.05 85% = $218.80
20542	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for pulmonary decortication (15 basic units) **Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45
20546	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for pulmonary resection with thoracoplasty (15 basic units) **Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45
20548	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for intrathoracic repair of trauma to trachea and bronchi (15 basic units) **Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45
20560	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on the heart, pericardium or great vessels of chest (20 basic units) **Fee:** $396.00 **Benefit:** 75% = $297.00 85% = $336.60
	SUBGROUP 5 - SPINE AND SPINAL CORD
20600	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on cervical spine and/or cord, not being a service to which another item in this Subgroup applies (for myelography and discography see Items 21908 and 21914) (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20604	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for posterior cervical laminectomy with the patient in the sitting position (13 basic units) **Fee:** $257.40 **Benefit:** 75% = $193.05 85% = $218.80
20620	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on thoracic spine and/or cord, not being a service to which another item in this Subgroup applies (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20622	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for thoracolumbar sympathectomy (13 basic units) **Fee:** $257.40 **Benefit:** 75% = $193.05 85% = $218.80
20630	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures in lumbar region, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
20632	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lumbar sympathectomy (7 basic units) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85

20634	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for chemonucleolysis (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20670	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for extensive spine and/or spinal cord procedures (13 basic units) *(See para T10.23 of explanatory notes to this Category)* **Fee:** $257.40 **Benefit:** 75% = $193.05 85% = $218.80
20680	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for manipulation of spine when performed in the operating theatre of a hospital (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
20690	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous spinal procedures, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
	SUBGROUP 6 - UPPER ABDOMEN
20700	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the upper anterior abdominal wall, not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
20702	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous liver biopsy (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20703	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for all procedures on the nerves, muscles, tendons and fascia of the upper abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20704	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20705	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for diagnostic laparoscopy procedures (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20706	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for laparoscopic procedures in the upper abdomen, not being a service to which another item in this Subgroup applies (7 basic units) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
20730	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20740	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for upper gastrointestinal endoscopic procedures (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20745	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20750	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for hernia repairs in upper abdomen, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20752	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of incisional hernia and/or wound dehiscence (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20754	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on an omphalocele (7 basic units) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
20756	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for transabdominal repair of diaphragmatic hernia (9 basic units) **Fee:** $178.20 **Benefit:** 75% = $133.65 85% = $151.50

20770	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on major upper abdominal blood vessels (15 basic units) **Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45
20790	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures within the peritoneal cavity in upper abdomen including cholecystectomy, gastrectomy, laparoscopic nephrectomy or bowel shunts (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
20791	Initiation of the management of anaesthesia for bariatric surgery in a patient with clinically severe obesity (10 basic units) *(See para T8.30 of explanatory notes to this Category)* **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20792	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for partial hepatectomy (excluding liver biopsy) (13 basic units) **Fee:** $257.40 **Benefit:** 75% = $193.05 85% = $218.80
20793	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for extended or trisegmental hepatectomy (15 basic units) **Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45
20794	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for pancreatectomy, partial or total (12 basic units) **Fee:** $237.60 **Benefit:** 75% = $178.20 85% = $202.00
20798	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for neuro endocrine tumour removal in the upper abdomen (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20799	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous procedures on an intra-abdominal organ in the upper abdomen (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
	SUBGROUP 7 - LOWER ABDOMEN
20800	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the lower anterior abdominal walls, not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
20802	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lipectomy of the lower abdomen (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20803	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for all procedures on the nerves, muscles, tendons and fascia of the lower abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20804	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20805	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for diagnostic laparoscopic procedures (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20806	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for laparoscopic procedures in the lower abdomen (7 basic units) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
20810	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lower intestinal endoscopic procedures (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20815	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for extracorporeal shock wave lithotripsy to urinary tract (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20820	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20830	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for hernia repairs in lower abdomen, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35

20832	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of incisional herniae and/or wound dehiscence of the lower abdomen (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20840	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for all procedures within the peritoneal cavity in lower abdomen including appendicectomy, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20841	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bowel resection, including laparoscopic bowel resection not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
20842	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for amniocentesis (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20844	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20845	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical prostatectomy (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20846	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical hysterectomy (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20847	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for ovarian malignancy (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20848	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for pelvic exenteration (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20850	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for Caesarean section (12 basic units) **Fee:** $237.60 **Benefit:** 75% = $178.20 85% = $202.00
20855	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for Caesarean hysterectomy or hysterectomy within 24 hours of delivery. (15 basic units) **Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45
20860	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for extraperitoneal procedures in lower abdomen, including those on the urinary tract, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20862	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for renal procedures, including upper 1/3 of ureter (7 basic units) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
20863	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for nephrectomy (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20864	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total cystectomy (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20866	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for adrenalectomy (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20867	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for neuro endocrine tumour removal in the lower abdomen (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20868	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for renal transplantation (donor or recipient) (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20880	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on major lower abdominal vessels, not being a service to which another item in this subgroup applies (15 basic units) **Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45
20882	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for inferior vena cava ligation (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30

20884	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous umbrella insertion (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20886	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous procedures on an intra-abdominal organ in the lower abdomen (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
	SUBGROUP 8 - PERINEUM
20900	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the perineum not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
20902	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for anorectal procedures (including endoscopy and/or biopsy) (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20904	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical perineal procedures including radical perineal prostatectomy or radical vulvectomy (7 basic units) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
20905	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the perineum (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20906	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vulvectomy (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20910	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for transurethral procedures (including urethrocystoscopy), not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20911	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for endoscopic ureteroscopic surgery including laser procedures (5 basic units) *(See para T10.29 of explanatory notes to this Category)* **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20912	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for transurethral resection of bladder tumour(s) (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20914	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for transurethral resection of prostate (7 basic units) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
20916	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bleeding post-transurethral resection (7 basic units) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
20920	**Initiation of management of anaesthesia** for procedures on external genitalia, not being a service to which another item in this Subgroup applies. (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20924	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on undescended testis, unilateral or bilateral (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20926	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical orchidectomy, inguinal approach (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20928	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical orchidectomy, abdominal approach (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20930	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for orchiopexy, unilateral or bilateral (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20932	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for complete amputation of penis (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35

20934	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for complete amputation of penis with bilateral inguinal lymphadenectomy (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20936	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
20938	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for insertion of penile prosthesis (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20940	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for per vagina and vaginal procedures (including biopsy of vagina, cervix or endometrium), not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20942	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vaginal procedures including repair operations and urinary incontinence procedures (perineal) (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20943	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for transvaginal assisted reproductive services (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20944	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vaginal hysterectomy (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
20946	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vaginal delivery (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
20948	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for purse string ligation of cervix, or removal of purse string ligature (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20950	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for culdoscopy (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20952	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for hysteroscopy (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20953	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for endometrial ablation or resection in association with hysteroscopy (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20954	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for correction of inverted uterus (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
20956	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for evacuation of retained products of conception, as a complication of confinement (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
20958	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for manual removal of retained placenta or for repair of vaginal or perineal tear following delivery (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
20960	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vaginal procedures in the management of post partum haemorrhage (blood loss > 500mls) (7 basic units) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
	SUBGROUP 9 - PELVIS (EXCEPT HIP)
21100	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the anterior pelvic region (anterior to iliac crest), except external genitalia (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
21110	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15

21112	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units) **Fee:** $79.20	**Benefit:** 75% = $59.40	85% = $67.35
21114	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units) **Fee:** $99.00	**Benefit:** 75% = $74.25	85% = $84.15
21116	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow harvesting from the pelvis (6 basic units) **Fee:** $118.80	**Benefit:** 75% = $89.10	85% = $101.00
21120	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the bony pelvis (6 basic units) **Fee:** $118.80	**Benefit:** 75% = $89.10	85% = $101.00
21130	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for body cast application or revision when performed in the operating theatre of a hospital (3 basic units) **Fee:** $59.40	**Benefit:** 75% = $44.55	85% = $50.50
21140	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for interpelviabdominal (hind-quarter) amputation (15 basic units) **Fee:** $297.00	**Benefit:** 75% = $222.75	85% = $252.45
21150	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical procedures for tumour of the pelvis, except hind-quarter amputation (10 basic units) **Fee:** $198.00	**Benefit:** 75% = $148.50	85% = $168.30
21155	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the anterior or posterior pelvis (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $198.00	**Benefit:** 75% = $148.50	85% = $168.30
21160	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures involving symphysis pubis or sacroiliac joint when performed in the operating theatre of a hospital (4 basic units) **Fee:** $79.20	**Benefit:** 75% = $59.40	85% = $67.35
21170	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures involving symphysis pubis or sacroiliac joint (8 basic units) **Fee:** $158.40	**Benefit:** 75% = $118.80	85% = $134.65
	SUBGROUP 10 - UPPER LEG (EXCEPT KNEE)		
21195	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the upper leg (3 basic units) **Fee:** $59.40	**Benefit:** 75% = $44.55	85% = $50.50
21199	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (4 basic units) **Fee:** $79.20	**Benefit:** 75% = $59.40	85% = $67.35
21200	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures involving hip joint when performed in the operating theatre of a hospital (4 basic units) **Fee:** $79.20	**Benefit:** 75% = $59.40	85% = $67.35
21202	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of the hip joint (4 basic units) **Fee:** $79.20	**Benefit:** 75% = $59.40	85% = $67.35
21210	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures involving hip joint, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $118.80	**Benefit:** 75% = $89.10	85% = $101.00
21212	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for hip disarticulation (10 basic units) **Fee:** $198.00	**Benefit:** 75% = $148.50	85% = $168.30
21214	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total hip replacement or revision (10 basic units) **Fee:** $198.00	**Benefit:** 75% = $148.50	85% = $168.30

21216	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bilateral total hip replacement (14 basic units) **Fee:** $277.20 **Benefit:** 75% = $207.90 85% = $235.65
21220	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures involving upper 2/3 of femur when performed in the operating theatre of a hospital (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21230	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures involving upper 2/3 of femur, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
21232	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for above knee amputation (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21234	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical resection of the upper 2/3 of femur (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
21260	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures involving veins of upper leg, including exploration (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21270	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures involving arteries of upper leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
21272	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for femoral artery ligation (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21274	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for femoral artery embolectomy (6 basic units) *(See para T10.24 of explanatory notes to this Category)* **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
21275	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the upper leg (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
21280	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of upper leg (15 basic units) **Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45
	SUBGROUP 11 - KNEE AND POPLITEAL AREA
21300	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the knee and/or popliteal area (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
21321	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, fascia or bursae of knee and/or popliteal area (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21340	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on lower 1/3 of femur when performed in the operating theatre of a hospital (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21360	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on lower 1/3 of femur (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21380	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on knee joint when performed in the operating theatre of a hospital (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
21382	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of knee joint (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21390	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on upper ends of tibia, fibula, and/or patella when performed in the operating theatre of a hospital (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50

21392	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on upper ends of tibia, fibula, and/or patella (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21400	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on knee joint, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21402	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for knee replacement (7 basic units) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
21403	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bilateral knee replacement (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
21404	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for disarticulation of knee (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21420	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for cast application, removal, or repair involving knee joint, undertaken in a hospital (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
21430	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on veins of knee or popliteal area, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21432	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of arteriovenous fistula of knee or popliteal area (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21440	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on arteries of knee or popliteal area, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
21445	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the knee and/or popliteal area (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
	SUBGROUP 12 - LOWER LEG (BELOW KNEE)
21460	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of lower leg, ankle, or foot (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
21461	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, or fascia of lower leg, ankle, or foot, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21462	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on lower leg, ankle, or foot (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
21464	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedure of ankle joint (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21472	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of Achilles tendon (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21474	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for gastrocnemius recession (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21480	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on bones of lower leg, ankle, or foot, including amputation, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21482	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical resection of bone involving lower leg, ankle or foot (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15

21484	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for osteotomy or osteoplasty of tibia or fibula (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21486	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total ankle replacement (7 basic units) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
21490	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lower leg cast application, removal or repair, undertaken in a hospital (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
21500	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on arteries of lower leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
21502	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for embolectomy of the lower leg (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
21520	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on veins of lower leg, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21522	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for venous thrombectomy of the lower leg (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21530	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of lower leg, ankle or foot (15 basic units) **Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45
21532	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of toe (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
21535	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the lower leg (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
	SUBGROUP 13 - SHOULDER AND AXILLA
21600	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
21610	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21620	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, or shoulder joint when performed in the operating theatre of a hospital (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21622	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of shoulder joint (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21630	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21632	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
21634	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for shoulder disarticulation (9 basic units) **Fee:** $178.20 **Benefit:** 75% = $133.65 85% = $151.50
21636	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for interthoracoscapular (forequarter) amputation (15 basic units) **Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45

21638	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total shoulder replacement (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
21650	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on arteries of shoulder or axilla, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
21652	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures for axillary-brachial aneurysm (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
21654	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bypass graft of arteries of shoulder or axilla (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
21656	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for axillary-femoral bypass graft (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
21670	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on veins of shoulder or axilla (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21680	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for shoulder cast application, removal or repair, not being a service to which another item in this Subgroup applies, when undertaken in a hospital (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
21682	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for shoulder spica application when undertaken in a hospital (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21685	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the shoulder or the axilla (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
	SUBGROUP 14 - UPPER ARM AND ELBOW
21700	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the upper arm or elbow (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
21710	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, fascia or bursae of upper arm or elbow, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21712	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open tenotomy of the upper arm or elbow (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21714	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for tenoplasty of the upper arm or elbow (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21716	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for tenodesis for rupture of long tendon of biceps (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21730	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on the upper arm or elbow when performed in the operating theatre of a hospital (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
21732	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of elbow joint (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21740	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on the upper arm or elbow, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21756	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical procedures on the upper arm or elbow (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
21760	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total elbow replacement (7 basic units) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85

21770	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on arteries of upper arm, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $158.40	**Benefit:** 75% = $118.80	85% = $134.65
21772	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for embolectomy of arteries of the upper arm (6 basic units) **Fee:** $118.80	**Benefit:** 75% = $89.10	85% = $101.00
21780	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on veins of upper arm, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $79.20	**Benefit:** 75% = $59.40	85% = $67.35
21785	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the upper arm or elbow (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $198.00	**Benefit:** 75% = $148.50	85% = $168.30
21790	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of upper arm (15 basic units) **Fee:** $297.00	**Benefit:** 75% = $222.75	85% = $252.45
	SUBGROUP 15 - FOREARM WRIST AND HAND		
21800	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the forearm, wrist or hand (3 basic units) **Fee:** $59.40	**Benefit:** 75% = $44.55	85% = $50.50
21810	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand (4 basic units) **Fee:** $79.20	**Benefit:** 75% = $59.40	85% = $67.35
21820	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on the radius, ulna, wrist, or hand bones when performed in the operating theatre of a hospital (3 basic units) **Fee:** $59.40	**Benefit:** 75% = $44.55	85% = $50.50
21830	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on the radius, ulna, wrist, or hand bones, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $79.20	**Benefit:** 75% = $59.40	85% = $67.35
21832	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total wrist replacement (7 basic units) **Fee:** $138.60	**Benefit:** 75% = $103.95	85% = $117.85
21834	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of the wrist joint (4 basic units) **Fee:** $79.20	**Benefit:** 75% = $59.40	85% = $67.35
21840	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the arteries of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $158.40	**Benefit:** 75% = $118.80	85% = $134.65
21842	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for embolectomy of artery of forearm, wrist or hand (6 basic units) **Fee:** $118.80	**Benefit:** 75% = $89.10	85% = $101.00
21850	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the veins of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $79.20	**Benefit:** 75% = $59.40	85% = $67.35
21860	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for forearm, wrist, or hand cast application, removal, or repair when rendered to a patient as part of an episode of hospital treatment (3 basic units) **Fee:** $59.40	**Benefit:** 75% = $44.55	85% = $50.50
21865	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the forearm, wrist or hand (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $198.00	**Benefit:** 75% = $148.50	85% = $168.30
21870	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of forearm, wrist or hand (15 basic units) **Fee:** $297.00	**Benefit:** 75% = $222.75	85% = $252.45

21872	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of a finger (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
	SUBGROUP 16 - ANAESTHESIA FOR BURNS
21878	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting where the area of burn involves not more than 3% of total body surface (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
21879	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting,where the area of burn involves more than 3% but less than 10% of total body surface (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21880	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 10% or more but less than 20% of total body surface (7 basic units) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
21881	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 20% or more but less than 30% of total body surface (9 basic units) **Fee:** $178.20 **Benefit:** 75% = $133.65 85% = $151.50
21882	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 30% or more but less than 40% of total body surface (11 basic units) **Fee:** $217.80 **Benefit:** 75% = $163.35 85% = $185.15
21883	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 40% or more but less than 50% of total body surface (13 basic units) **Fee:** $257.40 **Benefit:** 75% = $193.05 85% = $218.80
21884	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 50% or more but less than 60% of total body surface (15 basic units) **Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45
21885	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 60% or more but less than 70% of total body surface (17 basic units) **Fee:** $336.60 **Benefit:** 75% = $252.45 85% = $286.15
21886	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 70% or more but less than 80% of total body surface (19 basic units) **Fee:** $376.20 **Benefit:** 75% = $282.15 85% = $319.80
21887	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 80% or more of total body surface (21 basic units) **Fee:** $415.80 **Benefit:** 75% = $311.85 85% = $353.45
	SUBGROUP 17 - ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES
21900	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for hysterosalpingography (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
21906	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for myelography: lumbar or thoracic (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21908	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for myelography: cervical (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
21910	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for myelography: posterior fossa (9 basic units) **Fee:** $178.20 **Benefit:** 75% = $133.65 85% = $151.50
21912	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for discography: lumbar or thoracic (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15

21914	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for discography: cervical (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
21915	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for peripheral arteriogram (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21916	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arteriograms: cerebral, carotid or vertebral (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21918	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for retrograde arteriogram: brachial or femoral (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21922	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (7 basic units) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
21925	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for retrograde cystography, retrograde urethrography or retrograde cystourethrography (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21926	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for fluoroscopy (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21927	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for barium enema or other opaque study of the small bowel (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21930	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bronchography (6 basic units) **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
21935	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for phlebography (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21936	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for heart, 2 dimensional real time transoesophageal examination (6 basic units) *(See para T10.26 of explanatory notes to this Category)* **Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00
21939	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for peripheral venous cannulation (3 basic units) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
21941	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for cardiac catheterisation including coronary arteriography, ventriculography, cardiac mapping, insertion of automatic defibrillator or transvenous pacemaker (7 basic units) *(See para T10.25 of explanatory notes to this Category)* **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
21942	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for cardiac electrophysiological procedures including radio frequency ablation (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
21943	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for central vein catheterisation or insertion of right heart balloon catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21945	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lumbar puncture, cisternal puncture, or epidural injection (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21949	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for harvesting of bone marrow for the purpose of transplantation (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21952	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for muscle biopsy for malignant hyperpyrexia (10 basic units) **Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30
21955	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for electroencephalography (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15

21959	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for brain stem evoked response audiometry (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21962	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for electrocochleography by extratympanic method or transtympanic membrane insertion method (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21965	**INITIATION OF MANAGEMENT OF ANAESTHESIA** as a therapeutic procedure **where it can be demonstrated that there is a clinical need for anaesthesia, not for the treatment of headache of any etiology** (5 basic units) *(See para T10.11 of explanatory notes to this Category)* **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21969	**INITIATION OF MANAGEMENT OF ANAESTHESIA** during hyperbaric therapy where the medical practitioner is not confined in the chamber (including the administration of oxygen) (8 basic units) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
21970	**INITIATION OF MANAGEMENT OF ANAESTHESIA** during hyperbaric therapy where the medical practitioner is confined in the chamber (including the administration of oxygen) (15 basic units) **Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45
21973	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for brachytherapy using radioactive sealed sources (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21976	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for therapeutic nuclear medicine (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21980	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radiotherapy (5 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
21981	**ANAESTHETIC AGENT ALLERGY TESTING**, using skin sensitivity methods in a patient with a history of prior anaphylactic or anaphylactoid reaction or cardiovascular collapse associated with the management of anaesthesia agents (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
	SUBGROUP 18 - MISCELLANEOUS
21990	**INITIATION OF MANAGEMENT OF ANAESTHESIA** when no procedure ensues (3 basic units) *(See para T10.12 of explanatory notes to this Category)* **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
21992	**INITIATION OF MANAGEMENT OF ANAESTHESIA** performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
21997	**INITIATION OF MANAGEMENT OF ANAESTHESIA** in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic rebate, not being a service to which item 21992 or 21965 applies **where it can be demonstrated that there is a clinical need for anaesthesia** (4 basic units) *(See para T10.13 of explanatory notes to this Category)* **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
	SUBGROUP 19 - THERAPEUTIC AND DIAGNOSTIC SERVICES
22001	**COLLECTION OF BLOOD FOR AUTOLOGOUS TRANSFUSION** or when homologous blood is required for immediate transfusion in an emergency situation, **when performed in association with the administration of anaesthesia** (3 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
22002	**ADMINISTRATION OF BLOOD** or bone marrow already collected **when performed in association with the administration of anaesthesia** (4 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
22007	**ENDOTRACHEAL INTUBATION** with flexible fibreoptic scope associated with difficult airway **when performed in association with the administration of anaesthesia** (4 basic units) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35

22008	**DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER,** insertion of when **performed in association with the administration of anaesthesia** (4 basic units) **Fee:** $79.20	**Benefit:** 75% = $59.40	85% = $67.35
22012	**BLOOD PRESSURE MONITORING** (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - once only for each type of pressure on any calendar day, up to a maximum of 4 pressures (not being a service to which item 13876 applies) **when performed in association with the administration of anaesthesia** (3 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $59.40	**Benefit:** 75% = $44.55	85% = $50.50
22014	**BLOOD PRESSURE MONITORING** (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - once only for each type of pressure on any calendar day, up to a maximum of 4 pressures (not being a service to which item 13876 applies) **when performed in association with the administration of anaesthesia relating to another discrete operation on the same day** (3 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $59.40	**Benefit:** 75% = $44.55	85% = $50.50
22015	**RIGHT HEART BALLOON CATHETER,** insertion of, including pulmonary wedge pressure and cardiac output measurement, **when performed in association with the administration of anaesthesia** (6 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $118.80	**Benefit:** 75% = $89.10	85% = $101.00
22018	**MEASUREMENT OF THE MECHANICAL OR GAS EXCHANGE FUNCTION OF THE RESPIRATORY SYSTEM**, using measurements of parameters, including pressures, volumes, flow, gas concentrations in inspired or expired air, alveolar gas or blood and incorporating serial arterial blood gas analysis and a written record of the results, when performed in association with the administration of anaesthesia, not being a service associated with a service to which item 11503 applies (7 basic units) **Fee:** $138.60	**Benefit:** 75% = $103.95	85% = $117.85
22020	**CENTRAL VEIN CATHETERISATION** by percutaneous or open exposure, not being a service to which item 13318 applies, **when performed in association with the administration of anaesthesia** (4 basic units) *(See para T1.6 and T10.8 of explanatory notes to this Category)* **Fee:** $79.20	**Benefit:** 75% = $59.40	85% = $67.35
22025	**INTRAARTERIAL CANNULATION when performed in association with the administration of anaesthesia** (4 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $79.20	**Benefit:** 75% = $59.40	85% = $67.35
22031	**INTRATHECAL or EPIDURAL INJECTION** (initial) of a therapeutic substance or substances, with or without insertion of a catheter, **in association with anaesthesia and surgery**, for postoperative pain management, not being a service associated with a service to which 22036 applies (5 basic units) *(See para T10.19 of explanatory notes to this Category)* **Fee:** $99.00	**Benefit:** 75% = $74.25	85% = $84.15
22036	**INTRATHECAL or EPIDURAL INJECTION** (subsequent) of a therapeutic substance or substances, using an in-situ catheter, **in association with anaesthesia and surgery**, for postoperative pain management, not being a service associated with a service to which 22031 applies (3 basic units) *(See para T10.20 of explanatory notes to this Category)* **Fee:** $59.40	**Benefit:** 75% = $44.55	85% = $50.50
22040	**INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK** peri-operatively performed in the induction room theatre or recovery room for the control of post operative pain via the femoral **OR** sciatic nerves, **in conjunction with hip, knee, ankle or foot surgery** (2 basic units) *(See para T10.17 and T10.21 of explanatory notes to this Category)* **Fee:** $39.60	**Benefit:** 75% = $29.70	85% = $33.70
22045	**INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK** peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the femoral **AND** sciatic nerves, **in conjunction with hip, knee, ankle or foot surgery** (3 basic units) *(See para T10.17 and T10.21 of explanatory notes to this Category)* **Fee:** $59.40	**Benefit:** 75% = $44.55	85% = $50.50
22050	**INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK** peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the brachial plexus **in conjunction with shoulder surgery** (2 basic units) *(See para T10.17 and T10.21 of explanatory notes to this Category)* **Fee:** $39.60	**Benefit:** 75% = $29.70	85% = $33.70

22051	**INTRA-OPERATIVE TRANSOESOPHAGEAL ECHOCARDIOGRAPHY** - Monitoring in real time of the structure and function of the heart chambers, valves and surrounding structures, including assessment of blood flow, with appropriate permanent recording during procedures on the heart, pericardium or great vessels of the chest (not in association with items 55130, 55135 or 21936) (9 basic units) **Fee:** $178.20	**Benefit:** 75% = $133.65	85% = $151.50
22055	**PERFUSION OF LIMB OR ORGAN** using heart-lung machine or equivalent, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (12 basic units) *(See para T10.10 of explanatory notes to this Category)* **Fee:** $237.60	**Benefit:** 75% = $178.20	85% = $202.00
22060	**WHOLE BODY PERFUSION, CARDIAC BYPASS**, where the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies. (20 basic units) (20 basic units) *(See para T10.10 of explanatory notes to this Category)* **Fee:** $396.00	**Benefit:** 75% = $297.00	85% = $336.60
22065	**INDUCED CONTROLLED HYPOTHERMIA** total body, being a service to which item 22060 applies, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic units) *(See para T10.10 of explanatory notes to this Category)* **Fee:** $99.00	**Benefit:** 75% = $74.25	85% = $84.15
22070	**CARDIOPLEGIA**, blood or crystalloid, administration by any route, being a service to which item 22060 applies, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (10 basic units) *(See para T10.10 of explanatory notes to this Category)* **Fee:** $198.00	**Benefit:** 75% = $148.50	85% = $168.30
22075	**DEEP HYPOTHERMIC CIRCULATORY ARREST**, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (15 basic units) *(See para T10.10 of explanatory notes to this Category)* **Fee:** $297.00	**Benefit:** 75% = $222.75	85% = $252.45
	SUBGROUP 20 - ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE		
22900	**INITIATION OF MANAGEMENT BY A MEDICAL PRACTITIONER OF ANAESTHESIA** for extraction of tooth or teeth with or without incision of soft tissue or removal of bone (6 basic units) *(See para T10.14 of explanatory notes to this Category)* **Fee:** $118.80	**Benefit:** 75% = $89.10	85% = $101.00
22905	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for restorative dental work (6 basic units) *(See para T10.14 of explanatory notes to this Category)* **Fee:** $118.80	**Benefit:** 75% = $89.10	85% = $101.00
	SUBGROUP 21 - ANAESTHESIA/PERFUSION TIME UNITS		
23010	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA (a) administration of anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or (b) perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 For a period of: (FIFTEEN MINUTES OR LESS) (1 basic units) *(See para T10.3 of explanatory notes to this Category)* **Fee:** $19.80	**Benefit:** 75% = $14.85	85% = $16.85
23021	16 MINUTES TO 20 MINUTES (2 basic units) **Fee:** $39.60	**Benefit:** 75% = $29.70	85% = $33.70
23022	21 MINUTES TO 25 MINUTES (2 basic units) **Fee:** $39.60	**Benefit:** 75% = $29.70	85% = $33.70
23023	26 MINUTES TO 30 MINUTES (2 basic units) **Fee:** $39.60	**Benefit:** 75% = $29.70	85% = $33.70

23031	31 MINUTES TO 35 MINUTES (3 basic units) **Fee:** $59.40	**Benefit:** 75% = $44.55	85% = $50.50
23032	36 MINUTES TO 40 MINUTES (3 basic units) **Fee:** $59.40	**Benefit:** 75% = $44.55	85% = $50.50
23033	41 MINUTES TO 45 MINUTES (3 basic units) **Fee:** $59.40	**Benefit:** 75% = $44.55	85% = $50.50
23041	46 MINUTES TO 50 MINUTES (4 basic units) **Fee:** $79.20	**Benefit:** 75% = $59.40	85% = $67.35
23042	51 MINUTES TO 55 MINUTES (4 basic units) **Fee:** $79.20	**Benefit:** 75% = $59.40	85% = $67.35
23043	56 MINUTES TO 1:00 HOUR (4 basic units) **Fee:** $79.20	**Benefit:** 75% = $59.40	85% = $67.35
23051	1:01 HOURS TO 1:05 HOURS (5 basic units) **Fee:** $99.00	**Benefit:** 75% = $74.25	85% = $84.15
23052	1:06 HOURS TO 1:10 HOURS (5 basic units) **Fee:** $99.00	**Benefit:** 75% = $74.25	85% = $84.15
23053	1:11 HOURS TO 1:15 HOURS (5 basic units) **Fee:** $99.00	**Benefit:** 75% = $74.25	85% = $84.15
23061	1:16 HOURS TO 1:20 HOURS (6 basic units) **Fee:** $118.80	**Benefit:** 75% = $89.10	85% = $101.00
23062	1:21 HOURS TO 1:25 HOURS (6 basic units) **Fee:** $118.80	**Benefit:** 75% = $89.10	85% = $101.00
23063	1:26 HOURS TO 1:30 HOURS (6 basic units) **Fee:** $118.80	**Benefit:** 75% = $89.10	85% = $101.00
23071	1:31 HOURS TO 1:35 HOURS (7 basic units) **Fee:** $138.60	**Benefit:** 75% = $103.95	85% = $117.85
23072	1:36 HOURS TO 1:40 HOURS (7 basic units) **Fee:** $138.60	**Benefit:** 75% = $103.95	85% = $117.85
23073	1:41 HOURS TO 1:45 HOURS (7 basic units) **Fee:** $138.60	**Benefit:** 75% = $103.95	85% = $117.85
23081	1:46 HOURS TO 1:50 HOURS (8 basic units) **Fee:** $158.40	**Benefit:** 75% = $118.80	85% = $134.65
23082	1:51 HOURS TO 1:55 HOURS (8 basic units) **Fee:** $158.40	**Benefit:** 75% = $118.80	85% = $134.65
23083	1:56 HOURS TO 2:00 HOURS (8 basic units) **Fee:** $158.40	**Benefit:** 75% = $118.80	85% = $134.65
23091	2:01 HOURS TO 2:10 HOURS (9 basic units) **Fee:** $178.20	**Benefit:** 75% = $133.65	85% = $151.50
23101	2:11 HOURS TO 2:20 HOURS (10 basic units) **Fee:** $198.00	**Benefit:** 75% = $148.50	85% = $168.30
23111	2:21 HOURS TO 2:30 HOURS (11 basic units) **Fee:** $217.80	**Benefit:** 75% = $163.35	85% = $185.15
23112	2:31 HOURS TO 2:40 HOURS (12 basic units) **Fee:** $237.60	**Benefit:** 75% = $178.20	85% = $202.00

23113	2:41 HOURS TO 2:50 HOURS (13 basic units) **Fee:** $257.40	**Benefit:** 75% = $193.05	85% = $218.80
23114	2:51 HOURS TO 3:00 HOURS (14 basic units) **Fee:** $277.20	**Benefit:** 75% = $207.90	85% = $235.65
23115	3:01 HOURS TO 3:10 HOURS (15 basic units) **Fee:** $297.00	**Benefit:** 75% = $222.75	85% = $252.45
23116	3:11 HOURS TO 3:20 HOURS (16 basic units) **Fee:** $316.80	**Benefit:** 75% = $237.60	85% = $269.30
23117	3:21 HOURS TO 3:30 HOURS (17 basic units) **Fee:** $336.60	**Benefit:** 75% = $252.45	85% = $286.15
23118	3:31 HOURS TO 3:40 HOURS (18 basic units) **Fee:** $356.40	**Benefit:** 75% = $267.30	85% = $302.95
23119	3:41 HOURS TO 3:50 HOURS (19 basic units) **Fee:** $376.20	**Benefit:** 75% = $282.15	85% = $319.80
23121	3:51 HOURS TO 4:00 HOURS (20 basic units) **Fee:** $396.00	**Benefit:** 75% = $297.00	85% = $336.60
23170	4:01 HOURS TO 4:10 HOURS (21 basic units) **Fee:** $415.80	**Benefit:** 75% = $311.85	85% = $353.45
23180	4:11 HOURS TO 4:20 HOURS (22 basic units) **Fee:** $435.60	**Benefit:** 75% = $326.70	85% = $370.30
23190	4:21 HOURS TO 4:30 HOURS (23 basic units) **Fee:** $455.40	**Benefit:** 75% = $341.55	85% = $387.10
23200	4:31 HOURS TO 4:40 HOURS (24 basic units) **Fee:** $475.20	**Benefit:** 75% = $356.40	85% = $403.95
23210	4:41 HOURS TO 4:50 HOURS (25 basic units) **Fee:** $495.00	**Benefit:** 75% = $371.25	85% = $420.75
23220	4:51 HOURS TO 5:00 HOURS (26 basic units) **Fee:** $514.80	**Benefit:** 75% = $386.10	85% = $437.60
23230	5:01 HOURS TO 5:10 HOURS (27 basic units) **Fee:** $534.60	**Benefit:** 75% = $400.95	85% = $455.10
23240	5:11 HOURS TO 5:20 HOURS (28 basic units) **Fee:** $554.40	**Benefit:** 75% = $415.80	85% = $474.90
23250	5:21 HOURS TO 5:30 HOURS (29 basic units) **Fee:** $574.20	**Benefit:** 75% = $430.65	85% = $494.70
23260	5:31 HOURS TO 5:40 HOURS (30 basic units) **Fee:** $594.00	**Benefit:** 75% = $445.50	85% = $514.50
23270	5:41 HOURS TO 5:50 HOURS (31 basic units) **Fee:** $613.80	**Benefit:** 75% = $460.35	85% = $534.30
23280	(5:51 HOURS TO 6:00 HOURS (32 basic units) **Fee:** $633.60	**Benefit:** 75% = $475.20	85% = $554.10
23290	6:01 HOURS TO 6:10 HOURS (33 basic units) **Fee:** $653.40	**Benefit:** 75% = $490.05	85% = $573.90
23300	6:11 HOURS TO 6:20 HOURS (34 basic units) **Fee:** $673.20	**Benefit:** 75% = $504.90	85% = $593.70

23310	6:21 HOURS TO 6:30 HOURS (35 basic units) **Fee:** $693.00	**Benefit:** 75% = $519.75	85% = $613.50
23320	6:31 HOURS TO 6:40 HOURS (36 basic units) **Fee:** $712.80	**Benefit:** 75% = $534.60	85% = $633.30
23330	6:41 HOURS TO 6:50 HOURS (37 basic units) **Fee:** $732.60	**Benefit:** 75% = $549.45	85% = $653.10
23340	6:51 HOURS TO 7:00 HOURS (38 basic units) **Fee:** $752.40	**Benefit:** 75% = $564.30	85% = $672.90
23350	7:01 HOURS TO 7:10 HOURS (39 basic units) **Fee:** $772.20	**Benefit:** 75% = $579.15	85% = $692.70
23360	7:11 HOURS TO 7:20 HOURS (40 basic units) **Fee:** $792.00	**Benefit:** 75% = $594.00	85% = $712.50
23370	7:21 HOURS TO 7:30 HOURS (41 basic units) **Fee:** $811.80	**Benefit:** 75% = $608.85	85% = $732.30
23380	7:31 HOURS TO 7:40 HOURS (42 basic units) **Fee:** $831.60	**Benefit:** 75% = $623.70	85% = $752.10
23390	7:41 HOURS TO 7:50 HOURS (43 basic units) **Fee:** $851.40	**Benefit:** 75% = $638.55	85% = $771.90
23400	7:51 HOURS TO 8:00 HOURS (44 basic units) **Fee:** $871.20	**Benefit:** 75% = $653.40	85% = $791.70
23410	8:01 HOURS TO 8:10 HOURS (45 basic units) **Fee:** $891.00	**Benefit:** 75% = $668.25	85% = $811.50
23420	8:11 HOURS TO 8:20 HOURS (46 basic units) **Fee:** $910.80	**Benefit:** 75% = $683.10	85% = $831.30
23430	8:21 HOURS TO 8:30 HOURS (47 basic units) **Fee:** $930.60	**Benefit:** 75% = $697.95	85% = $851.10
23440	8:31 HOURS TO 8:40 HOURS (48 basic units) **Fee:** $950.40	**Benefit:** 75% = $712.80	85% = $870.90
23450	8:41 HOURS TO 8:50 HOURS (49 basic units) **Fee:** $970.20	**Benefit:** 75% = $727.65	85% = $890.70
23460	8:51 HOURS TO 9:00 HOURS (50 basic units) **Fee:** $990.00	**Benefit:** 75% = $742.50	85% = $910.50
23470	9:01 HOURS TO 9:10 HOURS (51 basic units) **Fee:** $1,009.80	**Benefit:** 75% = $757.35	85% = $930.30
23480	9:11 HOURS TO 9:20 HOURS (52 basic units) **Fee:** $1,029.60	**Benefit:** 75% = $772.20	85% = $950.10
23490	9:21 HOURS TO 9:30 HOURS (53 basic units) **Fee:** $1,049.40	**Benefit:** 75% = $787.05	85% = $969.90
23500	9:31 HOURS TO 9:40 HOURS (54 basic units) **Fee:** $1,069.20	**Benefit:** 75% = $801.90	85% = $989.70
23510	9:41 HOURS TO 9:50 HOURS (55 basic units) **Fee:** $1,089.00	**Benefit:** 75% = $816.75	85% = $1,009.50
23520	9:51 HOURS TO 10:00 HOURS (56 basic units) **Fee:** $1,108.80	**Benefit:** 75% = $831.60	85% = $1,029.30

23530	10:01 HOURS TO 10:10 HOURS (57 basic units) **Fee:** $1,128.60	**Benefit:** 75% = $846.45	85% = $1,049.10
23540	10:11 HOURS TO 10:20 HOURS (58 basic units) **Fee:** $1,148.40	**Benefit:** 75% = $861.30	85% = $1,068.90
23550	10:21 HOURS TO 10:30 HOURS (59 basic units) **Fee:** $1,168.20	**Benefit:** 75% = $876.15	85% = $1,088.70
23560	10:31 HOURS TO 10:40 HOURS (60 basic units) **Fee:** $1,188.00	**Benefit:** 75% = $891.00	85% = $1,108.50
23570	10:41 HOURS TO 10:50 HOURS (61 basic units) **Fee:** $1,207.80	**Benefit:** 75% = $905.85	85% = $1,128.30
23580	10:51 HOURS TO 11:00 HOURS (62 basic units) **Fee:** $1,227.60	**Benefit:** 75% = $920.70	85% = $1,148.10
23590	11:01 HOURS TO 11:10 HOURS (63 basic units) **Fee:** $1,247.40	**Benefit:** 75% = $935.55	85% = $1,167.90
23600	11:11 HOURS TO 11:20 HOURS (64 basic units) **Fee:** $1,267.20	**Benefit:** 75% = $950.40	85% = $1,187.70
23610	11:21 HOURS TO 11:30 HOURS (65 basic units) **Fee:** $1,287.00	**Benefit:** 75% = $965.25	85% = $1,207.50
23620	11:31 HOURS TO 11:40 HOURS (66 basic units) **Fee:** $1,306.80	**Benefit:** 75% = $980.10	85% = $1,227.30
23630	11:41 HOURS TO 11:50 HOURS (67 basic units) **Fee:** $1,326.60	**Benefit:** 75% = $994.95	85% = $1,247.10
23640	11:51 HOURS TO 12:00 HOURS (68 basic units) **Fee:** $1,346.40	**Benefit:** 75% = $1,009.80	85% = $1,266.90
23650	12:01 HOURS TO 12:10 HOURS (69 basic units) **Fee:** $1,366.20	**Benefit:** 75% = $1,024.65	85% = $1,286.70
23660	12:11 HOURS TO 12:20 HOURS (70 basic units) **Fee:** $1,386.00	**Benefit:** 75% = $1,039.50	85% = $1,306.50
23670	12:21 HOURS TO 12:30 HOURS (71 basic units) **Fee:** $1,405.80	**Benefit:** 75% = $1,054.35	85% = $1,326.30
23680	12:31 HOURS TO 12:40 HOURS (72 basic units) **Fee:** $1,425.60	**Benefit:** 75% = $1,069.20	85% = $1,346.10
23690	12:41 HOURS TO 12:50 HOURS (73 basic units) **Fee:** $1,445.40	**Benefit:** 75% = $1,084.05	85% = $1,365.90
23700	12:51 HOURS TO 13:00 HOURS (74 basic units) **Fee:** $1,465.20	**Benefit:** 75% = $1,098.90	85% = $1,385.70
23710	13:01 HOURS TO 13:10 HOURS (75 basic units) **Fee:** $1,485.00	**Benefit:** 75% = $1,113.75	85% = $1,405.50
23720	13:11 HOURS TO 13:20 HOURS (76 basic units) **Fee:** $1,504.80	**Benefit:** 75% = $1,128.60	85% = $1,425.30
23730	13:21 HOURS TO 13:30 HOURS (77 basic units) **Fee:** $1,524.60	**Benefit:** 75% = $1,143.45	85% = $1,445.10
23740	13:31 HOURS TO 13:40 HOURS (78 basic units) **Fee:** $1,544.40	**Benefit:** 75% = $1,158.30	85% = $1,464.90

23750	13:41 HOURS TO 13:50 HOURS (79 basic units) **Fee:** $1,564.20	**Benefit:** 75% = $1,173.15	85% = $1,484.70
23760	13:51 HOURS TO 14:00 HOURS (80 basic units) **Fee:** $1,584.00	**Benefit:** 75% = $1,188.00	85% = $1,504.50
23770	14:01 HOURS TO 14:10 HOURS (81 basic units) **Fee:** $1,603.80	**Benefit:** 75% = $1,202.85	85% = $1,524.30
23780	14:11 HOURS TO 14:20 HOURS (82 basic units) **Fee:** $1,623.60	**Benefit:** 75% = $1,217.70	85% = $1,544.10
23790	14:21 HOURS TO 14:30 HOURS (83 basic units) **Fee:** $1,643.40	**Benefit:** 75% = $1,232.55	85% = $1,563.90
23800	14:31 HOURS TO 14:40 HOURS (84 basic units) **Fee:** $1,663.20	**Benefit:** 75% = $1,247.40	85% = $1,583.70
23810	14:41 HOURS TO 14:50 HOURS (85 basic units) **Fee:** $1,683.00	**Benefit:** 75% = $1,262.25	85% = $1,603.50
23820	14:51 HOURS TO 15:00 HOURS (86 basic units) **Fee:** $1,702.80	**Benefit:** 75% = $1,277.10	85% = $1,623.30
23830	15:01 HOURS TO 15:10 HOURS (87 basic units) **Fee:** $1,722.60	**Benefit:** 75% = $1,291.95	85% = $1,643.10
23840	15:11 HOURS TO 15:20 HOURS (88 basic units) **Fee:** $1,742.40	**Benefit:** 75% = $1,306.80	85% = $1,662.90
23850	15:21 HOURS TO 15:30 HOURS (89 basic units) **Fee:** $1,762.20	**Benefit:** 75% = $1,321.65	85% = $1,682.70
23860	15:31 HOURS TO 15:40 HOURS (90 basic units) **Fee:** $1,782.00	**Benefit:** 75% = $1,336.50	85% = $1,702.50
23870	15:41 HOURS TO 15:50 HOURS (91 basic units) **Fee:** $1,801.80	**Benefit:** 75% = $1,351.35	85% = $1,722.30
23880	15:51 HOURS TO 16:00 HOURS (92 basic units) **Fee:** $1,821.60	**Benefit:** 75% = $1,366.20	85% = $1,742.10
23890	16:01 HOURS TO 16:10 HOURS (93 basic units) **Fee:** $1,841.40	**Benefit:** 75% = $1,381.05	85% = $1,761.90
23900	16:11 HOURS TO 16:20 HOURS (94 basic units) **Fee:** $1,861.20	**Benefit:** 75% = $1,395.90	85% = $1,781.70
23910	16:21 HOURS TO 16:30 HOURS (95 basic units) **Fee:** $1,881.00	**Benefit:** 75% = $1,410.75	85% = $1,801.50
23920	16:31 HOURS TO 16:40 HOURS (96 basic units) **Fee:** $1,900.80	**Benefit:** 75% = $1,425.60	85% = $1,821.30
23930	16:41 HOURS TO 16:50 HOURS (97 basic units) **Fee:** $1,920.60	**Benefit:** 75% = $1,440.45	85% = $1,841.10
23940	16:51 HOURS TO 17:00 HOURS (98 basic units) **Fee:** $1,940.40	**Benefit:** 75% = $1,455.30	85% = $1,860.90
23950	17:01 HOURS TO 17:10 HOURS (99 basic units) **Fee:** $1,960.20	**Benefit:** 75% = $1,470.15	85% = $1,880.70
23960	17:11 HOURS TO 17:20 HOURS (100 basic units) **Fee:** $1,980.00	**Benefit:** 75% = $1,485.00	85% = $1,900.50

	17:21 HOURS TO 17:30 HOURS (101 basic units)		
23970	**Fee:** $1,999.80	**Benefit:** 75% = $1,499.85	85% = $1,920.30
	17:31 HOURS TO 17:40 HOURS (102 basic units)		
23980	**Fee:** $2,019.60	**Benefit:** 75% = $1,514.70	85% = $1,940.10
	17:41 HOURS TO 17:50 HOURS (103 basic units)		
23990	**Fee:** $2,039.40	**Benefit:** 75% = $1,529.55	85% = $1,959.90
	17:51 HOURS TO 18:00 HOURS (104 basic units)		
24100	**Fee:** $2,059.20	**Benefit:** 75% = $1,544.40	85% = $1,979.70
	18:01 HOURS TO 18:10 HOURS (105 basic units)		
24101	**Fee:** $2,079.00	**Benefit:** 75% = $1,559.25	85% = $1,999.50
	18:11 HOURS TO 18:20 HOURS (106 basic units)		
24102	**Fee:** $2,098.80	**Benefit:** 75% = $1,574.10	85% = $2,019.30
	18:21 HOURS TO 18:30 HOURS (107 basic units)		
24103	**Fee:** $2,118.60	**Benefit:** 75% = $1,588.95	85% = $2,039.10
	18:31 HOURS TO 18:40 HOURS (108 basic units)		
24104	**Fee:** $2,138.40	**Benefit:** 75% = $1,603.80	85% = $2,058.90
	18:41 HOURS TO 18:50 HOURS (109 basic units)		
24105	**Fee:** $2,158.20	**Benefit:** 75% = $1,618.65	85% = $2,078.70
	18:51 HOURS TO 19:00 HOURS (110 basic units)		
24106	**Fee:** $2,178.00	**Benefit:** 75% = $1,633.50	85% = $2,098.50
	19:01 HOURS TO 19:10 HOURS (111 basic units)		
24107	**Fee:** $2,197.80	**Benefit:** 75% = $1,648.35	85% = $2,118.30
	19:11 HOURS TO 19:20 HOURS (112 basic units)		
24108	**Fee:** $2,217.60	**Benefit:** 75% = $1,663.20	85% = $2,138.10
	19:21 HOURS TO 19:30 HOURS (113 basic units)		
24109	**Fee:** $2,237.40	**Benefit:** 75% = $1,678.05	85% = $2,157.90
	19:31 HOURS TO 19:40 HOURS (114 basic units)		
24110	**Fee:** $2,257.20	**Benefit:** 75% = $1,692.90	85% = $2,177.70
	19:41 HOURS TO 19:50 HOURS (115 basic units)		
24111	**Fee:** $2,277.00	**Benefit:** 75% = $1,707.75	85% = $2,197.50
	19:51 HOURS TO 20:00 HOURS (116 basic units)		
24112	**Fee:** $2,296.80	**Benefit:** 75% = $1,722.60	85% = $2,217.30
	20:01 HOURS TO 20:10 HOURS (117 basic units)		
24113	**Fee:** $2,316.60	**Benefit:** 75% = $1,737.45	85% = $2,237.10
	20:11 HOURS TO 20:20 HOURS (118 basic units)		
24114	**Fee:** $2,336.40	**Benefit:** 75% = $1,752.30	85% = $2,256.90
	20:21 HOURS TO 20:30 HOURS (119 basic units)		
24115	**Fee:** $2,356.20	**Benefit:** 75% = $1,767.15	85% = $2,276.70
	20:31 HOURS TO 20:40 HOURS (120 basic units)		
24116	**Fee:** $2,376.00	**Benefit:** 75% = $1,782.00	85% = $2,296.50
	20:41 HOURS TO 20:50 HOURS (121 basic units)		
24117	**Fee:** $2,395.80	**Benefit:** 75% = $1,796.85	85% = $2,316.30
	20:51 HOURS TO 21:00 HOURS (122 basic units)		
24118	**Fee:** $2,415.60	**Benefit:** 75% = $1,811.70	85% = $2,336.10

	21:01 HOURS TO 21:10 HOURS (123 basic units)		
24119	**Fee:** $2,435.40	**Benefit:** 75% = $1,826.55	85% = $2,355.90
	21:11 HOURS TO 21:20 HOURS (124 basic units)		
24120	**Fee:** $2,455.20	**Benefit:** 75% = $1,841.40	85% = $2,375.70
	21:21 HOURS TO 21:30 HOURS (125 basic units)		
24121	**Fee:** $2,475.00	**Benefit:** 75% = $1,856.25	85% = $2,395.50
	21:31 HOURS TO 21:40 HOURS (126 basic units)		
24122	**Fee:** $2,494.80	**Benefit:** 75% = $1,871.10	85% = $2,415.30
	21:41 HOURS TO 21:50 HOURS (127 basic units)		
24123	**Fee:** $2,514.60	**Benefit:** 75% = $1,885.95	85% = $2,435.10
	21:51 HOURS TO 22:00 HOURS (128 basic units)		
24124	**Fee:** $2,534.40	**Benefit:** 75% = $1,900.80	85% = $2,454.90
	22:01 HOURS TO 22:10 HOURS (129 basic units)		
24125	**Fee:** $2,554.20	**Benefit:** 75% = $1,915.65	85% = $2,474.70
	22:11 HOURS TO 22:20 HOURS (130 basic units)		
24126	**Fee:** $2,574.00	**Benefit:** 75% = $1,930.50	85% = $2,494.50
	22:21 HOURS TO 22:30 HOURS (131 basic units)		
24127	**Fee:** $2,593.80	**Benefit:** 75% = $1,945.35	85% = $2,514.30
	22:31 HOURS TO 22:40 HOURS (132 basic units)		
24128	**Fee:** $2,613.60	**Benefit:** 75% = $1,960.20	85% = $2,534.10
	22:41 HOURS TO 22:50 HOURS (133 basic units)		
24129	**Fee:** $2,633.40	**Benefit:** 75% = $1,975.05	85% = $2,553.90
	22:51 HOURS TO 23:00 HOURS (134 basic units)		
24130	**Fee:** $2,653.20	**Benefit:** 75% = $1,989.90	85% = $2,573.70
	23:01 HOURS TO 23:10 HOURS (135 basic units)		
24131	**Fee:** $2,673.00	**Benefit:** 75% = $2,004.75	85% = $2,593.50
	23:11 HOURS TO 23:20 HOURS (136 basic units)		
24132	**Fee:** $2,692.80	**Benefit:** 75% = $2,019.60	85% = $2,613.30
	23:21 HOURS TO 23:30 HOURS (137 basic units)		
24133	**Fee:** $2,712.60	**Benefit:** 75% = $2,034.45	85% = $2,633.10
	23:31 HOURS TO 23:40 HOURS (138 basic units)		
24134	**Fee:** $2,732.40	**Benefit:** 75% = $2,049.30	85% = $2,652.90
	23:41 HOURS TO 23:50 HOURS (139 basic units)		
24135	**Fee:** $2,752.20	**Benefit:** 75% = $2,064.15	85% = $2,672.70
	23:51 HOURS TO 24:00 HOURS (140 basic units)		
24136	**Fee:** $2,772.00	**Benefit:** 75% = $2,079.00	85% = $2,692.50
	SUBGROUP 22 - ANAESTHESIA/PERFUSION MODIFYING UNITS - PHYSICAL STATUS		
	ANAESTHESIA, PERFUSION or ASSISTANCE AT ANAESTHESIA (a) for anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or (b) for perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 Where the patient has severe systemic disease equivalent to ASA physical status indicator 3 (1 basic units) *(See para T10.3 of explanatory notes to this Category)*		
25000	**Fee:** $19.80	**Benefit:** 75% = $14.85	85% = $16.85

25005	Where the patient has severe systemic disease which is a constant threat to life equivalent to ASA physical status indicator 4 (2 basic units) *(See para T10.3 of explanatory notes to this Category)* **Fee:** $39.60 **Benefit:** 75% = $29.70 85% = $33.70
25010	For a patient who is not expected to survive for 24 hours with or without the operation, equivalent to ASA physical status indicator 5 (3 basic units) *(See para T10.3 of explanatory notes to this Category)* **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
	SUBGROUP 23 - ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER
25015	**ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA** - where the patient is less than 12 months of age or 70 years or greater (1 basic units) **Fee:** $19.80 **Benefit:** 75% = $14.85 85% = $16.85
25020	**ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA** - where the patient requires immediate treatment without which there would be significant threat to life or body part - not being a service associated with a service to which item 25025 or 25030 or 25050 applies (2 basic units) *(See para T10.3 of explanatory notes to this Category)* **Fee:** $39.60 **Benefit:** 75% = $29.70 85% = $33.70
	SUBGROUP 24 - ANAESTHESIA AFTER HOURS EMERGENCY MODIFIER
25025	**EMERGENCY ANAESTHESIA** performed in the after hours period where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for the emergency anaesthesia service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25030 or 25050 applies *(See para T10.3 of explanatory notes to this Category)* **Derived Fee:** An additional amount of 50% of the fee for the anaesthetic service. That is: (a) an anaesthesia item/s in the range 20100 - 21997 or 22900, plus (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000-25015, plus (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22051
25030	**ASSISTANCE AT AFTER HOURS EMERGENCY ANAESTHESIA** where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for which the assistant is in professional attendance on the patient is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25050 applies *(See para T10.3 of explanatory notes to this Category)* **Derived Fee:** An additional amount of 50% of the fee for assistance at anaesthesia. That is: (a) an assistant anaesthesia item in the range 25200 - 25205, plus (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000-25015, plus (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22051
	SUBGROUP 25 - PERFUSION AFTER HOURS EMERGENCY MODIFIER
25050	**AFTER HOURS EMERGENCY PERFUSION** where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the perfusion service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25030 applies *(See para T10.3 of explanatory notes to this Category)* **Derived Fee:** An additional amount of 50% of the fee for the perfusion service. That is: (a) item 22060, plus (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000 - 25015, plus (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22051 or 22065-22075
	SUBGROUP 26 - ASSISTANCE AT ANAESTHESIA
25200	**ASSISTANCE IN THE ADMINISTRATION OF ANAESTHESIA** on a patient in imminent danger of death requiring continuous life saving emergency treatment, to the exclusion of all other patients (5 basic units) *(See para T10.9 of explanatory notes to this Category)* **Derived Fee:** An amount of $99.0 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable - an item in the range 25000 - 25020 plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22051

25205	**ASSISTANCE IN THE ADMINISTRATION OF ELECTIVE ANAESTHESIA** where: (i) the patient has complex airway problems; or (ii) the patient is a neonate or a complex paediatric case; or (iii) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or (iv) the patient is critically ill, with multiple organ failure; or (v) where the anaesthesia time exceeds 6 hours and the assistance is provided to the exclusion of all other patients (5 basic units) *(See para T10.9 of explanatory notes to this Category)* **Derived Fee:** An amount of $99.0 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable - an item in the range 25000 - 25020 plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22051

GROUP T8 - SURGICAL OPERATIONS

SUBGROUP 1 - GENERAL

30001 OPERATIVE PROCEDURE, not being a service to which any other item in this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds
(See para T8.5 of explanatory notes to this Category)
Derived Fee: 50% of the fee which would have applied had the procedure not been discontinued

30003 LOCALISED BURNS, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation
Fee: $36.30 **Benefit:** 75% = $27.25 85% = $30.90

30006 EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation
Fee: $46.50 **Benefit:** 75% = $34.90 85% = $39.55

30009 G LOCALISED BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.)
Fee: $60.75 **Benefit:** 75% = $45.60
30010 S **Fee:** $73.90 **Benefit:** 75% = $55.45

30013 G EXTENSIVE BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.)
Fee: $130.90 **Benefit:** 75% = $98.20
30014 S **Fee:** $155.40 **Benefit:** 75% = $116.55

30017 BURNS, excision of, under general anaesthesia, involving not more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.)
Fee: $326.05 **Benefit:** 75% = $244.55 85% = $277.15

30020 BURNS, excision of, under general anaesthesia, involving more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.)
Fee: $635.00 **Benefit:** 75% = $476.25

30023 WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.)
(See para T8.6 of explanatory notes to this Category)
Fee: $326.05 **Benefit:** 75% = $244.55 85% = $277.15

30024 WOUND OF SOFT TISSUE, debridement of extensively infected post-surgical incision or Fournier's Gangrene, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.)
Fee: $326.05 **Benefit:** 75% = $244.55 85% = $277.15

30026 SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.)
(See para T8.6 of explanatory notes to this Category)
Fee: $52.20 **Benefit:** 75% = $39.15 85% = $44.40

30029 SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)
(See para T8.6 of explanatory notes to this Category)
Fee: $90.00 **Benefit:** 75% = $67.50 85% = $76.50

30032 SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.)
(See para T8.6 of explanatory notes to this Category)
Fee: $82.50 **Benefit:** 75% = $61.90 85% = $70.15

30035 SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes.)
(See para T8.6 of explanatory notes to this Category)
Fee: $117.55 **Benefit:** 75% = $88.20 85% = $99.95

	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.) *(See para T8.6 of explanatory notes to this Category)*		
30038	**Fee:** $90.00	**Benefit:** 75% = $67.50	85% = $76.50
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.) *(See para T8.6 of explanatory notes to this Category)*		
30041 G	**Fee:** $144.00	**Benefit:** 75% = $108.00	85% = $122.40
30042 S	**Fee:** $185.60	**Benefit:** 75% = $139.20	85% = $157.80
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.) *(See para T8.6 of explanatory notes to this Category)*		
30045	**Fee:** $117.55	**Benefit:** 75% = $88.20	85% = $99.95
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) *(See para T8.6 of explanatory notes to this Category)*		
30048 G	**Fee:** $149.75	**Benefit:** 75% = $112.35	85% = $127.30
30049 S	**Fee:** $185.60	**Benefit:** 75% = $139.20	85% = $157.80
	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.)		
30052	**Fee:** $254.00	**Benefit:** 75% = $190.50	85% = $215.90
	WOUNDS, DRESSING OF, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in this Group applies (Anaes.)		
30055	**Fee:** $73.90	**Benefit:** 75% = $55.45	85% = $62.85
	POSTOPERATIVE HAEMORRHAGE, control of, under general anaesthesia, as an independent procedure (Anaes.)		
30058	**Fee:** $144.35	**Benefit:** 75% = $108.30	85% = $122.70
	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (Anaes.)		
30061	**Fee:** $23.50	**Benefit:** 75% = $17.65	85% = $20.00
	Etonogestrel subcutaneous implant, removal of, as an independent procedure (Anaes.)		
30062	**Fee:** $60.75	**Benefit:** 75% = $45.60	85% = $51.65
	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.)		
30064	**Fee:** $109.90	**Benefit:** 75% = $82.45	85% = $93.45
	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.)		
30067 G	**Fee:** $223.60	**Benefit:** 75% = $167.70	85% = $190.10
30068 S	**Fee:** $276.80	**Benefit:** 75% = $207.60	85% = $235.30
	DIAGNOSTIC BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)*		
	Fee: $52.20	**Benefit:** 75% = $39.15	85% = $44.40
30071	**Extended Medicare Safety Net Cap:** $41.80		
	DIAGNOSTIC BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)*		
30074 G	**Fee:** $117.55	**Benefit:** 75% = $88.20	85% = $99.95
30075 S	**Fee:** $149.75	**Benefit:** 75% = $112.35	85% = $127.30
	DIAGNOSTIC DRILL BIOPSY OF LYMPH GLAND, DEEP TISSUE OR ORGAN, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)*		
30078	**Fee:** $48.45	**Benefit:** 75% = $36.35	85% = $41.20

	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using open approach, where the biopsy specimen is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)*		
30081	**Fee:** $109.90	**Benefit:** 75% = $82.45	85% = $93.45
	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using percutaneous approach where the biopsy is sent for pathological examination (Anaes.) *(See para T8.2 and T8.7 of explanatory notes to this Category)*		
30084	**Fee:** $58.80	**Benefit:** 75% = $44.10	85% = $50.00
	DIAGNOSTIC BIOPSY OF BONE MARROW by aspiration or PUNCH BIOPSY OF SYNOVIAL MEMBRANE, where the biopsy is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)*		
30087	**Fee:** $29.45	**Benefit:** 75% = $22.10	85% = $25.05
	DIAGNOSTIC BIOPSY OF PLEURA, PERCUTANEOUS 1 or more biopsies on any 1 occasion, where the biopsy is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)*		
30090	**Fee:** $128.55	**Benefit:** 75% = $96.45	85% = $109.30
	DIAGNOSTIC NEEDLE BIOPSY OF VERTEBRA, where the biopsy is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)*		
30093	**Fee:** $171.55	**Benefit:** 75% = $128.70	85% = $145.85
	DIAGNOSTIC PERCUTANEOUS ASPIRATION BIOPSY of deep organ using interventional imaging techniques - but not including imaging, where the biopsy is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)*		
30094	**Fee:** $189.40	**Benefit:** 75% = $142.05	85% = $161.00
	DIAGNOSTIC SCALENE NODE BIOPSY, by open procedure, where the specimen excised is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)*		
30096	**Fee:** $183.90	**Benefit:** 75% = $137.95	85% = $156.35
	Personal performance of a Synacthen Stimulation Test, including associated consultation; by a medical practitioner with resuscitation training and access to facilities where life support procedures can be implemented.		
30097	**Fee:** $97.15	**Benefit:** 75% = $72.90	85% = $82.60
	SINUS, excision of, involving superficial tissue only (Anaes.)		
30099	**Fee:** $90.00	**Benefit:** 75% = $67.50	85% = $76.50
	SINUS, excision of, involving muscle and deep tissue (Anaes.)		
30102 G	**Fee:** $149.75	**Benefit:** 75% = $112.35	85% = $127.30
30103 S	**Fee:** $183.90	**Benefit:** 75% = $137.95	85% = $156.35
	PRE-AURICULAR SINUS, on a person 10 years of age or over. Excision of, (Anaes.)		
30104	**Fee:** $126.90	**Benefit:** 75% = $95.20	85% = $107.90
	PRE-AURICULAR SINUS, on a person under 10 years of age. Excision of, (Anaes.)		
30105	**Fee:** $164.95	**Benefit:** 75% = $123.75	85% = $140.25
	GANGLION OR SMALL BURSA, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.)		
30106 G	**Fee:** $155.40	**Benefit:** 75% = $116.55	85% = $132.10
30107 S	**Fee:** $219.95	**Benefit:** 75% = $165.00	85% = $187.00
	BURSA (LARGE), INCLUDING OLECRANON, CALCANEUM OR PATELLA, excision of (Anaes.) (Assist.)		
30110 G	**Fee:** $284.35	**Benefit:** 75% = $213.30	85% = $241.70
30111 S	**Fee:** $371.50	**Benefit:** 75% = $278.65	85% = $315.80
	BURSA, SEMIMEMBRANOSUS (Baker's cyst), excision of (Anaes.) (Assist.)		
30114	**Fee:** $371.50	**Benefit:** 75% = $278.65	
	LIPECTOMY transverse wedge excision of abdominal apron, not being a service performed within 12 months after the end of a pregnancy and not being a service associated with a service to which item 45564, 45565 or 45530 applies (H) (Anaes.) (Assist.) *(See para T8.8 of explanatory notes to this Category)*		
30165	**Fee:** $454.85	**Benefit:** 75% = $341.15	

30168	LIPECTOMY wedge excision of skin and fat, not being a service associated with items 45564, 45565 or 45530 and not being a service to which item 30165 applies, 1 EXCISION (H) (Anaes.) (Assist.) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $454.85 **Benefit:** 75% = $341.15
30171	LIPECTOMY wedge excision of skin and fat, not being a service associated with items 45564, 45565 or 45530 and not being a service to which item 30165 applies, 2 OR MORE EXCISIONS (H) (Anaes.) (Assist.) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $691.75 **Benefit:** 75% = $518.85
30174	LIPECTOMY subumbilical excision with undermining of skin edges and strengthening of musculoaponeurotic wall, not being a service associated with items 45564 or 45565 or 45530 (H) (Anaes.) (Assist.) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $691.75 **Benefit:** 75% = $518.85
30177	LIPECTOMY radical abdominoplasty (Pitanguy type or similar), with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a service performed within 12 months after the end of a pregnancy and not being a service associated with a service to which item 45564, 45565 or 45530 applies (Anaes.) (Assist.) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $985.70 **Benefit:** 75% = $739.30
30180	AXILLARY HYPERHIDROSIS, partial excision for (Anaes.) **Fee:** $136.50 **Benefit:** 75% = $102.40 85% = $116.05
30183	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes.) **Fee:** $246.50 **Benefit:** 75% = $184.90 85% = $209.55
30185	PALMAR OR PLANTAR WARTS (10 or more), definitive removal of, excluding ablative methods alone, not being a service to which item 30186 or 30187 applies (Anaes.) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $182.50 **Benefit:** 75% = $136.90 85% = $155.15
30186	PALMAR OR PLANTAR WARTS (less than 10), definitive removal of, excluding ablative methods alone, not being a service to which item 30185 or 30187 applies (Anaes.) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $47.45 **Benefit:** 75% = $35.60 85% = $40.35
30187	PALMAR OR PLANTAR WARTS, removal of, by carbon dioxide laser or erbium laser, requiring admission to a hospital, or when performed by a specialist in the practice of his/her specialty, (5 or more warts) (Anaes.) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $256.95 **Benefit:** 75% = $192.75 85% = $218.45
30189	WARTS or MOLLUSCUM CONTAGIOSUM (one or more), removal of, by any method (other than by chemical means), where undertaken in the operating theatre of a hospital, not being a service associated with a service to which another item in this Group applies (H) (Anaes.) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $147.30 **Benefit:** 75% = $110.50
30190	ANGIOFIBROMAS, TRICHOEPITHELIOMAS or other severely disfiguring tumours suitable for laser excision as confirmed by specialist opinion, of the face or neck, removal of, by carbon dioxide laser or erbium laser excision-ablation including associated resurfacing (10 or more tumours) (Anaes.) (Assist.) **Fee:** $397.75 **Benefit:** 75% = $298.35 85% = $338.10
30192	PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $39.55 **Benefit:** 75% = $29.70 85% = $33.65
30195	BENIGN NEOPLASM OF SKIN, other than viral verrucae (common warts) seborrheic keratoses, cysts and skin tags, treatment by electrosurgical destruction, simple curettage or shave excision, or laser photocoagulation, not being a service to which item 30196, 30197, 30202, 30203 or 30205 applies (1 or more lesions) (Anaes.) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00

30196	MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser or erbium laser excision-ablation, including any associated cryotherapy or diathermy, not being a service to which item 30197 applies (Anaes.) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $126.30	**Benefit:** 75% = $94.75	85% = $107.40
30197	MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser excision-ablation, including any associated cryotherapy or diathermy, (10 OR MORE LESIONS) (Anaes.) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $440.05	**Benefit:** 75% = $330.05	85% = $374.05
30202	MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles, not being a service to which item 30203 applies *(See para T8.10 of explanatory notes to this Category)* **Fee:** $48.35	**Benefit:** 75% = $36.30	85% = $41.10
30203	MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles (10 OR MORE LESIONS) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $170.25	**Benefit:** 75% = $127.70	85% = $144.75
30205	MALIGNANT NEOPLASM OF SKIN proven by histopathology, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles WHERE THE MALIGNANT NEOPLASM EXTENDS INTO CARTILAGE (Anaes.) **Fee:** $126.30	**Benefit:** 75% = $94.75	85% = $107.40
30207	SKIN LESIONS, multiple injections with hydrocortisone or similar preparations (Anaes.) **Fee:** $44.60	**Benefit:** 75% = $33.45	85% = $37.95
30210	KELOID and other SKIN LESIONS, EXTENSIVE, MULTIPLE INJECTIONS OF HYDROCORTISONE or similar preparations where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $162.95	**Benefit:** 75% = $122.25	
30213	TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - limited to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - for a session of at least 20 minutes duration (Anaes.) *(See para T8.11 of explanatory notes to this Category)* **Fee:** $109.80	**Benefit:** 75% = $82.35	85% = $93.35
30214	TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - session of at least 20 minutes duration ***- where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period*** *(See para T8.11 of explanatory notes to this Category)* **Fee:** $109.80	**Benefit:** 75% = $82.35	85% = $93.35
30216	HAEMATOMA, aspiration of (Anaes.) **Fee:** $27.35	**Benefit:** 75% = $20.55	85% = $23.25
30219	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital - INCISION WITH DRAINAGE OF (excluding aftercare) **Fee:** $27.35	**Benefit:** 75% = $20.55	85% = $23.25
30223	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.) **Fee:** $162.95	**Benefit:** 75% = $122.25	
30224	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $237.60	**Benefit:** 75% = $178.20	85% = $202.00
30225	ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $267.65	**Benefit:** 75% = $200.75	85% = $227.55
30226	MUSCLE, excision of (LIMITED), or fasciotomy (Anaes.) **Fee:** $149.75	**Benefit:** 75% = $112.35	85% = $127.30

30229	MUSCLE, excision of (EXTENSIVE) (Anaes.) (Assist.) **Fee:** $272.95 **Benefit:** 75% = $204.75 85% = $232.05
30232	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.) **Fee:** $223.60 **Benefit:** 75% = $167.70 85% = $190.10
30235	MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) **Fee:** $295.70 **Benefit:** 75% = $221.80 85% = $251.35
30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE (Anaes.) **Fee:** $149.75 **Benefit:** 75% = $112.35 85% = $127.30
30241	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $356.35 **Benefit:** 75% = $267.30 85% = $302.90
30244	STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.) **Fee:** $356.35 **Benefit:** 75% = $267.30
30246	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) **Fee:** $689.80 **Benefit:** 75% = $517.35
30247	PAROTID GLAND, total extirpation of (Anaes.) (Assist.) **Fee:** $739.35 **Benefit:** 75% = $554.55
30250	PAROTID GLAND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist.) **Fee:** $1,251.10 **Benefit:** 75% = $938.35
30251	RECURRENT PAROTID TUMOUR, excision of, with preservation of facial nerve (Anaes.) (Assist.) **Fee:** $1,921.75 **Benefit:** 75% = $1,441.35 85% = $1,842.25
30253	PAROTID GLAND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes.) (Assist.) **Fee:** $834.05 **Benefit:** 75% = $625.55
30255	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) **Fee:** $1,110.65 **Benefit:** 75% = $833.00
30256	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.) **Fee:** $445.40 **Benefit:** 75% = $334.05
30259	SUBLINGUAL GLAND, extirpation of (Anaes.) **Fee:** $198.50 **Benefit:** 75% = $148.90 85% = $168.75
30262	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) **Fee:** $58.80 **Benefit:** 75% = $44.10 85% = $50.00
30265 G 30266 S	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.) **Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95 **Fee:** $149.75 **Benefit:** 75% = $112.35 85% = $127.30
30269	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.) **Fee:** $149.75 **Benefit:** 75% = $112.35 85% = $127.30
30272	TONGUE, partial excision of (Anaes.) (Assist.) **Fee:** $295.70 **Benefit:** 75% = $221.80 85% = $251.35
30275	RADICAL EXCISION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE AND LYMPH GLANDS OF NECK (commandotype operation) (Anaes.) (Assist.) **Fee:** $1,762.75 **Benefit:** 75% = $1,322.10
30278	TONGUE TIE, repair of, not being a service to which another item in this Group applies (Anaes.) **Fee:** $46.50 **Benefit:** 75% = $34.90 85% = $39.55
30281	TONGUE TIE, MANDIBULAR FRENULUM or MAXILLARY FRENULUM, repair of, in a person aged 2 years and over, under general anaesthesia (Anaes.) **Fee:** $119.50 **Benefit:** 75% = $89.65 85% = $101.60

	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.)
30282 G	**Fee:** $155.40 **Benefit:** 75% = $116.55 85% = $132.10
30283 S	**Fee:** $204.70 **Benefit:** 75% = $153.55 85% = $174.00
	BRANCHIAL CYST, on a person 10 years of age or over. Removal of, (Anaes.) (Assist.)
30286	**Fee:** $397.85 **Benefit:** 75% = $298.40 85% = $338.20
	BRANCHIAL CYST, on a person under 10 years of age. Removal of, (Anaes.) (Assist.)
30287	**Fee:** $517.20 **Benefit:** 75% = $387.90 85% = $439.65
	BRANCHIAL FISTULA, on a person 10 years of age or over. Removal of, (Anaes.) (Assist.)
30289	**Fee:** $502.25 **Benefit:** 75% = $376.70
	CERVICAL OESOPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or without plastic repair (Anaes.) (Assist.)
30293	**Fee:** $445.40 **Benefit:** 75% = $334.05 85% = $378.60
	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.)
30294	**Fee:** $1,762.75 **Benefit:** 75% = $1,322.10
	THYROIDECTOMY, total (Anaes.) (Assist.)
30296	**Fee:** $1,023.70 **Benefit:** 75% = $767.80
	THYROIDECTOMY following previous thyroid surgery (Anaes.) (Assist.)
30297	**Fee:** $1,023.70 **Benefit:** 75% = $767.80
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level I axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30300, 30302 or 30303 applies (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)*
30299	**Fee:** $637.45 **Benefit:** 75% = $478.10
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level II/III axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30299, 30302 or 30303 applies (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)*
30300	**Fee:** $764.90 **Benefit:** 75% = $573.70
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level I axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30303 applies (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)*
30302	**Fee:** $509.95 **Benefit:** 75% = $382.50
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level II/III axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30302 applies (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)*
30303	**Fee:** $611.85 **Benefit:** 75% = $458.90
	TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.)
30306	**Fee:** $798.65 **Benefit:** 75% = $599.00
	BILATERAL SUBTOTAL THYROIDECTOMY (Anaes.) (Assist.)
30308	**Fee:** $798.65 **Benefit:** 75% = $599.00
	THYROIDECTOMY, SUBTOTAL for THYROTOXICOSIS (Anaes.) (Assist.)
30309	**Fee:** $1,023.70 **Benefit:** 75% = $767.80
	THYROID, unilateral subtotal thyroidectomy or equivalent partial thyroidectomy (Anaes.) (Assist.)
30310	**Fee:** $457.40 **Benefit:** 75% = $343.05
	THYROGLOSSAL CYST, removal of (Anaes.) (Assist.)
30313	**Fee:** $272.95 **Benefit:** 75% = $204.75 85% = $232.05

30314	THYROGLOSSAL CYST or FISTULA or both, on a person 10 years of age or over. Radical removal of, including thyroglossal duct and portion of hyoid bone (Anaes.) (Assist.) **Fee:** $457.40 **Benefit:** 75% = $343.05
30315	PARATHYROID operation for hyperparathyroidism (Anaes.) (Assist.) **Fee:** $1,139.90 **Benefit:** 75% = $854.95
30317	CERVICAL REEXPLORATION for recurrent or persistent hyperparathyroidism (Anaes.) (Assist.) **Fee:** $1,364.90 **Benefit:** 75% = $1,023.70
30318	MEDIASTINUM, exploration of, via the cervical route, for hyperparathyroidism (including thymectomy) (Anaes.) (Assist.) **Fee:** $907.60 **Benefit:** 75% = $680.70
30320	MEDIASTINUM, exploration of, via mediastinotomy, for hyperparathyroidism (including thymectomy) (Anaes.) (Assist.) **Fee:** $1,364.90 **Benefit:** 75% = $1,023.70
30321	RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of (Anaes.) (Assist.) **Fee:** $907.60 **Benefit:** 75% = $680.70
30323	RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of, requiring complex and extensive dissection (Anaes.) (Assist.) **Fee:** $1,364.90 **Benefit:** 75% = $1,023.70
30324	ADRENAL GLAND TUMOUR, excision of (Anaes.) (Assist.) **Fee:** $1,364.90 **Benefit:** 75% = $1,023.70
30326	THYROGLOSSAL CYST or FISTULA or both, radical removal of, including thyroglossal duct and portion of hyoid bone, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $594.60 **Benefit:** 75% = $445.95
30329	LYMPH GLANDS of GROIN, limited excision of (Anaes.) **Fee:** $246.95 **Benefit:** 75% = $185.25 85% = $209.95
30330	LYMPH GLANDS of GROIN, radical excision of (Anaes.) (Assist.) **Fee:** $718.75 **Benefit:** 75% = $539.10
30332	LYMPH NODES of AXILLA, limited excision of (sampling) (Anaes.) (Assist.) **Fee:** $346.75 **Benefit:** 75% = $260.10
30335	LYMPH NODES of AXILLA, complete excision of, to level I (Anaes.) (Assist.) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $866.85 **Benefit:** 75% = $650.15
30336	LYMPH NODES of AXILLA, complete excision of, to level II or level III (Anaes.) (Assist.) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $1,040.25 **Benefit:** 75% = $780.20
30373	LAPAROTOMY (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.) **Fee:** $483.25 **Benefit:** 75% = $362.45
30375	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, Gastrotomy, on a person 10 years of age or over. Reduction of intussusception, Removal of Meckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas (Anaes.) (Assist.) *(See para T8.14 of explanatory notes to this Category)* **Fee:** $521.25 **Benefit:** 75% = $390.95
30376	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intraabdominal procedure is performed) on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $521.25 **Benefit:** 75% = $390.95
30378	LAPAROTOMY involving division of adhesions in conjunction with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $523.70 **Benefit:** 75% = $392.80

30379	LAPAROTOMY WITH DIVISION OF EXTENSIVE ADHESIONS (duration greater than 2 hours) with or without insertion of long intestinal tube (Anaes.) (Assist.) **Fee:** $928.15 **Benefit:** 75% = $696.15
30382	ENTEROCUTANEOUS FISTULA, radical repair of, involving extensive dissection and resection of bowel (Anaes.) (Assist.) **Fee:** $1,306.90 **Benefit:** 75% = $980.20
30384	LAPAROTOMY FOR GRADING OF LYMPHOMA, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (Anaes.) (Assist.) **Fee:** $1,099.40 **Benefit:** 75% = $824.55
30385	LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $563.30 **Benefit:** 75% = $422.50
30387	LAPAROTOMY INVOLVING OPERATION ON ABDOMINAL VISCERA (including pelvic viscera), not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $635.00 **Benefit:** 75% = $476.25
30388	LAPAROTOMY for trauma involving 3 or more organs (Anaes.) (Assist.) **Fee:** $1,597.55 **Benefit:** 75% = $1,198.20
30390	LAPAROSCOPY, diagnostic, not being a service associated with any other laparoscopic procedure, on a person 10 years of age or over (Anaes.) *(See para T8.15 of explanatory notes to this Category)* **Fee:** $219.95 **Benefit:** 75% = $165.00
30391	LAPAROSCOPY with biopsy (Anaes.) (Assist.) **Fee:** $284.35 **Benefit:** 75% = $213.30
30392	RADICAL OR DEBULKING OPERATION for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Anaes.) (Assist.) **Fee:** $674.50 **Benefit:** 75% = $505.90
30393	LAPAROSCOPIC DIVISION OF ADHESIONS in association with another intra-abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.) **Fee:** $523.70 **Benefit:** 75% = $392.80
30394	LAPAROTOMY for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess, ruptured appendix or for peritonitis from any cause, with or without appendicectomy (Anaes.) (Assist.) **Fee:** $492.85 **Benefit:** 75% = $369.65
30396	LAPAROTOMY for gross intra peritoneal sepsis requiring debridement of fibrin, with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity via a major abdominal incision, with or without closure of abdomen and with or without mesh or zipper insertion (Anaes.) (Assist.) *(See para T8.16 of explanatory notes to this Category)* **Fee:** $1,016.55 **Benefit:** 75% = $762.45
30397	LAPAROSTOMY, via wound previously made and left open or closed with zipper, involving change of dressings or packs, and with or without drainage of loculated collections (Anaes.) **Fee:** $232.35 **Benefit:** 75% = $174.30
30399	LAPAROSTOMY, final closure of wound made at previous operation, after removal of dressings or packs and removal of mesh or zipper if previously inserted (Anaes.) (Assist.) **Fee:** $319.60 **Benefit:** 75% = $239.70
30400	LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic therapy including placement of reservoir (Anaes.) (Assist.) **Fee:** $632.50 **Benefit:** 75% = $474.40
30402	RETROPERITONEAL ABSCESS, drainage of, not involving laparotomy (Anaes.) (Assist.) **Fee:** $464.60 **Benefit:** 75% = $348.45
30403	VENTRAL, INCISIONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repair of with or without mesh (Anaes.) (Assist.) **Fee:** $521.25 **Benefit:** 75% = $390.95

30405	VENTRAL OR INCISIONAL HERNIA, (excluding recurrent inguinal or femoral hernia), repair of, requiring muscle transposition, mesh hernioplasty or resection of strangulated bowel (Anaes.) (Assist.) **Fee:** $914.95 **Benefit:** 75% = $686.25
30406	PARACENTESIS ABDOMINIS (Anaes.) **Fee:** $52.20 **Benefit:** 75% = $39.15 85% = $44.40
30408	PERITONEOVENOUS shunt, insertion of (Anaes.) (Assist.) **Fee:** $392.10 **Benefit:** 75% = $294.10
30409	LIVER BIOPSY, percutaneous (Anaes.) **Fee:** $174.45 **Benefit:** 75% = $130.85 85% = $148.30
30411	LIVER BIOPSY by wedge excision when performed in conjunction with another intraabdominal procedure (Anaes.) **Fee:** $88.80 **Benefit:** 75% = $66.60
30412	LIVER BIOPSY by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.) **Fee:** $52.35 **Benefit:** 75% = $39.30 85% = $44.50
30414	LIVER, subsegmental resection of, (local excision), other than for trauma (Anaes.) (Assist.) **Fee:** $689.80 **Benefit:** 75% = $517.35
30415	LIVER, segmental resection of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,379.50 **Benefit:** 75% = $1,034.65
30416	LIVER CYST, laparoscopic marsupialisation of, where the size of the cyst is greater than 5cm in diameter (Anaes.) (Assist.) **Fee:** $748.95 **Benefit:** 75% = $561.75
30417	LIVER CYSTS, laparoscopic marsupialisation of 5 or more, including any cyst greater than 5cm in diameter (Anaes.) (Assist.) **Fee:** $1,123.40 **Benefit:** 75% = $842.55
30418	LIVER, lobectomy of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,597.55 **Benefit:** 75% = $1,198.20
30419	LIVER TUMOURS, destruction of, by hepatic cryotherapy, not being a service associated with a service to which item 50950 or 50952 applies (Anaes.) (Assist.) **Fee:** $817.10 **Benefit:** 75% = $612.85 85% = $737.60
30421	LIVER, TRI-SEGMENTAL RESECTION (extended lobectomy) of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,996.55 **Benefit:** 75% = $1,497.45
30422	LIVER, repair of superficial laceration of, for trauma (Anaes.) (Assist.) **Fee:** $675.35 **Benefit:** 75% = $506.55
30425	LIVER, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.) **Fee:** $1,306.90 **Benefit:** 75% = $980.20
30427	LIVER, segmental resection of, for trauma (Anaes.) (Assist.) **Fee:** $1,560.95 **Benefit:** 75% = $1,170.75
30428	LIVER, lobectomy of, for trauma (Anaes.) (Assist.) **Fee:** $1,670.00 **Benefit:** 75% = $1,252.50 85% = $1,590.50
30430	LIVER, extended lobectomy (tri-segmental resection) of, for trauma (Anaes.) (Assist.) **Fee:** $2,323.30 **Benefit:** 75% = $1,742.50 85% = $2,243.80
30431	LIVER ABSCESS, open abdominal drainage of (Anaes.) (Assist.) **Fee:** $521.25 **Benefit:** 75% = $390.95 85% = $443.10
30433	LIVER ABSCESS (multiple), open abdominal drainage of (Anaes.) (Assist.) **Fee:** $726.05 **Benefit:** 75% = $544.55
30434	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles (Anaes.) (Assist.) **Fee:** $588.15 **Benefit:** 75% = $441.15

30436	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles, with omentoplasty or myeloplasty (Anaes.) (Assist.) **Fee:** $653.45 **Benefit:** 75% = $490.10
30437	HYDATID CYST OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall) (Anaes.) (Assist.) **Fee:** $813.30 **Benefit:** 75% = $610.00
30438	HYDATID CYST OF LIVER, excision of, with drainage and excision of liver tissue (Anaes.) (Assist.) **Fee:** $1,150.85 **Benefit:** 75% = $863.15 85% = $1,071.35
30439	OPERATIVE CHOLANGIOGRAPHY OR OPERATIVE PANCREATOGRAPHY OR INTRA OPERATIVE ULTRASOUND of the biliary tract (including 1 or more examinations performed during the 1 operation) (Anaes.) (Assist.) **Fee:** $185.60 **Benefit:** 75% = $139.20
30440	CHOLANGIOGRAM, percutaneous transhepatic, and insertion of biliary drainage tube, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30451 applies (Anaes.) (Assist.) **Fee:** $526.40 **Benefit:** 75% = $394.80 85% = $447.45
30441	INTRA OPERATIVE ULTRASOUND for staging of intra abdominal tumours (Anaes.) **Fee:** $136.25 **Benefit:** 75% = $102.20
30442	CHOLEDOCHOSCOPY in conjunction with another procedure (Anaes.) **Fee:** $185.60 **Benefit:** 75% = $139.20
30443	CHOLECYSTECTOMY (Anaes.) (Assist.) **Fee:** $739.35 **Benefit:** 75% = $554.55
30445	LAPAROSCOPIC CHOLECYSTECTOMY (Anaes.) (Assist.) **Fee:** $739.35 **Benefit:** 75% = $554.55
30446	LAPAROSCOPIC CHOLECYSTECTOMY when procedure is completed by laparotomy (Anaes.) (Assist.) **Fee:** $739.35 **Benefit:** 75% = $554.55
30448	LAPAROSCOPIC CHOLECYSTECTOMY, involving removal of common duct calculi via the cystic duct (Anaes.) (Assist.) **Fee:** $972.90 **Benefit:** 75% = $729.70
30449	LAPAROSCOPIC CHOLECYSTECTOMY with removal of common duct calculi via laparoscopic choledochotomy (Anaes.) (Assist.) **Fee:** $1,081.85 **Benefit:** 75% = $811.40
30450	CALCULUS OF BILIARY OR RENAL TRACT, extraction of, using interventional imaging techniques - not being a service associated with a service to which items 36627, 36630, 36645 or 36648 applies (Anaes.) (Assist.) **Fee:** $524.40 **Benefit:** 75% = $393.30 85% = $445.75
30451	BILIARY DRAINAGE TUBE, exchange of, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30440 applies (Anaes.) (Assist.) **Fee:** $267.65 **Benefit:** 75% = $200.75 85% = $227.55
30452	CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Anaes.) (Assist.) **Fee:** $377.50 **Benefit:** 75% = $283.15
30454	CHOLEDOCHOTOMY (with or without cholecystectomy), with or without removal of calculi (Anaes.) (Assist.) **Fee:** $862.50 **Benefit:** 75% = $646.90
30455	CHOLEDOCHOTOMY (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (Anaes.) (Assist.) **Fee:** $1,014.05 **Benefit:** 75% = $760.55
30457	CHOLEDOCHOTOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.) (Assist.) **Fee:** $1,379.50 **Benefit:** 75% = $1,034.65 85% = $1,300.00
30458	TRANSDUODENAL OPERATION ON SPHINCTER OF ODDI, involving 1 or more of, removal of calculi, sphincterotomy, sphincteroplasty, biopsy, local excision of peri-ampullary or duodenal tumour, sphincteroplasty of the pancreatic duct, pancreatic duct septoplasty, with or without choledochotomy (Anaes.) (Assist.) **Fee:** $1,014.05 **Benefit:** 75% = $760.55

30460	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes.) (Assist.) **Fee:** $862.50 **Benefit:** 75% = $646.90
30461	RADICAL RESECTION of porta hepatis with biliary-enteric anastomoses, not being a service associated with a service to which item 30443, 30454, 30455, 30458 or 30460 applies (Anaes.) (Assist.) **Fee:** $1,478.40 **Benefit:** 75% = $1,108.80
30463	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses (Anaes.) (Assist.) **Fee:** $1,815.20 **Benefit:** 75% = $1,361.40
30464	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, involving more than 2 anastomoses or resection of segment or major portion of segment of liver (Anaes.) (Assist.) **Fee:** $2,178.25 **Benefit:** 75% = $1,633.70
30466	INTRAHEPATIC biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) **Fee:** $1,256.05 **Benefit:** 75% = $942.05
30467	INTRAHEPATIC BYPASS of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) **Fee:** $1,553.70 **Benefit:** 75% = $1,165.30
30469	BILIARY STRICTURE, repair of, after 1 or more operations on the biliary tree (Anaes.) (Assist.) **Fee:** $1,720.90 **Benefit:** 75% = $1,290.70 85% = $1,641.40
30472	HEPATIC OR COMMON BILE DUCT, repair of, as the primary procedure subsequent to partial or total transection of bile duct or ducts (Anaes.) (Assist.) **Fee:** $929.35 **Benefit:** 75% = $697.05 85% = $849.85
30473	OESOPHAGOSCOPY (not being a service to which item 41816 or 41822 applies), GASTROSCOPY, DUODENOSCOPY or PANENDOSCOPY (1 or more such procedures), with or without biopsy, not being a service associated with a service to which item 30476 or 30478 applies (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $177.10 **Benefit:** 75% = $132.85 85% = $150.55
30475	ENDOSCOPY with balloon dilatation of gastric or gastroduodenal stricture (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $320.25 **Benefit:** 75% = $240.20 85% = $272.25
30476	OESOPHAGOSCOPY (not being a service to which item 41816 or 41822 applies), GASTROSCOPY, DUODENOSCOPY or PANENDOSCOPY (1 or more such procedures), with endoscopic sclerosing injection or banding of oesophageal or gastric varices, not being a service associated with a service to which item 30473 or 30478 applies (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $245.55 **Benefit:** 75% = $184.20 85% = $208.75
30478	OESOPHAGOSCOPY (not being a service to which item 41816, 41822 or 41825 applies), gastroscopy, duodenoscopy or panendoscopy (1 or more such procedures), with 1 or more of the following endoscopic procedures - polypectomy, removal of foreign body, diathermy, heater probe or laser coagulation, or sclerosing injection of bleeding upper gastrointestinal lesions, not being a service associated with a service to which item 30473 or 30476 applies (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $245.55 **Benefit:** 75% = $184.20 85% = $208.75
30479	ENDOSCOPY with LASER THERAPY or ARGON PLASMA COAGULATION, for the treatment of neoplasia, benign vascular lesions, strictures of the gastrointestinal tract, tumorous overgrowth through or over oesophageal stents, peptic ulcers, angiodysplasia, gastric antral vascular ectasia (GAVE) or post-polypectomy bleeding, 1 or more of (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $476.10 **Benefit:** 75% = $357.10 85% = $404.70
30481	PERCUTANEOUS GASTROSTOMY (initial procedure), including any associated imaging services (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $357.00 **Benefit:** 75% = $267.75 85% = $303.45
30482	PERCUTANEOUS GASTROSTOMY (repeat procedure), including any associated imaging services (Anaes.) **Fee:** $253.85 **Benefit:** 75% = $190.40 85% = $215.80
30483	GASTROSTOMY BUTTON, CAECOSTOMY ANTEGRADE ENEMA DEVICE (CHAIT etc) or STOMAL INDWELLING DEVICE non-endoscopic insertion of, or non-endoscopic replacement of, on a person 10 years of age or over (Anaes.) **Fee:** $177.05 **Benefit:** 75% = $132.80 85% = $150.50

30484	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $364.90 **Benefit:** 75% = $273.70 85% = $310.20
30485	ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from common bile duct (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $563.30 **Benefit:** 75% = $422.50 85% = $483.80
30487	SMALL BOWEL INTUBATION with biopsy, as an independent procedure (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $180.90 **Benefit:** 75% = $135.70 85% = $153.80
30488	SMALL BOWEL INTUBATION as an independent procedure (Anaes.) **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50
30490	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $526.40 **Benefit:** 75% = $394.80 85% = $447.45
30491	BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dilatation) (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $555.35 **Benefit:** 75% = $416.55 85% = $475.85
30492	BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when performed), using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $787.30 **Benefit:** 75% = $590.50
30493	BILIARY MANOMETRY (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $333.20 **Benefit:** 75% = $249.90 85% = $283.25
30494	ENDOSCOPIC BILIARY DILATATION (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $420.50 **Benefit:** 75% = $315.40
30495	PERCUTANEOUS BILIARY DILATATION for biliary stricture, using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $787.30 **Benefit:** 75% = $590.50
30496	VAGOTOMY, truncal or selective, with or without pyloroplasty or gastroenterostomy (Anaes.) (Assist.) **Fee:** $588.15 **Benefit:** 75% = $441.15 85% = $508.65
30497	VAGOTOMY and ANTRECTOMY (Anaes.) (Assist.) **Fee:** $701.30 **Benefit:** 75% = $526.00
30499	VAGOTOMY, highly selective (Anaes.) (Assist.) **Fee:** $834.05 **Benefit:** 75% = $625.55
30500	VAGOTOMY, highly selective with duodenoplasty for peptic stricture (Anaes.) (Assist.) **Fee:** $893.10 **Benefit:** 75% = $669.85 85% = $813.60
30502	VAGOTOMY, highly selective, with dilatation of pylorus (Anaes.) (Assist.) **Fee:** $985.70 **Benefit:** 75% = $739.30
30503	VAGOTOMY or ANTRECTOMY, or both, for peptic ulcer following previous operation for peptic ulcer (Anaes.) (Assist.) **Fee:** $1,103.80 **Benefit:** 75% = $827.85 85% = $1,024.30
30505	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision (Anaes.) (Assist.) **Fee:** $551.85 **Benefit:** 75% = $413.90
30506	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (Anaes.) (Assist.) **Fee:** $965.75 **Benefit:** 75% = $724.35
30508	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy (Anaes.) (Assist.) **Fee:** $1,016.55 **Benefit:** 75% = $762.45

30509	BLEEDING PEPTIC ULCER, control of, involving gastric resection (other than wedge resection) (Anaes.) (Assist.) **Fee:** $1,016.55 **Benefit:** 75% = $762.45 85% = $937.05
30515	Gastroenterostomy (including gastroduodenostomy) or enterocolostomy or enteroenterostomy, not being a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.) **Fee:** $704.35 **Benefit:** 75% = $528.30
30517	GASTROENTEROSTOMY, PYLOROPLASTY or GASTRODUODENOSTOMY, reconstruction of (Anaes.) (Assist.) **Fee:** $922.20 **Benefit:** 75% = $691.65
30518	Partial gastrectomy, not being a service associated with a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.) **Fee:** $987.50 **Benefit:** 75% = $740.65
30520	GASTRIC TUMOUR, removal of, by local excision, not being a service to which item 30518 applies (Anaes.) (Assist.) **Fee:** $675.35 **Benefit:** 75% = $506.55
30521	GASTRECTOMY, TOTAL, for benign disease (Anaes.) (Assist.) **Fee:** $1,444.90 **Benefit:** 75% = $1,083.70
30523	GASTRECTOMY, SUBTOTAL RADICAL, for carcinoma, (including splenectomy when performed) (Anaes.) (Assist.) *(See para T8.18 of explanatory notes to this Category)* **Fee:** $1,510.10 **Benefit:** 75% = $1,132.60
30524	GASTRECTOMY, TOTAL RADICAL, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (Anaes.) (Assist.) **Fee:** $1,662.65 **Benefit:** 75% = $1,247.00
30526	GASTRECTOMY, TOTAL, and including lower oesophagus, performed by left thoraco-abdominal incision or opening of diaphragmatic hiatus, (including splenectomy when performed) (Anaes.) (Assist.) **Fee:** $2,156.35 **Benefit:** 75% = $1,617.30
30527	ANTIREFLUX OPERATION by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus not being a service to which item 30601 applies (Anaes.) (Assist.) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $871.30 **Benefit:** 75% = $653.50
30529	ANTIREFLUX operation by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophagus (Anaes.) (Assist.) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $1,306.90 **Benefit:** 75% = $980.20
30530	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes.) (Assist.) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $784.20 **Benefit:** 75% = $588.15
30532	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $900.45 **Benefit:** 75% = $675.35
30533	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, WITH FUNDOPLASTY, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $1,071.00 **Benefit:** 75% = $803.25
30535	OESOPHAGECTOMY with gastric reconstruction by abdominal mobilisation and thoracotomy (Anaes.) (Assist.) **Fee:** $1,696.65 **Benefit:** 75% = $1,272.50
30536	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,720.90 **Benefit:** 75% = $1,290.70
30538	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest- conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,190.80 **Benefit:** 75% = $893.10

30539	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - conjoint surgery, co-surgeon (Assist.) **Fee:** $871.30 **Benefit:** 75% = $653.50
30541	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,517.50 **Benefit:** 75% = $1,138.15
30542	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,031.10 **Benefit:** 75% = $773.35
30544	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, co-surgeon (Assist.) **Fee:** $755.20 **Benefit:** 75% = $566.40
30545	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,837.10 **Benefit:** 75% = $1,377.85
30547	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,263.35 **Benefit:** 75% = $947.55 85% = $1,183.85
30548	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, co-surgeon (Assist.) **Fee:** $943.80 **Benefit:** 75% = $707.85 85% = $864.30
30550	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - 1 surgeon (Anaes.) (Assist.) **Fee:** $2,062.20 **Benefit:** 75% = $1,546.65
30551	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,423.15 **Benefit:** 75% = $1,067.40
30553	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,052.65 **Benefit:** 75% = $789.50 85% = $973.15
30554	OESOPHAGECTOMY with reconstruction by free jejunal graft - 1 surgeon (Anaes.) (Assist.) **Fee:** $2,294.45 **Benefit:** 75% = $1,720.85
30556	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,582.80 **Benefit:** 75% = $1,187.10
30557	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,169.00 **Benefit:** 75% = $876.75
30559	OESOPHAGUS, local excision for tumour of (Anaes.) (Assist.) **Fee:** $849.55 **Benefit:** 75% = $637.20 85% = $770.05
30560	OESOPHAGEAL PERFORATION, repair of, by thoracotomy (Anaes.) (Assist.) **Fee:** $943.80 **Benefit:** 75% = $707.85
30562	ENTEROSTOMY or COLOSTOMY, closure of (not involving resection of bowel), on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $595.00 **Benefit:** 75% = $446.25
30563	COLOSTOMY OR ILEOSTOMY, refashioning of, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $595.00 **Benefit:** 75% = $446.25 85% = $515.50
30564	SMALL BOWEL STRICTUREPLASTY for chronic inflammatory bowel disease (Anaes.) (Assist.) **Fee:** $772.30 **Benefit:** 75% = $579.25

30565	SMALL INTESTINE, resection of, without anastomosis (including formation of stoma) (Anaes.) (Assist.) **Fee:** $871.30 **Benefit:** 75% = $653.50
30566	SMALL INTESTINE, resection of, with anastomosis, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $967.85 **Benefit:** 75% = $725.90
30568	INTRAOPERATIVE ENTEROTOMY for visualisation of the small intestine by endoscopy (Anaes.) (Assist.) **Fee:** $726.05 **Benefit:** 75% = $544.55
30569	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy, with or without biopsies (Anaes.) (Assist.) **Fee:** $370.20 **Benefit:** 75% = $277.65
30571	APPENDICECTOMY, not being a service to which item 30574 applies on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $445.40 **Benefit:** 75% = $334.05
30572	LAPAROSCOPIC APPENDICECTOMY, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $445.40 **Benefit:** 75% = $334.05
30574	**NOTE:** *Multiple Operation and Multiple Anaesthetic rules apply to this item* APPENDICECTOMY, when performed in conjunction with any other intraabdominal procedure through the same incision (Anaes.) **Fee:** $123.25 **Benefit:** 75% = $92.45
30575	PANCREATIC ABSCESS, laparotomy and external drainage of, not requiring retro-pancreatic dissection (Anaes.) (Assist.) **Fee:** $512.70 **Benefit:** 75% = $384.55
30577	PANCREATIC NECROSECTOMY for PANCREATIC NECROSIS or ABSCESS FORMATION requiring major pancreatic or retro-pancreatic dissection, excluding aftercare (Anaes.) (Assist.) **Fee:** $1,089.15 **Benefit:** 75% = $816.90
30578	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of pancreatic tumour (Anaes.) (Assist.) **Fee:** $1,147.20 **Benefit:** 75% = $860.40
30580	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of duodenal tumour (Anaes.) (Assist.) **Fee:** $1,045.40 **Benefit:** 75% = $784.05
30581	ENDOCRINE TUMOUR, exploration of pancreas or duodenum for, but no tumour found (Anaes.) (Assist.) **Fee:** $762.35 **Benefit:** 75% = $571.80
30583	DISTAL PANCREATECTOMY (Anaes.) (Assist.) **Fee:** $1,194.25 **Benefit:** 75% = $895.70
30584	PANCREATICO-DUODENECTOMY, WHIPPLE'S OPERATION, with or without preservation of pylorus (Anaes.) (Assist.) **Fee:** $1,762.75 **Benefit:** 75% = $1,322.10
30586	PANCREATIC CYST ANASTOMOSIS TO STOMACH OR DUODENUM - by open or endoscopic means (Anaes.) (Assist.) **Fee:** $701.30 **Benefit:** 75% = $526.00
30587	PANCREATIC CYST, anastomosis to Roux loop of jejunum (Anaes.) (Assist.) **Fee:** $726.05 **Benefit:** 75% = $544.55
30589	PANCREATICO-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.) **Fee:** $1,251.10 **Benefit:** 75% = $938.35
30590	PANCREATICO-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.) **Fee:** $1,379.50 **Benefit:** 75% = $1,034.65
30593	PANCREATECTOMY, near total or total (including duodenum), with or without splenectomy (Anaes.) (Assist.) **Fee:** $1,887.75 **Benefit:** 75% = $1,415.85 85% = $1,808.25
30594	PANCREATECTOMY for pancreatitis following previously attempted drainage procedure or partial resection (Anaes.) (Assist.) **Fee:** $2,178.25 **Benefit:** 75% = $1,633.70
30596	SPLENORRHAPHY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.) **Fee:** $897.30 **Benefit:** 75% = $673.00

30597	SPLENECTOMY (Anaes.) (Assist.) **Fee:** $720.20 **Benefit:** 75% = $540.15
30599	SPLENECTOMY, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal incision (Anaes.) (Assist.) **Fee:** $1,306.90 **Benefit:** 75% = $980.20
30600	DIAPHRAGMATIC HERNIA, TRAUMATIC, repair of (Anaes.) (Assist.) **Fee:** $777.10 **Benefit:** 75% = $582.85
30601	Diaphragmatic hernia, congential repair of, by thoracic or abdominal approach, not being a service to which any of items 31569 to 31581 apply, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $957.30 **Benefit:** 75% = $718.00
30602	PORTAL HYPERTENSION, porto-caval shunt for (Anaes.) (Assist.) **Fee:** $1,553.70 **Benefit:** 75% = $1,165.30
30603	PORTAL HYPERTENSION, meso-caval shunt for (Anaes.) (Assist.) **Fee:** $1,640.90 **Benefit:** 75% = $1,230.70 85% = $1,561.40
30605	PORTAL HYPERTENSION, selective spleno-renal shunt for (Anaes.) (Assist.) **Fee:** $1,865.95 **Benefit:** 75% = $1,399.50
30606	PORTAL HYPERTENSION, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Anaes.) (Assist.) **Fee:** $1,110.80 **Benefit:** 75% = $833.10
30608	SMALL INTESTINE, resection of, with anastomosis, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $1,258.20 **Benefit:** 75% = $943.65
30609	FEMORAL OR INGUINAL HERNIA, laparoscopic repair of, not being a service associated with a service to which item 30614 applies (Anaes.) (Assist.) **Fee:** $464.50 **Benefit:** 75% = $348.40
30611	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata - removal of by surgical excision, where the specimen excised is sent for histological confirmation of diagnosis, on a person under 10 years of age , not being a service to which another item in this Group applies (Anaes.) (Assist.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $563.35 **Benefit:** 75% = $422.55 85% = $483.85
30614	FEMORAL OR INGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to which item 30403 or 30615 applies, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $464.50 **Benefit:** 75% = $348.40
30615	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel resection, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $521.25 **Benefit:** 75% = $390.95
30618	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, on a person under 10 years of age (Anaes.) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $522.25 **Benefit:** 75% = $391.70 85% = $443.95
30619	LAPAROSCOPIC SPLENECTOMY, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $936.25 **Benefit:** 75% = $702.20
30620 G 30621 S	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, in a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $299.45 **Benefit:** 75% = $224.60 **Fee:** $407.50 **Benefit:** 75% = $305.65
30622	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, Gastrotomy, Reduction of intussusception, Removal of Meckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty or Drainage of pancreas on a person under 10 years of age (Anaes.) (Assist.) *(See para T8.14 of explanatory notes to this Category)* **Fee:** $677.65 **Benefit:** 75% = $508.25

30623	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intraabdominal procedure is performed) on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $677.65 **Benefit:** 75% = $508.25
30626	LAPAROTOMY involving division of adhesions in conjunction with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $680.80 **Benefit:** 75% = $510.60
30627	LAPAROSCOPY, diagnostic, not being a service associated with any other laparoscopic procedure, on a person under 10 years of age (Anaes.) *(See para T8.15 of explanatory notes to this Category)* **Fee:** $285.95 **Benefit:** 75% = $214.50
30628	HYDROCELE, tapping of **Fee:** $35.60 **Benefit:** 75% = $26.70 85% = $30.30
30631	HYDROCELE, removal of, not being a service associated with a service to which items 30638, 30641 and 30644 apply (Anaes.) **Fee:** $236.65 **Benefit:** 75% = $177.50 85% = $201.20
30634 G 30635 S	VARICOCELE, surgical correction of, not being a service associated with a service to which items 30638, 30641 and 30644 apply, 1 procedure (Anaes.) (Assist.) **Fee:** $235.05 **Benefit:** 75% = $176.30 **Fee:** $291.80 **Benefit:** 75% = $218.85
30636	GASTROSTOMY BUTTON, caecostomy antegrade enema device (chait etc) and/or stomal indwelling device, non-endoscopic insertion of, or non-endoscopic replacement of, on a person under 10 years of age (Anaes.) **Fee:** $233.15 **Benefit:** 75% = $174.90 85% = $198.20
30637	ENTEROSTOMY or COLOSTOMY, closure of not involving resection of bowel, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $773.50 **Benefit:** 75% = $580.15
30638 G 30641 S	ORCHIDECTOMY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis (Anaes.) (Assist.) **Fee:** $299.45 **Benefit:** 75% = $224.60 **Fee:** $407.50 **Benefit:** 75% = $305.65
30639	COLOSTOMY OR ILEOSTOMY, refashioning of, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $773.50 **Benefit:** 75% = $580.15 85% = $694.00
30643	EXPLORATION OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $677.65 **Benefit:** 75% = $508.25
30644	EXPLORATION OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $521.25 **Benefit:** 75% = $390.95
30645	APPENDICECTOMY, not being a service to which item 30574 applies, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $579.00 **Benefit:** 75% = $434.25
30646	LAPAROSCOPIC APPENDICECTOMY, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $579.00 **Benefit:** 75% = $434.25
30649	HAEMORRHAGE, arrest of, following circumcision requiring general anaesthesia on a person under 10 years of age (Anaes.) **Fee:** $187.65 **Benefit:** 75% = $140.75 85% = $159.55
30653	**Circumcision** of the penis, on a person **under 6 months** of age (Anaes.) **Fee:** $46.50 **Benefit:** 75% = $34.90 85% = $39.55
30656	**Circumcision** of the penis, on a person **under 10 years** of age but not less than 6 months of age (Anaes.) **Fee:** $108.15 **Benefit:** 75% = $81.15 85% = $91.95
30659 G 30660 S	**Circumcision of the penis**, on a person 10 years of age or over (Anaes.) **Fee:** $149.75 **Benefit:** 75% = $112.35 85% = $127.30 **Fee:** $185.60 **Benefit:** 75% = $139.20 85% = $157.80

30663	HAEMORRHAGE, arrest of, following circumcision requiring general anaesthesia on a person 10 years of age or over (Anaes.) **Fee:** $144.35 **Benefit:** 75% = $108.30 85% = $122.70
30666	PARAPHIMOSIS or PHIMOSIS, reduction of, under general anaesthesia, with or without dorsal incision, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $47.45 **Benefit:** 75% = $35.60 85% = $40.35
30672	COCCYX, excision of (Anaes.) (Assist.) **Fee:** $445.40 **Benefit:** 75% = $334.05
30675 G 30676 S	PILONIDAL SINUS OR CYST, OR SACRAL SINUS OR CYST, excision of (Anaes.) **Fee:** $299.45 **Benefit:** 75% = $224.60 85% = $254.55 **Fee:** $379.05 **Benefit:** 75% = $284.30 85% = $322.20
30679	PILONIDAL SINUS, injection of sclerosant fluid under anaesthesia (Anaes.) **Fee:** $96.30 **Benefit:** 75% = $72.25 85% = $81.90
30680	Balloon enteroscopy, examination of the small bowel (oral approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $1,170.00 **Benefit:** 75% = $877.50 85% = $1,090.50
30682	Balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $1,170.00 **Benefit:** 75% = $877.50 85% = $1,090.50
30684	Balloon enteroscopy, examination of the small bowel (oral approach), with or without biopsy, WITH 1 or more of the following procedures (snare polypectomy, removal of foreign body, diathermy, heater probe, laser coagulation or argon plasma coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $1,439.85 **Benefit:** 75% = $1,079.90 85% = $1,360.35
30686	Balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, WITH 1 or more of the following procedures (snare polypectomy, removal of foreign body, diathermy, heater probe, laser coagulation or argon plasma coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $1,439.85 **Benefit:** 75% = $1,079.90 85% = $1,360.35

30687	ENDOSCOPY with RADIOFREQUENCY ABLATION of mucosal metaplasia for the treatment of Barrett's Oesophagus in a single course of treatment, following diagnosis of high grade dysplasia confirmed by histological examination (Anaes.) *(See para T8.17 and T8.20 of explanatory notes to this Category)* **Fee:** $476.10 **Benefit:** 75% = $357.10 85% = $404.70
30688	ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) *(See para T8.17 and T8.21 of explanatory notes to this Category)* **Fee:** $364.90 **Benefit:** 75% = $273.70 85% = $310.20
30690	ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, WITH FINE NEEDLE ASPIRATION, including aspiration of the locoregional lymph nodes if performed, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) *(See para T8.17 and T8.21 of explanatory notes to this Category)* **Fee:** $563.30 **Benefit:** 75% = $422.50 85% = $483.80
30692	ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) *(See para T8.17 and T8.21 of explanatory notes to this Category)* **Fee:** $364.90 **Benefit:** 75% = $273.70 85% = $310.20
30694	ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, WITH FINE NEEDLE ASPIRATION for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) *(See para T8.17 and T8.21 of explanatory notes to this Category)* **Fee:** $563.30 **Benefit:** 75% = $422.50 85% = $483.80
30696	ENDOSCOPIC ULTRASOUND GUIDED FINE NEEDLE ASPIRATION BIOPSY(S) (endoscopy with ultrasound imaging) to obtain one or more specimens from either: (a) mediastinal mass(es) or (b) locoregional nodes to stage non-small cell lung carcinoma not being a service associated with another item in this subgroup or to which items 30710 and 55054 apply (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $563.30 **Benefit:** 75% = $422.50 85% = $483.80
30710	ENDOBRONCHIAL ULTRASOUND GUIDED BIOPSY(S) (bronchoscopy with ultrasound imaging, with or without associated fluoroscopic imaging) to obtain one or more specimens by either: (a) transbronchial biopsy(s) of peripheral lung lesions; or (b) fine needle aspiration(s) of a mediastinal mass(es); or (c) fine needle aspiration(s) of locoregional nodes to stage non-small cell lung carcinoma not being a service associated with another item in this subgroup or to which items 30696, 41892, 41898, and 60500 to 60509 applies (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $563.30 **Benefit:** 75% = $422.50 85% = $483.80
31000	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 6 or fewer sections (Anaes.) **Fee:** $580.90 **Benefit:** 75% = $435.70 85% = $501.40
31001	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 7 to 12 sections (inclusive) (Anaes.) **Fee:** $726.05 **Benefit:** 75% = $544.55 85% = $646.55
31002	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 13 or more sections (Anaes.) **Fee:** $871.30 **Benefit:** 75% = $653.50 85% = $791.80

31200	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach to an operation), **removal by surgical excision (other than shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** not being a service associated with a service to which item 45200, 45203 or 45206 applies and not being a service to which another item in this Group applies *(See para T8.22 of explanatory notes to this Category)* **Fee:** $34.00 **Benefit:** 75% = $25.50 85% = $28.90 **Extended Medicare Safety Net Cap:** $27.20
31205	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size up to and including 10mm in diameter**, **removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $95.45 **Benefit:** 75% = $71.60 85% = $81.15 **Extended Medicare Safety Net Cap:** $76.40
31210	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size more than 10mm and up to and including 20mm in diameter, removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $123.10 **Benefit:** 75% = $92.35 85% = $104.65
31215	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size more than 20mm in diameter, removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $143.55 **Benefit:** 75% = $107.70 85% = $122.05
31220	TUMOURS (other than viral verrucae [common warts] and seborrheic keratoses), CYSTS, ULCERS OR SCARS (other than scars removed during the surgical approach at an operation), **lesion size up to and including 10mm in diameter, removal of 4 to 10 lesions by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where the specimens excised are sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $214.55 **Benefit:** 75% = $160.95 85% = $182.40
31225	TUMOURS (other than viral verrucae [common warts] and seborrheic keratoses), CYSTS, ULCERS OR SCARS (other than scars removed during the surgical approach at an operation), **lesion size up to and including 10mm in diameter, removal of more than 10 lesions by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where the specimens excised are sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $381.30 **Benefit:** 75% = $286.00 85% = $324.15
31230	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision (other than by shave excision) and suture from nose, eyelid, lip, ear, digit or genitalia,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $168.05 **Benefit:** 75% = $126.05 85% = $142.85
31235	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision (other than by shave excision) and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, **lesion size up to and including 10mm in diameter** - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $143.55 **Benefit:** 75% = $107.70 85% = $122.05

31240	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision (other than by shave excision) and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, **lesion size more than 10mm in diameter** - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $168.05 **Benefit:** 75% = $126.05 85% = $142.85
31245	SKIN AND SUBCUTANEOUS TISSUE, extensive excision of, in the treatment of SUPPURATIVE HIDRADENITIS (excision from axilla, groin or natal cleft) or SYCOSIS BARBAE or NUCHAE (excision from face or neck) (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $369.00 **Benefit:** 75% = $276.75 85% = $313.65
31250	GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of body surface ***where the specimen excised is sent for histological confirmation of diagnosis*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $369.00 **Benefit:** 75% = $276.75 85% = $313.65
31255	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to and including 10mm in diameter -** where removal is by therapeutic **surgical excision (other than by shave excision) and suture and** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $221.35 **Benefit:** 75% = $166.05 85% = $188.15
31256	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***where previous excision was performed by the same practitioner***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $221.35 **Benefit:** 75% = $166.05 85% = $188.15
31257	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***where performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and where** ***the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $221.35 **Benefit:** 75% = $166.05 85% = $188.15
31258	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the tumour size is up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and where** ***the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $221.35 **Benefit:** 75% = $166.05 85% = $188.15
31260	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter** - where removal is by **therapeutic surgical excision (other than shave excision) and suture** ***and where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $315.65 **Benefit:** 75% = $236.75 85% = $268.35
31261	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***where previous excision was performed by the same practitioner***, **where the original tumour size was more than 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $315.65 **Benefit:** 75% = $236.75 85% = $268.35
31262	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***where performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the original tumour size was more than 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $315.65 **Benefit:** 75% = $236.75 85% = $268.35

31263	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the tumour size is more than 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $315.65 **Benefit:** 75% = $236.75 85% = $268.35
31265	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck, (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size up to and including 10mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $184.50 **Benefit:** 75% = $138.40 85% = $156.85
31266	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where previous excision was performed by the same practitioner***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $184.50 **Benefit:** 75% = $138.40 85% = $156.85
31267	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $184.50 **Benefit:** 75% = $138.40 85% = $156.85
31268	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the tumour size is up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $184.50 **Benefit:** 75% = $138.40 85% = $156.85
31270	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck, (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $258.25 **Benefit:** 75% = $193.70 85% = $219.55
31271	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where previous excision was performed by the same practitioner***, **where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $258.25 **Benefit:** 75% = $193.70 85% = $219.55
31272	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $258.25 **Benefit:** 75% = $193.70 85% = $219.55

31273	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the tumour size is more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $258.25 **Benefit:** 75% = $193.70 85% = $219.55
31275	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 20mm in diameter** and where removal is by **therapeutic surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $299.25 **Benefit:** 75% = $224.45 85% = $254.40
31276	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where previous excision was performed by the same practitioner***, **where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $299.25 **Benefit:** 75% = $224.45 85% = $254.40
31277	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $299.25 **Benefit:** 75% = $224.45 85% = $254.40
31278	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the tumour size is more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $299.25 **Benefit:** 75% = $224.45 85% = $254.40
31280	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31255* and *31265*, tumour size up to and including 10mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $155.85 **Benefit:** 75% = $116.90 85% = $132.50
31281	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items *31255* and *31265*, *where previous excision was performed by the same practitioner***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $156.40 **Benefit:** 75% = $117.30 85% = $132.95
31282	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items *31255* and *31265*, *performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $156.40 **Benefit:** 75% = $117.30 85% = $132.95

	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from areas of the body not covered by items *31255* and *31265*, *whether previous excision was performed by the same practitioner* OR *performed by a practitioner other than the practitioner who provided the previous treatment*, where the tumour size is up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)*
31283	**Fee:** $156.40 **Benefit:** 75% = $117.30 85% = $132.95
	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31270*, tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture, *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)*
31285	**Fee:** $212.95 **Benefit:** 75% = $159.75 85% = $181.05
	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31270, *where previous excision was performed by the same practitioner*, where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)*
31286	**Fee:** $212.95 **Benefit:** 75% = $159.75 85% = $181.05
	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31270, *performed by a practitioner other than the practitioner who provided the previous treatment*, where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)*
31287	**Fee:** $212.95 **Benefit:** 75% = $159.75 85% = $181.05
	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from areas of the body not covered by items 31260 and 31270, *whether previous excision was performed by the same practitioner* OR *performed by a practitioner other than the practitioner who provided the previous treatment*, where the tumour size is more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)*
31288	**Fee:** $212.95 **Benefit:** 75% = $159.75 85% = $181.05
	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31275*, tumour size more than 20mm in diameter** and where removal is by **therapeutic surgical excision (other than by shave excision) and suture, *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)*
31290	**Fee:** $245.90 **Benefit:** 75% = $184.45 85% = $209.05
	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31275, *where previous excision was performed by the same practitioner*, where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)*
31291	**Fee:** $245.90 **Benefit:** 75% = $184.45 85% = $209.05
	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31275, *performed by a practitioner other than the practitioner who provided the previous treatment*, where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)*
31292	**Fee:** $245.90 **Benefit:** 75% = $184.45 85% = $209.05
	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from areas of the body not covered by items 31260 and 31275, *whether previous excision was performed by the same practitioner* OR *performed by a practitioner other than the practitioner who provided the previous treatment,* where the tumour size is more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)*
31293	**Fee:** $245.90 **Benefit:** 75% = $184.45 85% = $209.05

	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT (where lesion was treated by previous surgery, serial cautery and curettage, radiotherapy or two prolonged freeze/thaw cycles of liquid nitrogen therapy), ***performed by a specialist in the practice of his or her specialty or by a practitioner other than the practitioner who provided the previous treatment***, **removal from the head or neck (anterior to the sternomastoid muscles)**, where removal is by **surgical excision and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)*
31295	**Fee:** $292.85 **Benefit:** 75% = $219.65 85% = $248.95
	TREATMENT OF MALIGNANT MELANOMA AND LOCALLY AGGRESSIVE SKIN TUMOURS Definitive surgical excision for items 31300-31335 is defined as "surgical removal with an adequate margin and as a result, no further surgery is indicated at that site of excision". MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to and including 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)*
31300	**Fee:** $319.90 **Benefit:** 75% = $239.95 85% = $271.95
	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE and **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)*
31305	**Fee:** $393.50 **Benefit:** 75% = $295.15 85% = $334.50
	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size up to and including 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)*
31310	**Fee:** $278.65 **Benefit:** 75% = $209.00 85% = $236.90
	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)*
31315	**Fee:** $352.50 **Benefit:** 75% = $264.40 85% = $299.65
	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 20mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)*
31320	**Fee:** $393.50 **Benefit:** 75% = $295.15 85% = $334.50
	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31300* and *31310* - tumour size up to and including 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)*
31325	**Fee:** $270.55 **Benefit:** 75% = $202.95 85% = $230.00

31330	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31305* and *31310* - <u>tumour size more than 10mm and up to and including 20mm in diameter</u>** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $319.90 **Benefit:** 75% = $239.95 85% = $271.95
31335	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31305* and *31320* - <u>tumour size more than 20mm in diameter</u>** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $369.00 **Benefit:** 75% = $276.75 85% = $313.65
31340	**NOTE:** *Multiple Operation and Multiple Anaesthetic rules apply to this item.* MUSCLE, BONE OR CARTILAGE, excision of one or more of, where clinically indicated, where the specimen excised is sent for histological confirmation, performed in association with excision of malignant tumour of skin covered by item **31255, 31256, 31257, 31258, 31260, 31261, 31262, 31263, 31265, 31266, 31267, 31268, 31270, 31271, 31272, 31273, 31275, 31276, 31277, 31278, 31280, 31281, 31282, 31283, 31285, 31286, 31287, 31288, 31290, 31291, 31292, 31293, 31295, 31300, 31305, 31310, 31315, 31320, 31325, 31330 or 31335** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Derived Fee:** 75% of the fee for excision of malignant tumour
31345	LIPOMA, removal of by surgical excision or liposuction, where lesion is subcutaneous and **<u>50mm or more in diameter</u>**, or is sub-fascial, ***where the specimen is sent for histological confirmation of diagnosis*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $210.95 **Benefit:** 75% = $158.25 85% = $179.35
31346	LIPOSUCTION (suction assisted lipolysis) to 1 regional area for treatment of contour problems of abdominal or upper arm or thigh fat due to repeated insulin injections, ***where the lesion is subcutaneous and 50mm or more in diameter*** (Anaes.) **Fee:** $210.95 **Benefit:** 75% = $158.25 85% = $179.35
31350	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata, removal of by surgical excision, where the specimen excised is sent for histological confirmation of diagnosis, on a person 10 years of age or over, not being a service to which another item in this Group applies (Anaes.) (Assist.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $433.35 **Benefit:** 75% = $325.05 85% = $368.35
31355	MALIGNANT TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage and bone, removal of by **surgical excision**, where ***histological proof of malignancy has been obtained***, not being a service to which another item in this Group applies (Anaes.) (Assist.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $714.45 **Benefit:** 75% = $535.85 85% = $634.95
31400	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR up to and including 20mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.) **Fee:** $261.05 **Benefit:** 75% = $195.80 85% = $221.90
31403	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 20mm and up to and including 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.) **Fee:** $301.35 **Benefit:** 75% = $226.05
31406	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.) **Fee:** $502.15 **Benefit:** 75% = $376.65 85% = $426.85
31409	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) **Fee:** $1,560.15 **Benefit:** 75% = $1,170.15
31412	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) **Fee:** $1,921.75 **Benefit:** 75% = $1,441.35
31420	LYMPH NODE OF NECK, biopsy of (Anaes.) **Fee:** $183.90 **Benefit:** 75% = $137.95 85% = $156.35

31423	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, on a person 10 years of age or over (Anaes.) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $401.75 **Benefit:** 75% = $301.35 85% = $341.50
31426	LYMPH NODES OF NECK, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $803.45 **Benefit:** 75% = $602.60
31429	LYMPH NODES OF NECK, selective dissection of 4 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes.) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $1,252.10 **Benefit:** 75% = $939.10
31432	LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections) (Anaes.) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $1,339.15 **Benefit:** 75% = $1,004.40
31435	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck (Anaes.) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $984.30 **Benefit:** 75% = $738.25
31438	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes.) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $1,560.15 **Benefit:** 75% = $1,170.15
31450	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken is 1 hour or less (Anaes.) (Assist.) **Fee:** $406.65 **Benefit:** 75% = $305.00
31452	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken in more than 1 hour (Anaes.) (Assist.) **Fee:** $711.50 **Benefit:** 75% = $533.65
31454	LAPAROSCOPY with drainage of pus, bile or blood, as an independent procedure (Anaes.) (Assist.) **Fee:** $563.30 **Benefit:** 75% = $422.50
31456	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition (Anaes.) **Fee:** $245.55 **Benefit:** 75% = $184.20
31458	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition, and where the use of imaging intensification is clinically indicated (Anaes.) **Fee:** $294.65 **Benefit:** 75% = $221.00
31460	PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes.) (Assist.) **Fee:** $357.00 **Benefit:** 75% = $267.75
31462	OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestinal resection (Anaes.) (Assist.) **Fee:** $521.25 **Benefit:** 75% = $390.95
31464	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopic technique - not being a service to which item 30601 applies (Anaes.) (Assist.) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $871.30 **Benefit:** 75% = $653.50
31466	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, revision procedure, by laparoscopy or open operation (Anaes.) (Assist.) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $1,306.95 **Benefit:** 75% = $980.25

31468	PARA-OESOPHAGEAL HIATUS HERNIA, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication (Anaes.) (Assist.) **Fee:** $1,435.85 **Benefit:** 75% = $1,076.90
31470	LAPAROSCOPIC SPLENECTOMY, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $720.20 **Benefit:** 75% = $540.15
31472	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY OR ROUX-EN-Y as a bypass procedure where prior biliary surgery has been performed (Anaes.) (Assist.) **Fee:** $1,169.80 **Benefit:** 75% = $877.35
31500	BREAST, BENIGN LESION up to and including 50mm in diameter, including simple cyst, fibroadenoma or fibrocystic disease, open surgical biopsy or excision of, with or without frozen section histology (Anaes.) *(See para T8.25 of explanatory notes to this Category)* **Fee:** $260.05 **Benefit:** 75% = $195.05 85% = $221.05
31503	BREAST, BENIGN LESION more than 50mm in diameter, excision of (Anaes.) (Assist.) *(See para T8.25 of explanatory notes to this Category)* **Fee:** $346.75 **Benefit:** 75% = $260.10 85% = $294.75
31506	BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes.) (Assist.) *(See para T8.25 of explanatory notes to this Category)* **Fee:** $390.10 **Benefit:** 75% = $292.60
31509	BREAST, MALIGNANT TUMOUR, open surgical biopsy of, with or without frozen section histology (Anaes.) *(See para T8.25 of explanatory notes to this Category)* **Fee:** $346.75 **Benefit:** 75% = $260.10 85% = $294.75
31512	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology (Anaes.) (Assist.) **Fee:** $650.15 **Benefit:** 75% = $487.65
31515	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes.) (Assist.) *(See para T8.25 of explanatory notes to this Category)* **Fee:** $436.15 **Benefit:** 75% = $327.15
31516	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology when targeted intraoperative radiotherapy (using an Intrabeam® device) is performed concurrently, if the requirements of item 15900 are met for the patient (Anaes.) (Assist.) **Fee:** $867.00 **Benefit:** 75% = $650.25
31519	BREAST, total mastectomy (H) (Anaes.) (Assist.) **Fee:** $736.05 **Benefit:** 75% = $552.05
31524	BREAST, subcutaneous mastectomy (H) (Anaes.) (Assist.) **Fee:** $1,040.25 **Benefit:** 75% = $780.20
31525	BREAST, mastectomy for gynecomastia, with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which item 45585 applies (H) (Anaes.) (Assist.) **Fee:** $520.00 **Benefit:** 75% = $390.00
31530	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, where imaging has demonstrated: (a) microcalcification of lesion; or (b) impalpable lesion less than 1cm in diameter - including pre-operative localisation of lesion where performed, not being a service to which items 31539, 31545 or 31548 apply **Fee:** $595.65 **Benefit:** 75% = $446.75 85% = $516.15
31533	FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes.) *(See para T8.27 of explanatory notes to this Category)* **Fee:** $137.90 **Benefit:** 75% = $103.45 85% = $117.25
31536	BREAST, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques - but not including imaging, not being a service to which item 31539, 31542 or 31545 applies (Anaes.) **Fee:** $189.40 **Benefit:** 75% = $142.05 85% = $161.00

31539	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a bore-enbloc stereotactic biopsy, for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons, and where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, not being a service to which item 31530, 31536 or 31548 applies (Anaes.) *(See para T8.2 and T8.28 of explanatory notes to this Category)* **Fee:** $398.80 **Benefit:** 75% = $299.10
31542	BREAST, initial guidewire localisation of lesion, by hookwire or similar device, when conducted by a radiologist as determined by the Royal Australian and New Zealand College of Radiologists, using interventional imaging techniques prior to using a bore-enbloc stereotactic biopsy - including imaging not being a service associated with a service to which item 31536 applies (Anaes.) *(See para T8.2 and T8.29 of explanatory notes to this Category)* **Fee:** $196.95 **Benefit:** 75% = $147.75 85% = $167.45
31545	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a bore-enbloc stereotactic biopsy, for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons; where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, including initial guidewire localisation of lesion, by hookwire or similar device, using interventional imaging techniques and including imaging not being a service associated with a service to which item 31530, 31536 or 31548 applies (Anaes.) *(See para T8.2 and T8.28 of explanatory notes to this Category)* **Fee:** $595.65 **Benefit:** 75% = $446.75 85% = $516.15
31548	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using mechanical biopsy device, for histological examination, not being a service to which items 31530, 31539 or 31545 apply (Anaes.) **Fee:** $137.90 **Benefit:** 75% = $103.45 85% = $117.25
31551	BREAST, HAEMATOMA, SEROMA OR INFLAMMATORY CONDITION including abscess, granulomatous mastitis or similar, exploration and drainage of when undertaken in the operating theatre of a hospital, excluding aftercare (Anaes.) **Fee:** $216.75 **Benefit:** 75% = $162.60 85% = $184.25
31554	BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.) **Fee:** $433.50 **Benefit:** 75% = $325.15
31557	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.) (Assist.) **Fee:** $346.75 **Benefit:** 75% = $260.10 85% = $294.75
31560	ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.) **Fee:** $346.75 **Benefit:** 75% = $260.10 85% = $294.75 **Extended Medicare Safety Net Cap:** $277.40
31563	INVERTED NIPPLE, surgical eversion of (Anaes.) **Fee:** $259.75 **Benefit:** 75% = $194.85 85% = $220.80
31566	ACCESSORY NIPPLE, excision of (Anaes.) **Fee:** $129.95 **Benefit:** 75% = $97.50 85% = $110.50
	BARIATRIC
31569	Adjustable gastric band, placement of, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.) *(See para T8.30 of explanatory notes to this Category)* **Fee:** $849.55 **Benefit:** 75% = $637.20
31572	Gastric bypass by Roux-en-Y including associated anastomoses, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity not being associated with a service to which item 30515 applies (Anaes.) (Assist.) *(See para T8.30 of explanatory notes to this Category)* **Fee:** $1,045.40 **Benefit:** 75% = $784.05
31575	Sleeve gastrectomy, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.) *(See para T8.30 of explanatory notes to this Category)* **Fee:** $849.55 **Benefit:** 75% = $637.20
31578	Gastroplasty (excluding by gastric plication), with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.) *(See para T8.30 of explanatory notes to this Category)* **Fee:** $849.55 **Benefit:** 75% = $637.20

31581	Gastric bypass by biliopancreatic diversion with or without duodenal switch including gastric resection and anastomoses, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.) *(See para T8.30 of explanatory notes to this Category)* **Fee:** $1,045.40 **Benefit:** 75% = $784.05
31584	Surgical reversal of adjustable gastric banding (removal or replacement of gastric band), gastric bypass, gastroplasty (excluding by gastric plication) or biliopancreatic diversion being services to which items 31569 to 31581 apply (Anaes.) (Assist.) *(See para T8.31 of explanatory notes to this Category)* **Fee:** $1,539.10 **Benefit:** 75% = $1,154.35 85% = $1,459.60
31587	Adjustment of gastric band as an independent procedure including any associated consultation **Fee:** $97.95 **Benefit:** 75% = $73.50 85% = $83.30
31590	Adjustment of gastric band reservoir, repair, revision or replacement of (Anaes.) (Assist.) **Fee:** $251.70 **Benefit:** 75% = $188.80 85% = $213.95
	SUBGROUP 2 - COLORECTAL
32000	LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.) **Fee:** $1,031.35 **Benefit:** 75% = $773.55
32003	LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.) **Fee:** $1,078.80 **Benefit:** 75% = $809.10
32004	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32005 or 32006 applies (Anaes.) (Assist.) **Fee:** $1,150.35 **Benefit:** 75% = $862.80
32005	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004 or 32006 applies (Anaes.) (Assist.) **Fee:** $1,299.55 **Benefit:** 75% = $974.70
32006	LEFT HEMICOLECTOMY, including the descending and sigmoid colon (including formation of stoma) (Anaes.) (Assist.) **Fee:** $1,150.35 **Benefit:** 75% = $862.80
32009	TOTAL COLECTOMY AND ILEOSTOMY (Anaes.) (Assist.) **Fee:** $1,364.60 **Benefit:** 75% = $1,023.45
32012	TOTAL COLECTOMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.) **Fee:** $1,507.40 **Benefit:** 75% = $1,130.55
32015	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anaes.) (Assist.) **Fee:** $1,852.50 **Benefit:** 75% = $1,389.40
32018	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.) **Fee:** $1,570.85 **Benefit:** 75% = $1,178.15
32021	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION (Assist.) **Fee:** $563.30 **Benefit:** 75% = $422.50
32023	Endoscopic insertion of stent or stents for large bowel obstruction, stricture or stenosis, including colonoscopy and any image intensification, where the obstruction is due to: a) a pre-diagnosed colorectal cancer, or cancer of an organ adjacent to the bowel; or b) an unknown diagnosis (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $555.35 **Benefit:** 75% = $416.55
32024	RECTUM, HIGH RESTORATIVE ANTERIOR RESECTION WITH INTRAPERITONEAL ANASTOMOSIS (of the rectum) greater than 10 centimetres from the anal verge excluding resection of sigmoid colon alone not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.) **Fee:** $1,364.60 **Benefit:** 75% = $1,023.45

32025	RECTUM, LOW RESTORATIVE ANTERIOR RESECTION WITH EXTRAPERITONEAL ANASTOMOSIS (of the rectum) less than 10 centimetres from the anal verge, with or without covering stoma not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.) **Fee:** $1,825.30 **Benefit:** 75% = $1,369.00
32026	RECTUM, ULTRA LOW RESTORATIVE RESECTION, with or without covering stoma, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge (Anaes.) (Assist.) **Fee:** $1,965.65 **Benefit:** 75% = $1,474.25
32028	RECTUM, LOW OR ULTRA LOW RESTORATIVE RESECTION, with peranal sutured coloanal anastomosis, with or without covering stoma (Anaes.) (Assist.) **Fee:** $2,106.20 **Benefit:** 75% = $1,579.65
32029	COLONIC RESERVOIR, construction of, being a service associated with a service to which any other item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $421.20 **Benefit:** 75% = $315.90
32030	RECTOSIGMOIDECTOMY (Hartmann's operation) (Anaes.) (Assist.) **Fee:** $1,031.35 **Benefit:** 75% = $773.55
32033	RESTORATION OF BOWEL following Hartmann's or similar operation, including dismantling of the stoma (Anaes.) (Assist.) **Fee:** $1,507.40 **Benefit:** 75% = $1,130.55
32036	SACROCOCCYGEAL AND PRESACRAL TUMOUR excision of (Anaes.) (Assist.) **Fee:** $1,911.80 **Benefit:** 75% = $1,433.85
32039	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF 1 surgeon (Anaes.) (Assist.) **Fee:** $1,535.05 **Benefit:** 75% = $1,151.30
32042	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.) **Fee:** $1,293.15 **Benefit:** 75% = $969.90
32045	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.) **Fee:** $483.95 **Benefit:** 75% = $363.00
32046	RECTUM and ANUS, abdomino-perineal resection of, combined synchronous operation - perineal resection where the perineal surgeon also provides assistance to the abdominal surgeon (Assist.) **Fee:** $747.90 **Benefit:** 75% = $560.95
32047	PERINEAL PROCTECTOMY (Anaes.) (Assist.) **Fee:** $871.30 **Benefit:** 75% = $653.50
32051	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy 1 surgeon (Anaes.) (Assist.) **Fee:** $2,316.60 **Benefit:** 75% = $1,737.45
32054	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $2,126.20 **Benefit:** 75% = $1,594.65
32057	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.) **Fee:** $563.30 **Benefit:** 75% = $422.50
32060	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy 1 surgeon (Anaes.) (Assist.) **Fee:** $2,316.60 **Benefit:** 75% = $1,737.45
32063	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $2,126.20 **Benefit:** 75% = $1,594.65
32066	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, perineal surgeon (Assist.) **Fee:** $563.30 **Benefit:** 75% = $422.50

32069	ILEOSTOMY RESERVOIR, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.) **Fee:** $1,713.65 **Benefit:** 75% = $1,285.25
32072	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), with or without biopsy **Fee:** $47.85 **Benefit:** 75% = $35.90 85% = $40.70
32075	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), UNDER GENERAL ANAESTHESIA, with or without biopsy, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $75.05 **Benefit:** 75% = $56.30 85% = $63.80
32078	SIGMOIDOSCOPIC EXAMINATION with diathermy OR resection of 1 or more polyps where the time taken is less than or equal to 45 minutes (Anaes.) **Fee:** $168.55 **Benefit:** 75% = $126.45 85% = $143.30
32081	SIGMOIDOSCOPIC EXAMINATION with diathermy OR resection of 1 or more polyps where the time taken is greater than 45 minutes (Anaes.) **Fee:** $231.45 **Benefit:** 75% = $173.60 85% = $196.75
32084	FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY up to the hepatic flexure, WITH or WITHOUT BIOPSY (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $111.35 **Benefit:** 75% = $83.55 85% = $94.65
32087	Endoscopic examination of the colon up to the hepatic flexure by FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY for the REMOVAL OF 1 OR MORE POLYPS or the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding by ARGON PLASMA COAGULATION, 1 or more of, not being a service to which item 32078 applies (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $204.70 **Benefit:** 75% = $153.55 85% = $174.00
32090	FIBREOPTIC COLONOSCOPY examination of colon beyond the hepatic flexure WITH or WITHOUT BIOPSY (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $334.35 **Benefit:** 75% = $250.80 85% = $284.20
32093	Endoscopic examination of the colon beyond the hepatic flexure by FIBREOPTIC COLONOSCOPY for the REMOVAL OF 1 OR MORE POLYPS, or the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding by ARGON PLASMA COAGULATION, 1 or more of (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $469.20 **Benefit:** 75% = $351.90 85% = $398.85
32094	ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES including colonoscopy (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $551.85 **Benefit:** 75% = $413.90
32095	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed by stoma, with or without biopsies (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $127.80 **Benefit:** 75% = $95.85 85% = $108.65
32096	RECTAL BIOPSY, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital (Anaes.) (Assist.) **Fee:** $256.95 **Benefit:** 75% = $192.75
32099	RECTAL TUMOUR of 5 centimetres or less in diameter, per anal submucosal excision of (Anaes.) (Assist.) **Fee:** $333.20 **Benefit:** 75% = $249.90
32102	RECTAL TUMOUR of greater than 5 centimetres in diameter, indicated by pathological examination, per anal submucosal excision of (Anaes.) (Assist.) **Fee:** $634.70 **Benefit:** 75% = $476.05
32103	RECTAL TUMOUR, of less than 4 cm in diameter, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32104 or 32106 applies (Anaes.) (Assist.) *(See para T8.17 and T8.32 of explanatory notes to this Category)* **Fee:** $772.30 **Benefit:** 75% = $579.25

32104	RECTAL TUMOUR, of 4 cm or greater in diameter, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32103 or 32106 applies (Anaes.) (Assist.) *(See para T8.17 and T8.32 of explanatory notes to this Category)* **Fee:** $999.65 **Benefit:** 75% = $749.75
32105	ANORECTAL CARCINOMA per anal full thickness excision of (Anaes.) (Assist.) **Fee:** $483.95 **Benefit:** 75% = $363.00 85% = $411.40
32106	ANTEROLATERAL INTRAPERITONEAL RECTAL TUMOUR, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy and if removal requires dissection within the peritoneal cavity, other than a service associated with a service to which item 32024, 32025, 32103 or 32104 applies (Anaes.) (Assist.) *(See para T8.17 and T8.32 of explanatory notes to this Category)* **Fee:** $1,364.60 **Benefit:** 75% = $1,023.45 85% = $1,285.10
32108	RECTAL TUMOUR, transsphincteric excision of (Kraske or similar operation) (Anaes.) (Assist.) **Fee:** $999.65 **Benefit:** 75% = $749.75
32111	RECTAL PROLAPSE Delorme procedure for (Anaes.) (Assist.) **Fee:** $634.70 **Benefit:** 75% = $476.05
32112	RECTAL PROLAPSE, perineal recto-sigmoidectomy for (Anaes.) (Assist.) **Fee:** $772.30 **Benefit:** 75% = $579.25
32114	RECTAL STRICTURE, per anal release of (Anaes.) **Fee:** $174.45 **Benefit:** 75% = $130.85 85% = $148.30
32115	RECTAL STRICTURE, dilatation of (Anaes.) **Fee:** $126.85 **Benefit:** 75% = $95.15
32117	RECTAL PROLAPSE, abdominal rectopexy of (Anaes.) (Assist.) **Fee:** $999.65 **Benefit:** 75% = $749.75
32120	RECTAL PROLAPSE, perineal repair of (Anaes.) (Assist.) **Fee:** $256.95 **Benefit:** 75% = $192.75
32123	ANAL STRICTURE, anoplasty for (Anaes.) (Assist.) **Fee:** $333.20 **Benefit:** 75% = $249.90 85% = $283.25
32126	ANAL INCONTINENCE, Parks' intersphincteric procedure for (Anaes.) (Assist.) **Fee:** $483.95 **Benefit:** 75% = $363.00
32129	ANAL SPHINCTER, direct repair of (Anaes.) (Assist.) **Fee:** $634.70 **Benefit:** 75% = $476.05
32131	RECTOCELE, transanal repair of rectocele (Anaes.) (Assist.) **Fee:** $533.60 **Benefit:** 75% = $400.20
32132	HAEMORRHOIDS OR RECTAL PROLAPSE sclerotherapy for (Anaes.) **Fee:** $45.10 **Benefit:** 75% = $33.85 85% = $38.35
32135	HAEMORRHOIDS OR RECTAL PROLAPSE rubber band ligation of, with or without sclerotherapy, cryotherapy or infra red therapy for (Anaes.) **Fee:** $67.50 **Benefit:** 75% = $50.65 85% = $57.40
32138	HAEMORRHOIDECTOMY including excision of anal skin tags when performed (Anaes.) **Fee:** $367.75 **Benefit:** 75% = $275.85 85% = $312.60
32139	HAEMORRHOIDECTOMY involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed (Anaes.) (Assist.) **Fee:** $367.75 **Benefit:** 75% = $275.85
32142	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of (Anaes.) **Fee:** $67.50 **Benefit:** 75% = $50.65 85% = $57.40

32145	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $135.05 **Benefit:** 75% = $101.30 85% = $114.80
32147	PERIANAL THROMBOSIS, incision of (Anaes.) **Fee:** $45.10 **Benefit:** 75% = $33.85 85% = $38.35
32150	OPERATION FOR FISSUREINANO, including excision or sphincterotomy, but excluding dilatation only (Anaes.) (Assist.) **Fee:** $256.95 **Benefit:** 75% = $192.75 85% = $218.45
32153	ANUS, DILATATION OF, under general anaesthesia, with or without disimpaction of faeces, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $70.10 **Benefit:** 75% = $52.60
32156	FISTULA-IN-ANO, SUBCUTANEOUS, excision of (Anaes.) **Fee:** $131.75 **Benefit:** 75% = $98.85 85% = $112.00
32159	ANAL FISTULA, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the lower half of the anal sphincter mechanism (Anaes.) (Assist.) **Fee:** $333.20 **Benefit:** 75% = $249.90
32162	ANAL FISTULA, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the upper half of the anal sphincter mechanism (Anaes.) (Assist.) **Fee:** $483.95 **Benefit:** 75% = $363.00
32165	ANAL FISTULA, repair of, by mucosal flap advancement (Anaes.) (Assist.) **Fee:** $634.70 **Benefit:** 75% = $476.05 85% = $555.20
32166	ANAL FISTULA - readjustment of Seton (Anaes.) **Fee:** $206.20 **Benefit:** 75% = $154.65 85% = $175.30
32168	FISTULA WOUND, review of, under general or regional anaesthetic, as an independent procedure (Anaes.) **Fee:** $131.75 **Benefit:** 75% = $98.85
32171	ANORECTAL EXAMINATION, with or without biopsy, under general anaesthetic, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $88.80 **Benefit:** 75% = $66.60
32174	INTR-AANAL, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.) **Fee:** $88.80 **Benefit:** 75% = $66.60 85% = $75.50
32175	INTRA-ANAL, PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating theatre of a hospital (excluding aftercare) (Anaes.) **Fee:** $162.65 **Benefit:** 75% = $122.00
32177	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.) **Fee:** $174.25 **Benefit:** 75% = $130.70
32180	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.) **Fee:** $256.95 **Benefit:** 75% = $192.75
32183	INTESTINAL SLING PROCEDURE prior to radiotherapy (Anaes.) (Assist.) **Fee:** $561.65 **Benefit:** 75% = $421.25
32186	COLONIC LAVAGE, total, intra operative (Anaes.) (Assist.) **Fee:** $561.65 **Benefit:** 75% = $421.25
32200	DISTAL MUSCLE, devascularisation of (Anaes.) (Assist.) **Fee:** $295.70 **Benefit:** 75% = $221.80 85% = $251.35
32203	ANAL OR PERINEAL GRACILOPLASTY (Anaes.) (Assist.) **Fee:** $635.00 **Benefit:** 75% = $476.25

32206	STIMULATOR AND ELECTRODES, insertion of, following previous graciloplasty (Anaes.) (Assist.) **Fee:** $573.70 **Benefit:** 75% = $430.30
32209	ANAL OR PERINEAL GRACILOPLASTY with insertion of stimulator and electrodes (Anaes.) (Assist.) **Fee:** $921.95 **Benefit:** 75% = $691.50
32210	GRACILIS NEOSPHINCTER PACEMAKER, replacement of (Anaes.) **Fee:** $255.45 **Benefit:** 75% = $191.60 85% = $217.15
32212	ANO-RECTAL APPLICATION OF FORMALIN in the treatment of radiation proctitis, where performed in the operating theatre of a hospital, excluding aftercare (Anaes.) **Fee:** $136.25 **Benefit:** 75% = $102.20 85% = $115.85
32213	SACRAL NERVE LEAD(S), placement of, percutaneous using fluoroscopic guidance, or open, and intraoperative test stimulation, for the management of faecal incontinence in a patient who has an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment. Contraindicated in: (a) patients under 18 years of age; and (b) patients 18 years of age or older who: (i) are medically unfit for surgery; or (ii) are pregnant or planning pregnancy; or (iii) have irritable bowel syndrome; or (iv) have congenital anorectal malformations; or (v) have active anal abscesses or fistulas; or (vi) have anorectal organic bowel disease, including cancer; or (vii) have functional effects of previous pelvic irradiation; or (viii) have congenital or acquired malformations of the sacrum; or (ix) have had rectal or anal surgery within the previous 12 months. (Anaes.) **Fee:** $660.95 **Benefit:** 75% = $495.75
32214	NEUROSTIMULATOR or RECEIVER, subcutaneous placement of, and placement and connection of extension wire(s) to sacral nerve electrode(s), for the management of faecal incontinence in a patient who has an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, using fluoroscopic guidance. Contraindicated in: (a) patients under 18 years of age; and (b) patients 18 years of age or older who: (i) are medically unfit for surgery; or (ii) are pregnant or planning pregnancy; or (iii) have irritable bowel syndrome; or (iv) have congenital anorectal malformations; or (v) have active anal abscesses or fistulas; or (vi) have anorectal organic bowel disease, including cancer; or (vii) have functional effects of previous pelvic irradiation; or (viii) have congenital or acquired malformations of the sacrum; or (ix) have had rectal or anal surgery within the previous 12 months. (Anaes.) (Assist.) **Fee:** $334.00 **Benefit:** 75% = $250.50
32215	SACRAL NERVE ELECTRODE(S), management, adjustment, and electronic programming of neurostimulator by a medical practitioner, for the management of faecal incontinence - each day. Contraindicated in: (a) patients under 18 years of age; and (b) patients 18 years of age or older who: (i) are medically unfit for surgery; or (ii) are pregnant or planning pregnancy; or (iii) have irritable bowel syndrome; or (iv) have congenital anorectal malformations; or (v) have active anal abscesses or fistulas; or (vi) have anorectal organic bowel disease, including cancer; or (vii) have functional effects of previous pelvic irradiation; or (viii) have congenital or acquired malformations of the sacrum; or (ix) have had rectal or anal surgery within the previous 12 months. **Fee:** $125.40 **Benefit:** 75% = $94.05 85% = $106.60

32216	SACRAL NERVE LEAD(S), inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, surgical repositioning of, percutaneous using fluoroscopic guidance, or open, to correct displacement or unsatisfactory positioning, and intraoperative test simulation, not being a service to which item 32213 applies. Contraindicated in: (a) patients under 18 years of age; and (b) patients 18 years of age or older who: (i) are medically unfit for surgery; or (ii) are pregnant or planning pregnancy; or (iii) have irritable bowel syndrome; or (iv) have congenital anorectal malformations; or (v) have active anal abscesses or fistulas; or (vi) have anorectal organic bowel disease, including cancer; or (vii) have functional effects of previous pelvic irradiation; or (viii) have congenital or acquired malformations of the sacrum; or (ix) have had rectal or anal surgery within the previous 12 months. (Anaes.) **Fee:** $593.55 **Benefit:** 75% = $445.20
32217	NEUROSTIMULATOR or RECEIVER, inserted for the management of faecal incontinence in a patient who had an anatomically intact but funcionaly deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, removal of. Contraindicated in: (a) patients under 18 years of age; and (b) patients 18 years of age or older who: (i) are medically unfit for surgery; or (ii) are pregnant or planning pregnancy; or (iii) have irritable bowel syndrome; or (iv) have congenital anorectal malformations; or (v) have active anal abscesses or fistulas; or (vi) have anorectal organic bowel disease, including cancer; or (vii) have functional effects of previous pelvic irradiation; or (viii) have congenital or acquired malformations of the sacrum; or (ix) have had rectal or anal surgery within the previous 12 months. (Anaes.) **Fee:** $156.30 **Benefit:** 75% = $117.25
32218	SACRAL NERVE LEAD(S), inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, removal of Contraindicated in: (a) patients under 18 years of age; and (b) patients 18 years of age or older who: (i) are medically unfit for surgery; or (ii) are pregnant or planning pregnancy; or (iii) have irritable bowel syndrome; or (iv) have congenital anorectal malformations; or (v) have active anal abscesses or fistulas; or (vi) have anorectal organic bowel disease, including cancer; or (vii) have functional effects of previous pelvic irradiation; or (viii) have congenital or acquired malformations of the sacrum; or (ix) have had rectal or anal surgery within the previous 12 months. (Anaes.) **Fee:** $156.30 **Benefit:** 75% = $117.25
32220	Insertion of an artificial bowel sphincter for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed. Contraindicated in: (a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and (b) patients who have had an adverse reaction or radiopaque solution; and (c) patients who enage in receptive anal intercourse (Anaes.) (Assist.) **Fee:** $903.90 **Benefit:** 75% = $677.95 85% = $824.40
32221	Removal or revision of an artificial bowel sphincter (with or without replacement) for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed. Contraindicated in: (a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and (b) patients who have had an adverse reaction to radiopaque solution; and (c) patients who engage in receptive anal intercourse (Anaes.) (Assist.) **Fee:** $903.90 **Benefit:** 75% = $677.95 85% = $824.40

	SUBGROUP 3 - VASCULAR
	VARICOSE VEINS
32500	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg (excluding after-care) - to a maximum of 6 treatments in a 12 month period (Anaes.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $109.80 **Benefit:** 75% = $82.35 85% = $93.35 **Extended Medicare Safety Net Cap:** $120.80
32501	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg, (excluding after-care) where it can be demonstrated that truncal reflux in the long or short saphenous veins has been excluded by duplex examination ***- and that a 7th or subsequent treatment (including any treatments to which item 32500 applies) is indicated in a 12 month period*** *(See para T8.33 of explanatory notes to this Category)* **Fee:** $109.80 **Benefit:** 75% = $82.35 85% = $93.35 **Extended Medicare Safety Net Cap:** $87.85
32504	VARICOSE VEINS, multiple excision of tributaries, with or without division of 1 or more perforating veins - 1 leg - not being a service associated with a service to which item 32507, 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $267.65 **Benefit:** 75% = $200.75 85% = $227.55 **Extended Medicare Safety Net Cap:** $214.15
32507	VARICOSE VEINS, sub-fascial surgical exploration of one or more incompetent perforating veins - 1 leg - not being a service associated with a service to which item 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.) (Assist.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $533.60 **Benefit:** 75% = $400.20 85% = $454.10 **Extended Medicare Safety Net Cap:** $426.90
32508	VARICOSE VEINS, complete dissection at the sapheno-femoral **OR** sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $533.60 **Benefit:** 75% = $400.20
32511	VARICOSE VEINS, complete dissection at the sapheno-femoral **AND** sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $793.30 **Benefit:** 75% = $595.00
32514	VARICOSE VEINS, ligation of the long or short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in the same territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $926.80 **Benefit:** 75% = $695.10
32517	VARICOSE VEINS, ligation of the long and short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in either territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $1,193.40 **Benefit:** 75% = $895.05
32520	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a laser probe introduced by an endovenous catheter, where it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer, including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) but not including radiofrequency diathermy or radiofrequency ablation, and not provided on the same occasion as a service described in any of items 32500, 32501, 32504 or 32507 (Anaes.) *(See para T8.34 of explanatory notes to this Category)* **Fee:** $533.60 **Benefit:** 75% = $400.20 85% = $454.10 **Extended Medicare Safety Net Cap:** $80.05

32522	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a laser probe introduced by an endovenous catheter, where it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer, including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) but not including radiofrequency diathermy or radiofrequency ablation, and not provided on the same occasion as a service described in any of items 32500, 32501, 32504 or 32507 (Anaes.) *(See para T8.34 of explanatory notes to this Category)* **Fee:** $793.30 **Benefit:** 75% = $595.00 85% = $713.80 **Extended Medicare Safety Net Cap:** $79.35
32523	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a radiofrequency catheter introduced by an endovenous catheter, where it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer, including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both), but not including endovenous laser therapy, and not provided on the same occasion as a service described in any of items 32500, 32501, 32504 or 32507 (Anaes.) *(See para T8.34 of explanatory notes to this Category)* **Fee:** $533.60 **Benefit:** 75% = $400.20 85% = $454.10 **Extended Medicare Safety Net Cap:** $80.05
32526	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a radiofrequency catheter introduced by an endovenous catheter, where it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer, including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both), but not including endovenous laser therapy, and not provided on the same occasion as a service described in any of items 32500, 32501, 32504 or 32507 (Anaes.) *(See para T8.34 of explanatory notes to this Category)* **Fee:** $793.30 **Benefit:** 75% = $595.00 85% = $713.80 **Extended Medicare Safety Net Cap:** $79.35
	BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE
32700	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,436.30 **Benefit:** 75% = $1,077.25
32703	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Anaes.) (Assist.) **Fee:** $1,188.20 **Benefit:** 75% = $891.15
32708	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes.) (Assist.) **Fee:** $1,421.35 **Benefit:** 75% = $1,066.05
32710	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Anaes.) (Assist.) **Fee:** $1,579.30 **Benefit:** 75% = $1,184.50
32711	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the common femoral or profunda femoris arteries (Anaes.) (Assist.) **Fee:** $1,737.25 **Benefit:** 75% = $1,302.95
32712	ILIO-FEMORAL BYPASS GRAFTING (Anaes.) (Assist.) **Fee:** $1,255.80 **Benefit:** 75% = $941.85
32715	AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (Anaes.) (Assist.) **Fee:** $1,255.80 **Benefit:** 75% = $941.85
32718	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.) **Fee:** $1,188.20 **Benefit:** 75% = $891.15
32721	RENAL ARTERY, bypass grafting to (Anaes.) (Assist.) **Fee:** $1,887.35 **Benefit:** 75% = $1,415.55
32724	RENAL ARTERIES (both), bypass grafting to (Anaes.) (Assist.) **Fee:** $2,143.10 **Benefit:** 75% = $1,607.35
32730	MESENTERIC VESSEL (single), bypass grafting to (Anaes.) (Assist.) **Fee:** $1,624.30 **Benefit:** 75% = $1,218.25

32733	MESENTERIC VESSELS (multiple), bypass grafting to (Anaes.) (Assist.) **Fee:** $1,887.35 **Benefit:** 75% = $1,415.55
32736	INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intra-abdominal vascular operation (Anaes.) (Assist.) **Fee:** $413.55 **Benefit:** 75% = $310.20
32739	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (Anaes.) (Assist.) **Fee:** $1,293.40 **Benefit:** 75% = $970.05
32742	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to below knee popliteal artery (Anaes.) (Assist.) **Fee:** $1,481.50 **Benefit:** 75% = $1,111.15
32745	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal artery (Anaes.) (Assist.) **Fee:** $1,691.95 **Benefit:** 75% = $1,269.00
32748	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis within 5cms of the ankle joint (Anaes.) (Assist.) **Fee:** $1,834.80 **Benefit:** 75% = $1,376.10
32751	FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (Anaes.) (Assist.) **Fee:** $1,188.20 **Benefit:** 75% = $891.15
32754	FEMORAL ARTERY BYPASS GRAFTING, using a composite graft (synthetic material and vein) with lower anastomosis above or below the knee, including use of a cuff or sleeve of vein at 1 or both anastomoses (Anaes.) (Assist.) **Fee:** $1,481.50 **Benefit:** 75% = $1,111.15
32757	FEMORAL ARTERY SEQUENTIAL BYPASS GRAFTING, (using a vein or synthetic material) where an additional anastomosis is made to separately revascularise more than 1 artery - each additional artery revascularised beyond a femoral bypass (Anaes.) (Assist.) **Fee:** $413.55 **Benefit:** 75% = $310.20
32760	VEIN, HARVESTING OF, FROM LEG OR ARM for bypass or replacement graft when not performed on the limb which is the subject of the bypass or graft - each vein (Anaes.) (Assist.) **Fee:** $406.05 **Benefit:** 75% = $304.55
32763	ARTERIAL BYPASS GRAFTING, using vein or synthetic material, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,188.20 **Benefit:** 75% = $891.15
32766	ARTERIAL OR VENOUS ANASTOMOSIS, not being a service to which another item in this Sub-group applies, as an independent procedure (Anaes.) (Assist.) **Fee:** $789.65 **Benefit:** 75% = $592.25
32769	ARTERIAL OR VENOUS ANASTOMOSIS not being a service to which another item in this Sub-group applies, when performed in combination with another vascular operation (including graft to graft anastomosis) (Anaes.) (Assist.) **Fee:** $273.65 **Benefit:** 75% = $205.25
	BYPASS, REPLACEMENT, LIGATION OF ANEURYSMS
33050	BYPASS GRAFTING to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Anaes.) (Assist.) **Fee:** $1,455.30 **Benefit:** 75% = $1,091.50
33055	BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.) **Fee:** $1,167.05 **Benefit:** 75% = $875.30
33070	ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $842.00 **Benefit:** 75% = $631.50 85% = $762.50
33075	ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,071.05 **Benefit:** 75% = $803.30

33080	INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,307.45 **Benefit:** 75% = $980.60
33100	ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replacement by graft of vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,436.30 **Benefit:** 75% = $1,077.25 85% = $1,356.80
33103	THORACIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,015.30 **Benefit:** 75% = $1,511.50
33109	THORACO-ABDOMINAL ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) **Fee:** $2,436.50 **Benefit:** 75% = $1,827.40 85% = $2,357.00
33112	SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) **Fee:** $2,113.10 **Benefit:** 75% = $1,584.85
33115	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a service associated with a service to which item 33116 applies (Anaes.) (Assist.) **Fee:** $1,421.35 **Benefit:** 75% = $1,066.05
33116	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.) **Fee:** $1,399.00 **Benefit:** 75% = $1,049.25 85% = $1,319.50
33118	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision of common iliac aneurysms) not being a service associated with a service to which item 33119 applies (Anaes.) (Assist.) **Fee:** $1,579.30 **Benefit:** 75% = $1,184.50
33119	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to one or both iliac arteries using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.) **Fee:** $1,554.55 **Benefit:** 75% = $1,165.95 85% = $1,475.05
33121	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.) **Fee:** $1,737.25 **Benefit:** 75% = $1,302.95
33124	ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft - unilateral (Anaes.) (Assist.) **Fee:** $1,210.80 **Benefit:** 75% = $908.10
33127	ANEURYSMS OF ILIAC ARTERIES (common, external or internal), replacement by graft - bilateral (Anaes.) (Assist.) **Fee:** $1,586.75 **Benefit:** 75% = $1,190.10 85% = $1,507.25
33130	ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (Anaes.) (Assist.) **Fee:** $1,383.65 **Benefit:** 75% = $1,037.75
33133	ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of continuity (Anaes.) (Assist.) **Fee:** $1,037.65 **Benefit:** 75% = $778.25
33136	FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.) (Assist.) **Fee:** $2,616.75 **Benefit:** 75% = $1,962.60
33139	FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.) **Fee:** $1,586.75 **Benefit:** 75% = $1,190.10
33142	FALSE ANEURYSM, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.) **Fee:** $1,481.50 **Benefit:** 75% = $1,111.15 85% = $1,402.00
33145	RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,549.20 **Benefit:** 75% = $1,911.90
33148	RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $3,165.80 **Benefit:** 75% = $2,374.35
33151	RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $3,007.90 **Benefit:** 75% = $2,255.95

33154	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (Anaes.) (Assist.) **Fee:** $2,225.90 **Benefit:** 75% = $1,669.45
33157	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.) **Fee:** $2,481.50 **Benefit:** 75% = $1,861.15
33160	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (Anaes.) (Assist.) **Fee:** $2,481.50 **Benefit:** 75% = $1,861.15
33163	RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,105.70 **Benefit:** 75% = $1,579.30
33166	RUPTURED ANEURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.) (Assist.) **Fee:** $2,105.70 **Benefit:** 75% = $1,579.30 85% = $2,026.20
33169	RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.) **Fee:** $1,639.35 **Benefit:** 75% = $1,229.55
33172	ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,278.35 **Benefit:** 75% = $958.80
33175	RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,178.10 **Benefit:** 75% = $883.60
33178	RUPTURED ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,498.20 **Benefit:** 75% = $1,123.65
33181	RUPTURED INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,831.70 **Benefit:** 75% = $1,373.80
	ENDARTERECTOMY AND ARTERIAL PATCH
33500	ARTERY OR ARTERIES OF NECK, endarterectomy of, including closure by suture (where endarterectomy of 1 or more arteries is undertaken through 1 arteriotomy incision) (Anaes.) (Assist.) **Fee:** $1,135.40 **Benefit:** 75% = $851.55
33506	INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes.) (Assist.) **Fee:** $1,270.90 **Benefit:** 75% = $953.20
33509	AORTIC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the aorta (Anaes.) (Assist.) **Fee:** $1,421.35 **Benefit:** 75% = $1,066.05
33512	AORTO-ILIAC ENDARTERECTOMY (1 or both iliac arteries), including closure by suture not being a service associated with a service to which item 33515 applies (Anaes.) (Assist.) **Fee:** $1,579.30 **Benefit:** 75% = $1,184.50
33515	AORTO-FEMORAL ENDARTERECTOMY (1 or both femoral arteries) or BILATERAL ILIO-FEMORAL ENDARTERECTOMY, including closure by suture, not being a service associated with a service to which item 33512 applies (Anaes.) (Assist.) **Fee:** $1,737.25 **Benefit:** 75% = $1,302.95
33518	ILIAC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the iliac artery (Anaes.) (Assist.) **Fee:** $1,270.90 **Benefit:** 75% = $953.20 85% = $1,191.40
33521	ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.) **Fee:** $1,376.10 **Benefit:** 75% = $1,032.10
33524	RENAL ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $1,624.30 **Benefit:** 75% = $1,218.25

33527	RENAL ARTERIES (both), endarterectomy of (Anaes.) (Assist.) **Fee:** $1,887.35 **Benefit:** 75% = $1,415.55
33530	COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $1,624.30 **Benefit:** 75% = $1,218.25
33533	COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $1,887.35 **Benefit:** 75% = $1,415.55
33536	INFERIOR MESENTERIC ARTERY, endarterectomy of, not being a service associated with a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,346.10 **Benefit:** 75% = $1,009.60
33539	ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (Anaes.) (Assist.) **Fee:** $970.05 **Benefit:** 75% = $727.55
33542	EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long (Anaes.) (Assist.) **Fee:** $1,383.65 **Benefit:** 75% = $1,037.75
33545	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is less than 3cm long (Anaes.) (Assist.) *(See para T8.37 of explanatory notes to this Category)* **Fee:** $273.65 **Benefit:** 75% = $205.25
33548	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Anaes.) (Assist.) *(See para T8.37 of explanatory notes to this Category)* **Fee:** $556.60 **Benefit:** 75% = $417.45
33551	VEIN, harvesting of from leg or arm for patch when not performed through same incision as operation (Anaes.) (Assist.) *(See para T8.37 of explanatory notes to this Category)* **Fee:** $273.65 **Benefit:** 75% = $205.25
33554	ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (Anaes.) (Assist.) **Fee:** $272.40 **Benefit:** 75% = $204.30
	EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA
33800	EMBOLUS, removal of, from artery of neck (Anaes.) (Assist.) **Fee:** $1,180.60 **Benefit:** 75% = $885.45 85% = $1,101.10
33803	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (Anaes.) (Assist.) **Fee:** $1,128.05 **Benefit:** 75% = $846.05
33806	Embolectomy or thrombectomy (including the infusion of thrombolytic or other agents) from an artery or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery, item to be claimed once per extremity, regardless of the number of incisions required to access the artery or bypass graft (Anaes.) (Assist.) **Fee:** $812.15 **Benefit:** 75% = $609.15 85% = $732.65
33810	INFERIOR VENA CAVA OR ILIAC VEIN, closed thrombectomy by catheter via the femoral vein (Anaes.) (Assist.) **Fee:** $592.45 **Benefit:** 75% = $444.35 85% = $512.95
33811	INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes.) (Assist.) **Fee:** $1,763.80 **Benefit:** 75% = $1,322.85
33812	THROMBUS, removal of, from femoral or other similar large vein (Anaes.) (Assist.) **Fee:** $932.45 **Benefit:** 75% = $699.35 85% = $852.95
33815	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) **Fee:** $857.30 **Benefit:** 75% = $643.00
33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) **Fee:** $1,000.15 **Benefit:** 75% = $750.15

33821	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.) **Fee:** $1,143.00 **Benefit:** 75% = $857.25
33824	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) **Fee:** $1,090.35 **Benefit:** 75% = $817.80
33827	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) **Fee:** $1,278.35 **Benefit:** 75% = $958.80
33830	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.) **Fee:** $1,466.30 **Benefit:** 75% = $1,099.75
33833	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (Anaes.) (Assist.) **Fee:** $1,331.15 **Benefit:** 75% = $998.40
33836	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.) (Assist.) **Fee:** $1,586.75 **Benefit:** 75% = $1,190.10
33839	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.) (Assist.) **Fee:** $1,857.40 **Benefit:** 75% = $1,393.05
33842	ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes.) (Assist.) **Fee:** $917.40 **Benefit:** 75% = $688.05
33845	LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $639.20 **Benefit:** 75% = $479.40
33848	EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $639.20 **Benefit:** 75% = $479.40
	LIGATION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS
34100	MAJOR ARTERY OF NECK, elective ligation or exploration of, not being a service associated with any other vascular procedure (Anaes.) (Assist.) **Fee:** $707.00 **Benefit:** 75% = $530.25
34103	GREAT ARTERY OR GREAT VEIN (including subclavian, axillary, iliac, femoral or popliteal), ligation of, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes.) (Assist.) **Fee:** $413.55 **Benefit:** 75% = $310.20
34106	ARTERY OR VEIN (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes.) (Assist.) **Fee:** $291.70 **Benefit:** 75% = $218.80 85% = $247.95 **Extended Medicare Safety Net Cap:** $233.40
34109	TEMPORAL ARTERY, biopsy of (Anaes.) (Assist.) **Fee:** $338.35 **Benefit:** 75% = $253.80 85% = $287.60
34112	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assist.) **Fee:** $857.30 **Benefit:** 75% = $643.00
34115	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.) **Fee:** $970.05 **Benefit:** 75% = $727.55
34118	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and ligation (Anaes.) (Assist.) **Fee:** $1,383.65 **Benefit:** 75% = $1,037.75 85% = $1,304.15

34121	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,105.35 **Benefit:** 75% = $829.05
34124	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,210.80 **Benefit:** 75% = $908.10
34127	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,586.75 **Benefit:** 75% = $1,190.10
34130	SURGICALLY CREATED ARTERIO-VENOUS FISTULA OF AN EXTREMITY, closure of (Anaes.) (Assist.) **Fee:** $496.30 **Benefit:** 75% = $372.25 85% = $421.90
34133	SCALENOTOMY (Anaes.) (Assist.) **Fee:** $556.60 **Benefit:** 75% = $417.45
34136	FIRST RIB, resection of portion of (Anaes.) (Assist.) **Fee:** $894.75 **Benefit:** 75% = $671.10
34139	CERVICAL RIB, removal of, or other operation for removal of thoracic outlet compression, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $894.75 **Benefit:** 75% = $671.10
34142	COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent procedure (Anaes.) (Assist.) **Fee:** $1,105.35 **Benefit:** 75% = $829.05
34145	POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Anaes.) (Assist.) **Fee:** $804.65 **Benefit:** 75% = $603.50
34148	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is 4cm or less in maximum diameter (Anaes.) (Assist.) **Fee:** $1,436.30 **Benefit:** 75% = $1,077.25
34151	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is greater than 4cm in maximum diameter (Anaes.) (Assist.) **Fee:** $1,962.65 **Benefit:** 75% = $1,472.00
34154	RECURRENT CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes.) (Assist.) **Fee:** $2,338.75 **Benefit:** 75% = $1,754.10 85% = $2,259.25
34157	NECK, excision of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.) **Fee:** $1,188.20 **Benefit:** 75% = $891.15
34160	AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.) (Assist.) **Fee:** $2,225.90 **Benefit:** 75% = $1,669.45
34163	AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (Anaes.) (Assist.) **Fee:** $2,857.55 **Benefit:** 75% = $2,143.20
34166	AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (Anaes.) (Assist.) **Fee:** $2,857.55 **Benefit:** 75% = $2,143.20
34169	INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.) (Assist.) **Fee:** $1,586.75 **Benefit:** 75% = $1,190.10
34172	INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (Anaes.) (Assist.) **Fee:** $1,293.40 **Benefit:** 75% = $970.05
34175	INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (Anaes.) (Assist.) **Fee:** $1,188.20 **Benefit:** 75% = $891.15

	OPERATIONS FOR VASCULAR ACCESS
34500	ARTERIOVENOUS SHUNT, EXTERNAL, insertion of (Anaes.) (Assist.) **Fee:** $308.40 **Benefit:** 75% = $231.30 85% = $262.15
34503	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (Anaes.) (Assist.) **Fee:** $413.55 **Benefit:** 75% = $310.20
34506	ARTERIOVENOUS SHUNT, EXTERNAL, removal of (Anaes.) (Assist.) **Fee:** $210.45 **Benefit:** 75% = $157.85
34509	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conjunction with another venous or arterial operation (Anaes.) (Assist.) **Fee:** $977.55 **Benefit:** 75% = $733.20
34512	ARTERIOVENOUS ACCESS DEVICE, insertion of (Anaes.) (Assist.) **Fee:** $1,075.40 **Benefit:** 75% = $806.55
34515	ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (Anaes.) (Assist.) **Fee:** $767.00 **Benefit:** 75% = $575.25
34518	STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (Anaes.) (Assist.) **Fee:** $1,285.75 **Benefit:** 75% = $964.35
34521	INTRA-ABDOMINAL ARTERY OR VEIN, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Anaes.) (Assist.) **Fee:** $789.95 **Benefit:** 75% = $592.50
34524	ARTERIAL CANNULATION for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Anaes.) (Assist.) **Fee:** $413.55 **Benefit:** 75% = $310.20
34527	CENTRAL VEIN CATHETERISATION by open technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterization, on a person 10 years of age or over (Anaes.) *(See para T8.2 of explanatory notes to this Category)* **Fee:** $551.60 **Benefit:** 75% = $413.70 85% = $472.10
34528	CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a person 10 years of age or over (Anaes.) *(See para T8.2 of explanatory notes to this Category)* **Fee:** $272.40 **Benefit:** 75% = $204.30 85% = $231.55
34529	CENTRAL VEIN CATHETERISATION by open technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterization, on a person under 10 years of age (Anaes.) **Fee:** $717.10 **Benefit:** 75% = $537.85 85% = $637.60
34530	CENTRAL VENOUS LINE, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital on a person 10 years of age or over (Anaes.) *(See para T8.2 of explanatory notes to this Category)* **Fee:** $204.25 **Benefit:** 75% = $153.20 85% = $173.65
34533	ISOLATED LIMB PERFUSION, including cannulation of artery and vein at commencement of procedure, regional perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy at conclusion of procedure (excluding aftercare) (Anaes.) (Assist.) **Fee:** $1,240.65 **Benefit:** 75% = $930.50 85% = $1,161.15
34534	CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a person under 10 years of age (Anaes.) **Fee:** $354.10 **Benefit:** 75% = $265.60 85% = $301.00
34538	CENTRAL VEIN CATHERTERISATION by percutaneous technique, using subcutaneous tunnelled cuffed catheter or similar device, for the administration of haemodialysis or parenteral nutrition (Anaes.) **Fee:** $272.40 **Benefit:** 75% = $204.30 85% = $231.55

34539	TUNNELLED CUFFED CATHETER, OR SIMILAR DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital (Anaes.) **Fee:** $204.25 **Benefit:** 75% = $153.20 85% = $173.65
34540	CENTRAL VENOUS LINE, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital, on a person under 10 years of age (Anaes.) **Fee:** $265.50 **Benefit:** 75% = $199.15 85% = $225.70
	COMPLEX VENOUS OPERATIONS
34800	INFERIOR VENA CAVA, plication, ligation, or application of caval clip (Anaes.) (Assist.) **Fee:** $812.15 **Benefit:** 75% = $609.15 85% = $732.65
34803	INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,789.85 **Benefit:** 75% = $1,342.40
34806	CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.) **Fee:** $970.05 **Benefit:** 75% = $727.55
34809	SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.) (Assist.) **Fee:** $970.05 **Benefit:** 75% = $727.55
34812	VENOUS STENOSIS OR OCCLUSION, vein bypass for, using vein or synthetic material, not being a service associated with a service to which item 34806 or 34809 applies (Anaes.) (Assist.) **Fee:** $1,173.05 **Benefit:** 75% = $879.80
34815	VEIN STENOSIS, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material (Anaes.) (Assist.) *(See para T8.37 of explanatory notes to this Category)* **Fee:** $970.05 **Benefit:** 75% = $727.55
34818	VENOUS VALVE, plication or repair to restore valve competency (Anaes.) (Assist.) **Fee:** $1,067.80 **Benefit:** 75% = $800.85
34821	VEIN TRANSPLANT to restore valvular function (Anaes.) (Assist.) **Fee:** $1,451.45 **Benefit:** 75% = $1,088.60 85% = $1,371.95
34824	EXTERNAL STENT, application of, to restore venous valve competency to superficial vein - 1 stent (Anaes.) (Assist.) **Fee:** $496.30 **Benefit:** 75% = $372.25
34827	EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (Anaes.) (Assist.) **Fee:** $601.65 **Benefit:** 75% = $451.25
34830	EXTERNAL STENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.) (Assist.) **Fee:** $707.00 **Benefit:** 75% = $530.25 85% = $627.50
34833	EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Anaes.) (Assist.) **Fee:** $917.40 **Benefit:** 75% = $688.05
	SYMPATHECTOMY
35000	LUMBAR SYMPATHECTOMY (Anaes.) (Assist.) **Fee:** $707.00 **Benefit:** 75% = $530.25 85% = $627.50
35003	CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.) (Assist.) **Fee:** $917.40 **Benefit:** 75% = $688.05
35006	CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes.) (Assist.) **Fee:** $1,150.55 **Benefit:** 75% = $862.95
35009	LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Anaes.) (Assist.) **Fee:** $894.75 **Benefit:** 75% = $671.10

35012	SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes.) (Assist.) **Fee:** $707.00 **Benefit:** 75% = $530.25
	DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE
35100	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, when debridement includes muscle, tendon or bone (Anaes.) (Assist.) **Fee:** $368.55 **Benefit:** 75% = $276.45
35103	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.) **Fee:** $234.55 **Benefit:** 75% = $175.95 85% = $199.40
	MISCELLANEOUS VASCULAR PROCEDURES
35200	OPERATIVE ARTERIOGRAPHY OR VENOGRAPHY, 1 or more of, performed during the course of an operative procedure on an artery or vein, 1 site (Anaes.) **Fee:** $171.50 **Benefit:** 75% = $128.65
35202	MAJOR ARTERIES OR VEINS IN THE NECK, ABDOMEN OR EXTREMITIES, access to, as part of RE-OPERATION after prior surgery on these vessels (Anaes.) (Assist.) **Fee:** $817.10 **Benefit:** 75% = $612.85
	ENDOVASCULAR INTERVENTIONAL PROCEDURES
35300	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $515.35 **Benefit:** 75% = $386.55 85% = $438.05
35303	TRANSLUMINAL BALLOON ANGIOPLASTY of aortic arch branches, aortic visceral branches, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $660.80 **Benefit:** 75% = $495.60 85% = $581.30
35306	TRANSLUMINAL STENT INSERTION including associated balloon dilatation for 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $609.90 **Benefit:** 75% = $457.45 85% = $530.40
35307	TRANSLUMINAL STENT INSERTION, 1 or more stents (not drug-eluting), with or without associated balloon dilatation, for 1 carotid artery, percutaneous (not direct), with or without the use of an embolic protection device, in patients who: - meet the indications for carotid endarterectomy; and - have medical or surgical comorbidities that would make them at high risk of perioperative complications from carotid endarterectomy, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.38 of explanatory notes to this Category)* **Fee:** $1,121.15 **Benefit:** 75% = $840.90
35309	TRANSLUMINAL STENT INSERTION including associated balloon dilatation for visceral arteries or veins, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $762.35 **Benefit:** 75% = $571.80 85% = $682.85
35312	PERIPHERAL ARTERIAL ATHERECTOMY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $864.05 **Benefit:** 75% = $648.05
35315	PERIPHERAL LASER ANGIOPLASTY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $864.05 **Benefit:** 75% = $648.05
35317	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY CONTINUOUS INFUSION, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35319 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) *(See para T8.39 of explanatory notes to this Category)* **Fee:** $355.80 **Benefit:** 75% = $266.85 85% = $302.45

35319	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY PULSE SPRAY TECHNIQUE, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) **Fee:** $637.80 **Benefit:** 75% = $478.35 85% = $558.30
35320	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY OPEN EXPOSURE, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35319 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) **Fee:** $856.70 **Benefit:** 75% = $642.55 85% = $777.20
35321	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION to administer agents to occlude arteries, veins or arterio-venous fistulae or to arrest haemorrhage, (but not for the treatment of uterine fibroids or varicose veins) percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.) *(See para T8.40 of explanatory notes to this Category)* **Fee:** $813.30 **Benefit:** 75% = $610.00 85% = $733.80
35324	ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $304.95 **Benefit:** 75% = $228.75
35327	ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $408.70 **Benefit:** 75% = $306.55
35330	INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $515.35 **Benefit:** 75% = $386.55 85% = $438.05
35331	RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (Anaes.) **Fee:** $592.45 **Benefit:** 75% = $444.35
35360	Retrieval of foreign body in PULMONARY ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare *(**foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $828.20 **Benefit:** 75% = $621.15
35361	Retrieval of foreign body in RIGHT ATRIUM, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare *(**foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $710.30 **Benefit:** 75% = $532.75
35362	Retrieval of foreign body in INFERIOR VENA CAVA or AORTA, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare *(**foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $592.45 **Benefit:** 75% = $444.35
35363	Retrieval of foreign body in PERIPHERAL VEIN or PERIPHERAL ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare *(**foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $474.65 **Benefit:** 75% = $356.00

	INTERVENTIONAL RADIOLOGY PROCEDURES
35404	DOSIMETRY, HANDLING AND INJECTION OF SIR-SPHERES for selective internal radiation therapy of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies The procedure must be performed by a specialist or consultant physician recognised in the specialties of nuclear medicine or radiation oncology on an admitted patient in a hospital. To be claimed once in the patient's lifetime only. *(See para T8.41 of explanatory notes to this Category)* **Fee:** $346.60 **Benefit:** 75% = $259.95
35406	Trans-femoral catheterisation of the hepatic artery to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.41 of explanatory notes to this Category)* **Fee:** $813.30 **Benefit:** 75% = $610.00
35408	Catheterisation of the hepatic artery via a permanently implanted hepatic artery port to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.41 of explanatory notes to this Category)* **Fee:** $610.10 **Benefit:** 75% = $457.60
35410	UTERINE ARTERY CATHETERISATION with percutaneous administration of occlusive agents, for the treatment of symptomatic uterine fibroids in a patient who has been referred for uterine artery embolisation by a specialist gynaecologist, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.35 of explanatory notes to this Category)* **Fee:** $813.30 **Benefit:** 75% = $610.00 85% = $733.80
35412	Intracranial aneurysm, ruptured or unruptured, endovascular occlusion with detachable coils, and assisted coiling if performed, with parent artery preservation, not for use with liquid embolics only, including aftercare, including intra-operative imaging, but in association with the following pre-operative diagnostic imaging items: - either 60009 or 60010; and - either 60072, 60073, 60075, 60076, 60078 or 60079 (Anaes.) (Assist.) *(See para T8.36 of explanatory notes to this Category)* **Fee:** $2,857.55 **Benefit:** 75% = $2,143.20 85% = $2,778.05
	SUBGROUP 4 - GYNAECOLOGICAL
35500	GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $81.30 **Benefit:** 75% = $61.00 85% = $69.15
35502	INTRAUTERINE DEVICE, INTRODUCTION OF, for the control of idiopathic menorrhagia, AND ENDOMETRIAL BIOPSY to exclude endometrial pathology, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $80.15 **Benefit:** 75% = $60.15 85% = $68.15
35503	Intra uterine contraceptive device, introduction of, if the service is not associated with a service to which another item in this Group applies (other than a service mentioned in item 30062) (Anaes.) **Fee:** $53.55 **Benefit:** 75% = $40.20 85% = $45.55
35506	INTRAUTERINE CONTRACEPTIVE DEVICE, REMOVAL OF UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $53.70 **Benefit:** 75% = $40.30 85% = $45.65
35507	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes.) **Fee:** $174.45 **Benefit:** 75% = $130.85 85% = $148.30

35508	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes.) (Assist.) **Fee:** $256.95	**Benefit:** 75% = $192.75	85% = $218.45
35509	HYMENECTOMY (Anaes.) **Fee:** $89.45	**Benefit:** 75% = $67.10	85% = $76.05
35512 G 35513 S	BARTHOLIN'S CYST, excision of (Anaes.) **Fee:** $179.40 **Fee:** $221.70	**Benefit:** 75% = $134.55 **Benefit:** 75% = $166.30	85% = $152.50 85% = $188.45
35516 G 35517 S	BARTHOLIN'S CYST OR GLAND, marsupialisation of (Anaes.) **Fee:** $116.35 **Fee:** $146.00	**Benefit:** 75% = $87.30 **Benefit:** 75% = $109.50	85% = $98.90 85% = $124.10
35518	OVARIAN CYST ASPIRATION, for cysts of at least 4cm in diameter in a premenopausal person and at least 2cm in diameter in a postmenopausal person, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques (Anaes.) *(See para T8.2 of explanatory notes to this Category)* **Fee:** $207.85	**Benefit:** 75% = $155.90	85% = $176.70
35520	BARTHOLIN'S ABSCESS, incision of (Anaes.) **Fee:** $58.30	**Benefit:** 75% = $43.75	85% = $49.60
35523	URETHRA OR URETHRAL CARUNCLE, cauterisation of (Anaes.) **Fee:** $58.30	**Benefit:** 75% = $43.75	85% = $49.60
35526 G 35527 S	URETHRAL CARUNCLE, excision of (Anaes.) **Fee:** $116.35 **Fee:** $146.00	**Benefit:** 75% = $87.30 **Benefit:** 75% = $109.50	85% = $98.90 85% = $124.10
35530	CLITORIS, amputation of, where medically indicated (Anaes.) (Assist.) **Fee:** $269.85	**Benefit:** 75% = $202.40	
35533	VULVOPLASTY or LABIOPLASTY, for repair of: (a) female genital mutilation; or (b) anomalies associated with major congenital anomalies of the uro-gynaecological tract other than a service associated with a service to which item 35536, 37050, 37836, 37842, 37851 or 43882 applies (H) (Anaes.) *(See para T8.125 of explanatory notes to this Category)* **Fee:** $349.85 **Extended Medicare Safety Net Cap:** $279.90	**Benefit:** 75% = $262.40	
35534	VULVOPLASTY or LABIOPLASTY, for localised gigantism if it can be demonstrated that: (a) the structural abnormality is causing significant functional impairment; and (b) non-surgical treatments have failed (H) (Anaes.) *(See para T8.125 of explanatory notes to this Category)* **Fee:** $349.85	**Benefit:** 75% = $262.40	
35536	VULVA, wide local excision of suspected malignancy or hemivulvectomy, 1 or both procedures (Anaes.) (Assist.) **Fee:** $348.45	**Benefit:** 75% = $261.35	85% = $296.20
35539	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 1 anatomical site (Anaes.) **Fee:** $272.95	**Benefit:** 75% = $204.75	85% = $232.05
35542	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 2 or more anatomical sites (Anaes.) (Assist.) **Fee:** $319.60	**Benefit:** 75% = $239.70	85% = $271.70
35545	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for condylomata, unsuccessfully treated by other methods (Anaes.) **Fee:** $183.60	**Benefit:** 75% = $137.70	85% = $156.10
35548	VULVECTOMY, radical, for malignancy (Anaes.) (Assist.) **Fee:** $834.05	**Benefit:** 75% = $625.55	

35551	PELVIC LYMPH GLANDS, excision of (radical) (Anaes.) (Assist.) **Fee:** $683.90 **Benefit:** 75% = $512.95
35554	VAGINA, DILATATION OF, as an independent procedure including any associated consultation (Anaes.) **Fee:** $43.50 **Benefit:** 75% = $32.65 85% = $37.00
35557	VAGINA, removal of simple tumour (including Gartner duct cyst) (Anaes.) **Fee:** $214.50 **Benefit:** 75% = $160.90 85% = $182.35
35560	VAGINA, partial or complete removal of (Anaes.) (Assist.) **Fee:** $683.90 **Benefit:** 75% = $512.95
35561	VAGINECTOMY, radical, for proven invasive malignancy - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,379.50 **Benefit:** 75% = $1,034.65
35562	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,132.60 **Benefit:** 75% = $849.45
35564	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - perineal surgeon (Assist.) **Fee:** $522.85 **Benefit:** 75% = $392.15
35565	VAGINAL RECONSTRUCTION for congenital absence, gynatresia or urogenital sinus (Anaes.) (Assist.) **Fee:** $683.90 **Benefit:** 75% = $512.95
35566	VAGINAL SEPTUM, excision of, for correction of double vagina (Anaes.) (Assist.) **Fee:** $397.25 **Benefit:** 75% = $297.95
35568	SACROSPINOUS COLPOPEXY FOR MANAGEMENT OF UPPER VAGINAL PROLAPSE (Anaes.) (Assist.) **Fee:** $624.60 **Benefit:** 75% = $468.45
35569	PLASTIC REPAIR TO ENLARGE VAGINAL ORIFICE (Anaes.) **Fee:** $160.85 **Benefit:** 75% = $120.65 85% = $136.75
35570	ANTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving repair of urethrocoele and cystocoele) with or without mesh, not being a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.) **Fee:** $553.85 **Benefit:** 75% = $415.40
35571	POSTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving one or more of the following; repair of perineum, rectocoele or enterocoele) with or without mesh, not being a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.) **Fee:** $553.85 **Benefit:** 75% = $415.40
35572	COLPOTOMY not being a service to which another item in this Group applies (Anaes.) **Fee:** $123.80 **Benefit:** 75% = $92.85
35573	ANTERIOR AND POSTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving both anterior and posterior compartment defects) with or without mesh, not being a service associated with a service to which item 35577 or 35578 applies (Anaes.) (Assist.) **Fee:** $830.90 **Benefit:** 75% = $623.20
35577	MANCHESTER (DONALD FOTHERGILL) OPERATION for genital prolapse, with or without mesh (Anaes.) (Assist.) **Fee:** $674.50 **Benefit:** 75% = $505.90
35578	LE FORT OPERATION for genital prolapse, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $674.50 **Benefit:** 75% = $505.90
35595	LAPAROSCOPIC OR ABDOMINAL PELVIC FLOOR REPAIR INCORPORATING THE FIXATION OF THE UTEROSACRAL AND CARDINAL LIGAMENTS TO RECTOVAGINAL AND PUBOCERVICAL FASCIA for symptomatic upper vaginal vault prolapse (Anaes.) (Assist.) **Fee:** $1,155.00 **Benefit:** 75% = $866.25
35596	FISTULA BETWEEN GENITAL AND URINARY OR ALIMENTARY TRACTS, repair of, not being a service to which item 37029, 37333 or 37336 applies (Anaes.) (Assist.) **Fee:** $683.90 **Benefit:** 75% = $512.95

35597	SACRAL COLPOPEXY, laparoscopic or open procedure where graft or mesh secured to vault, anterior and posterior compartment and to sacrum for correction of symptomatic upper vaginal vault prolapse (Anaes.) (Assist.) **Fee:** $1,473.20	**Benefit:** 75% = $1,104.90	
35599	STRESS INCONTINENCE, sling operation for, with or without mesh or tape, not being a service associated with a service to which item 30405 applies (Anaes.) (Assist.) **Fee:** $674.50	**Benefit:** 75% = $505.90	
35602	STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; abdominal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Anaes.) (Assist.) **Fee:** $674.50	**Benefit:** 75% = $505.90	
35605	STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; vaginal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Assist.) **Fee:** $365.95	**Benefit:** 75% = $274.50	85% = $311.10
35608	CERVIX, cauterisation (other than by chemical means), ionisation, diathermy or biopsy of, with or without dilatation of cervix (Anaes.) **Fee:** $64.00	**Benefit:** 75% = $48.00	85% = $54.40
35611	CERVIX, removal of polyp or polypi, with or without dilatation of cervix, not being a service associated with a service to which item 35608 applies (Anaes.) **Fee:** $64.00	**Benefit:** 75% = $48.00	85% = $54.40
35612	CERVIX, RESIDUAL STUMP, removal of, by abdominal approach (Anaes.) (Assist.) **Fee:** $506.00	**Benefit:** 75% = $379.50	85% = $430.10
35613	CERVIX, RESIDUAL STUMP, removal of, by vaginal approach (Anaes.) (Assist.) **Fee:** $404.80	**Benefit:** 75% = $303.60	
35614	EXAMINATION OF LOWER TRACT by a Hinselmanntype colposcope in a patient with a previous abnormal cervical smear or a history of maternal ingestion of oestrogen or where a patient, because of suspicious signs of cancer, has been referred by another medical practitioner (Anaes.) *(See para T8.2 and T8.43 of explanatory notes to this Category)* **Fee:** $63.90	**Benefit:** 75% = $47.95	85% = $54.35
35615	VULVA, biopsy of, when performed in conjunction with a service to which item 35614 applies **Fee:** $53.70	**Benefit:** 75% = $40.30	85% = $45.65
35616	ENDOMETRIUM, endoscopic examination of and ablation of, by microwave or thermal balloon or radiofrequency electrosurgery, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage (Anaes.) **Fee:** $449.60	**Benefit:** 75% = $337.20	
35617 G 35618 S	CERVIX, cone biopsy, amputation or repair of, not being a service to which item 35577 or 35578 applies (Anaes.) **Fee:** $173.70 **Fee:** $218.00	**Benefit:** 75% = $130.30 **Benefit:** 75% = $163.50	85% = $147.65 85% = $185.30
35620	ENDOMETRIAL BIOPSY where malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (Anaes.) **Fee:** $53.35	**Benefit:** 75% = $40.05	85% = $45.35
35622	ENDOMETRIUM, endoscopic ablation of, by laser or diathermy, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage, not being a service associated with a service to which item 30390 applies (Anaes.) **Fee:** $602.45	**Benefit:** 75% = $451.85	
35623	HYSTEROSCOPIC RESECTION of myoma, or myoma and uterine septum resection (where both are performed), followed by endometrial ablation by laser or diathermy (Anaes.) **Fee:** $819.25	**Benefit:** 75% = $614.45	
35626	HYSTEROSCOPY, including biopsy, performed by a specialist in the practice of his or her specialty where the patient is referred to him or her for the investigation of suspected intrauterine pathology (with or without local anaesthetic), not being a service associated with a service to which item 35627 or 35630 applies *(See para T8.44 of explanatory notes to this Category)* **Fee:** $82.80	**Benefit:** 75% = $62.10	85% = $70.40

35627	HYSTEROSCOPY with dilatation of the cervix performed in the operating theatre of a hospital - not being a service associated with a service to which item 35626 or 35630 applies (Anaes.) **Fee:** $107.15 **Benefit:** 75% = $80.40
35630	HYSTEROSCOPY, with endometrial biopsy, performed in the operating theatre of a hospital - not being a service associated with a service to which item 35626 or 35627 applies (Anaes.) **Fee:** $183.00 **Benefit:** 75% = $137.25 85% = $155.55
35633	HYSTEROSCOPY with uterine adhesiolysis or polypectomy or tubal catheterisation (including for insertion of device for sterilisation) or removal of IUD which cannot be removed by other means, 1 or more of (Anaes.) **Fee:** $218.00 **Benefit:** 75% = $163.50 85% = $185.30
35634	HYSTEROSCOPIC RESECTION of uterine septum followed by endometrial ablation by laser or diathermy (Anaes.) **Fee:** $685.70 **Benefit:** 75% = $514.30 85% = $606.20
35635	HYSTEROSCOPY involving resection of the uterine septum (Anaes.) **Fee:** $299.45 **Benefit:** 75% = $224.60
35636	HYSTEROSCOPY, involving resection of myoma, or resection of myoma and uterine septum (where both are performed) (Anaes.) **Fee:** $433.00 **Benefit:** 75% = $324.75
35637	LAPAROSCOPY, involving puncture of cysts, diathermy of endometriosis, ventrosuspension, division of adhesions or similar procedure - 1 or more procedures with or without biopsy - not being a service associated with any other laparoscopic procedure or hysterectomy (Anaes.) (Assist.) **Fee:** $406.65 **Benefit:** 75% = $305.00
35638	COMPLICATED OPERATIVE LAPAROSCOPY, including use of laser when required, for 1 or more of the following procedures; oophorectomy, ovarian cystectomy, myomectomy, salpingectomy or salpingostomy, ablation of moderate or severe endometriosis requiring more than 1 hours operating time, or division of utero-sacral ligaments for significant dysmenorrhoea - not being a service associated with any other intraperitoneal or retroperitoneal procedure except item 30393 (Anaes.) (Assist.) **Fee:** $711.50 **Benefit:** 75% = $533.65
35639 G 35640 S	UTERUS, CURETTAGE OF, with or without dilatation (including curettage for incomplete miscarriage) under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes.) *(See para T8.45 of explanatory notes to this Category)* **Fee:** $134.90 **Benefit:** 75% = $101.20 **Fee:** $183.00 **Benefit:** 75% = $137.25
35641	ENDOMETRIOSIS LEVEL 4 OR 5, LAPAROSCOPIC RESECTION OF, involving any two of the following procedures, resection of the pelvic side wall including dissection of endometriosis or scar tissue from the ureter, resection of the Pouch of Douglas, resection of an ovarian endometrioma greater than 2 cms in diameter, dissection of bowel from uterus from the level of the endocervical junction or above: where the operating time exceeds 90 minutes (Anaes.) (Assist.) **Fee:** $1,242.65 **Benefit:** 75% = $932.00
35643	EVACUATION OF THE CONTENTS OF THE GRAVID UTERUS BY CURETTAGE OR SUCTION CURETTAGE not being a service to which item 35639/35640 applies, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes.) **Fee:** $218.00 **Benefit:** 75% = $163.50 85% = $185.30
35644	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35639, 35640 or 35647 applies (Anaes.) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $203.65 **Benefit:** 75% = $152.75 85% = $173.15
35645	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative therapy of additional areas of intraepithelial change in 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35648 applies (Anaes.) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $318.70 **Benefit:** 75% = $239.05 85% = $270.90
35646	CERVIX, colposcopy with radical diathermy of, with or without cervical biopsy, for previously confirmed intraepithelial neoplastic changes of the cervix, where performed in the operating theatre of a hospital (Anaes.) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $203.65 **Benefit:** 75% = $152.75 85% = $173.15

35647	CERVIX, large loop excision of transformation zone together with colposcopy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35644 applies (Anaes.) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $203.65 **Benefit:** 75% = $152.75 85% = $173.15
35648	CERVIX, large loop excision diathermy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of intraepithelial change of 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35645 applies (Anaes.) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $318.70 **Benefit:** 75% = $239.05 85% = $270.90
35649	HYSTEROTOMY or UTERINE MYOMECTOMY, abdominal (Anaes.) (Assist.) **Fee:** $536.00 **Benefit:** 75% = $402.00
35653	HYSTERECTOMY, ABDOMINAL, SUBTOTAL or TOTAL, with or without removal of uterine adnexae (Anaes.) (Assist.) **Fee:** $674.70 **Benefit:** 75% = $506.05
35657	HYSTERECTOMY, VAGINAL, with or without uterine curettage, not being a service to which item 35673 applies **NOTE:** ***Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim***. (Anaes.) (Assist.) *(See para T8.47 of explanatory notes to this Category)* **Fee:** $674.70 **Benefit:** 75% = $506.05
35658	UTERUS (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal removal at hysterectomy (Anaes.) (Assist.) *(See para T8.48 of explanatory notes to this Category)* **Fee:** $416.05 **Benefit:** 75% = $312.05
35661	HYSTERECTOMY, ABDOMINAL, requiring extensive retroperitoneal dissection, with or without exposure of 1 or both ureters, for the management of severe endometriosis, pelvic inflammatory disease or benign pelvic tumours, with or without conservation of the ovaries (Anaes.) (Assist.) **Fee:** $871.30 **Benefit:** 75% = $653.50
35664	RADICAL HYSTERECTOMY with radical excision of pelvic lymph glands (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.) **Fee:** $1,452.20 **Benefit:** 75% = $1,089.15
35667	RADICAL HYSTERECTOMY without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.) **Fee:** $1,234.25 **Benefit:** 75% = $925.70
35670	HYSTERECTOMY, abdominal, with radical excision of pelvic lymph glands, with or without removal of uterine adnexae (Anaes.) (Assist.) **Fee:** $1,016.30 **Benefit:** 75% = $762.25
35673	HYSTERECTOMY, VAGINAL (with or without uterine curettage) with salpingectomy, oophorectomy or excision of ovarian cyst, 1 or more, 1 or both sides (Anaes.) (Assist.) **Fee:** $757.80 **Benefit:** 75% = $568.35
35674	ULTRASOUND GUIDED NEEDLING and injection of ectopic pregnancy **Fee:** $207.85 **Benefit:** 75% = $155.90 85% = $176.70
35676 G 35677 S	ECTOPIC PREGNANCY, removal of (Anaes.) (Assist.) **Fee:** $425.00 **Benefit:** 75% = $318.75 **Fee:** $536.00 **Benefit:** 75% = $402.00
35678	ECTOPIC PREGNANCY, laparoscopic removal of (Anaes.) (Assist.) **Fee:** $646.25 **Benefit:** 75% = $484.70
35680	BICORNUATE UTERUS, plastic reconstruction for (Anaes.) (Assist.) **Fee:** $582.05 **Benefit:** 75% = $436.55 85% = $502.55

	UTERUS, SUSPENSION OR FIXATION OF, as an independent procedure (Anaes.) (Assist.)
35683 G	**Fee:** $351.30 **Benefit:** 75% = $263.50
35684 S	**Fee:** $471.15 **Benefit:** 75% = $353.40
	STERILISATION BY TRANSECTION OR RESECTION OF FALLOPIAN TUBES, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method. **NOTE:** ***Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim***. (Anaes.) (Assist.) *(See para T8.47 of explanatory notes to this Category)*
35687 G	**Fee:** $325.20 **Benefit:** 75% = $243.90
35688 S	**Fee:** $397.25 **Benefit:** 75% = $297.95
	STERILISATION BY INTERRUPTION OF FALLOPIAN TUBES, when performed in conjunction with Caesarean section **NOTE:** ***Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explantory note before submitting a claim***. (Anaes.) (Assist.) *(See para T8.47 of explanatory notes to this Category)*
35691	**Fee:** $158.70 **Benefit:** 75% = $119.05
	TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)
35694	**Fee:** $637.70 **Benefit:** 75% = $478.30
	MICROSURGICAL TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)
35697	**Fee:** $946.20 **Benefit:** 75% = $709.65
	FALLOPIAN TUBES, unilateral microsurgical anastomosis of, using operating microscope (Anaes.) (Assist.)
35700	**Fee:** $730.05 **Benefit:** 75% = $547.55
	HYDROTUBATION OF FALLOPIAN TUBES as a nonrepetitive procedure not being a service associated with a service to which another item in this Sub-group applies (Anaes.)
35703	**Fee:** $67.50 **Benefit:** 75% = $50.65 85% = $57.40
	RUBIN TEST FOR PATENCY OF FALLOPIAN TUBES (Anaes.)
35706	**Fee:** $67.50 **Benefit:** 75% = $50.65 85% = $57.40
	FALLOPIAN TUBES, hydrotubation of, as a repetitive postoperative procedure (Anaes.)
35709	**Fee:** $43.50 **Benefit:** 75% = $32.65 85% = $37.00
	FALLOPOSCOPY, unilateral or bilateral, including hysteroscopy and tubal catheterization (Anaes.) (Assist.)
35710	**Fee:** $463.30 **Benefit:** 75% = $347.50
	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGOOOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - 1 such procedure, not being a service associated with hysterectomy (Anaes.) (Assist.)
35712 G	**Fee:** $362.15 **Benefit:** 75% = $271.65
35713 S	**Fee:** $452.85 **Benefit:** 75% = $339.65
	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGOOOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - 2 or more such procedures, unilateral or bilateral, not being a service associated with hysterectomy (Anaes.) (Assist.)
35716 G	**Fee:** $434.35 **Benefit:** 75% = $325.80
35717 S	**Fee:** $545.30 **Benefit:** 75% = $409.00
	RADICAL OR DEBULKING OPERATION for advanced gynaecological malignancy, with or without omentectomy (Anaes.) (Assist.) *(See para T8.58 of explanatory notes to this Category)*
35720	**Fee:** $674.50 **Benefit:** 75% = $505.90
	RETROPERITONEAL LYMPH NODE BIOPSIES from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (Anaes.) (Assist.)
35723	**Fee:** $483.10 **Benefit:** 75% = $362.35

35726	INFRACOLIC OMENTECTOMY with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (Anaes.) (Assist.) **Fee:** $483.10 **Benefit:** 75% = $362.35
35729	OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (Anaes.) **Fee:** $217.80 **Benefit:** 75% = $163.35
35750	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, including any associated laparoscopy (Anaes.) (Assist.) **Fee:** $784.60 **Benefit:** 75% = $588.45
35753	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst or treatment of moderate endometriosis, one or both sides, including any associated laparoscopy (Anaes.) (Assist.) **Fee:** $867.60 **Benefit:** 75% = $650.70
35754	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY which requires dissection of endometriosis, or other pathology, from the ureter, one or both sides, including any associated laparoscopy, including when performed with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst, or treatment of endometriosis, not being a service to which item 35641 applies (Anaes.) (Assist.) **Fee:** $1,091.90 **Benefit:** 75% = $818.95
35756	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, when procedure is completed by open hysterectomy, including any associated laparoscopy (Anaes.) (Assist.) **Fee:** $784.60 **Benefit:** 75% = $588.45
35759	Procedure for the control of POST OPERATIVE HAEMORRHAGE following gynaecological surgery, under general anaesthesia, utilising a vaginal or abdominal and vaginal approach where no other procedure is performed (Anaes.) (Assist.) **Fee:** $563.30 **Benefit:** 75% = $422.50
	SUBGROUP 5 - UROLOGICAL
	GENERAL
36500	ADRENAL GLAND, excision of partial or total (Anaes.) (Assist.) **Fee:** $924.70 **Benefit:** 75% = $693.55
36502	PELVIC LYMPHADENECTOMY, open or laparoscopic, or both, unilateral or bilateral (Anaes.) (Assist.) **Fee:** $683.90 **Benefit:** 75% = $512.95
36503	RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes.) (Assist.) **Fee:** $1,391.15 **Benefit:** 75% = $1,043.40
36506	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together vascular anastomosis including aftercare (Anaes.) (Assist.) **Fee:** $924.70 **Benefit:** 75% = $693.55
36509	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together ureterovesical anastomosis including aftercare (Assist.) **Fee:** $782.95 **Benefit:** 75% = $587.25
36516	NEPHRECTOMY, complete (Anaes.) (Assist.) **Fee:** $924.70 **Benefit:** 75% = $693.55
36519	NEPHRECTOMY, complete, complicated by previous surgery on the same kidney (Anaes.) (Assist.) **Fee:** $1,291.10 **Benefit:** 75% = $968.35
36522	NEPHRECTOMY, partial (Anaes.) (Assist.) **Fee:** $1,107.95 **Benefit:** 75% = $831.00
36525	NEPHRECTOMY, partial, complicated by previous surgery on the same kidney (Anaes.) (Assist.) **Fee:** $1,574.45 **Benefit:** 75% = $1,180.85
36526	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10cms in diameter, where performed if malignancy is clinically suspected but not confirmed by histopathological examination (Anaes.) (Assist.) *(See para T8.49 of explanatory notes to this Category)* **Fee:** $1,291.10 **Benefit:** 75% = $968.35 85% = $1,211.60

36527	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney, where performed if malignancy is clinically suspected but not confirmed by histopathological examination (Anaes.) (Assist.) *(See para T8.49 of explanatory notes to this Category)* **Fee:** $1,593.40 **Benefit:** 75% = $1,195.05 85% = $1,513.90
36528	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10 cms in diameter (Anaes.) (Assist.) **Fee:** $1,291.10 **Benefit:** 75% = $968.35
36529	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10 cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney (Anaes.) (Assist.) **Fee:** $1,593.40 **Benefit:** 75% = $1,195.05
36531	NEPHROURETERECTOMY, complete, including associated bladder repair and any associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $1,157.85 **Benefit:** 75% = $868.40
36532	NEPHRO-URETERECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $1,661.85 **Benefit:** 75% = $1,246.40
36533	NEPHRO-URETERECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, complicated by previous open or laparoscopic surgery on the same kidney or ureter (Anaes.) (Assist.) **Fee:** $1,964.15 **Benefit:** 75% = $1,473.15
36537	KIDNEY OR PERINEPHRIC AREA, EXPLORATION OF, with or without drainage of, by open exposure, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $691.40 **Benefit:** 75% = $518.55
36540	NEPHROLITHOTOMY OR PYELOLITHOTOMY, or both, through the same skin incision, for 1 or 2 stones (Anaes.) (Assist.) **Fee:** $1,107.95 **Benefit:** 75% = $831.00 85% = $1,028.45
36543	NEPHROLITHOTOMY OR PYELOLITHOTOMY, or both, extended, for staghorn stone or 3 or more stones, including 1 or more of the following: nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (Anaes.) (Assist.) **Fee:** $1,291.10 **Benefit:** 75% = $968.35 85% = $1,211.60
36546	EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment care for 3 days, including pretreatment consultation, unilateral (Anaes.) **Fee:** $691.40 **Benefit:** 75% = $518.55 85% = $611.90
36549	URETEROLITHOTOMY (Anaes.) (Assist.) **Fee:** $833.10 **Benefit:** 75% = $624.85
36552	NEPHROSTOMY or pyelostomy, open, as an independent procedure (Anaes.) (Assist.) **Fee:** $741.50 **Benefit:** 75% = $556.15
36558	RENAL CYST OR CYSTS, excision or unroofing of (Anaes.) (Assist.) **Fee:** $649.80 **Benefit:** 75% = $487.35 85% = $570.30
36561	RENAL BIOPSY (closed) (Anaes.) **Fee:** $172.50 **Benefit:** 75% = $129.40 85% = $146.65
36564	PYELOPLASTY, (plastic reconstruction of the pelvi-ureteric junction) by open exposure, laparoscopy or laparoscopic assisted techniques (Anaes.) (Assist.) **Fee:** $924.70 **Benefit:** 75% = $693.55
36567	PYELOPLASTY in a kidney that is congenitally abnormal in addition to the presence of PUJ obstruction, or in a solitary kidney, by open exposure (Anaes.) (Assist.) **Fee:** $1,016.30 **Benefit:** 75% = $762.25
36570	PYELOPLASTY, complicated by previous surgery on the same kidney, by open exposure (Anaes.) (Assist.) **Fee:** $1,291.10 **Benefit:** 75% = $968.35

36573	DIVIDED URETER, repair of (Anaes.) (Assist.) **Fee:** $924.70 **Benefit:** 75% = $693.55
36576	KIDNEY, exposure and exploration of, including repair or nephrectomy, for trauma, not being a service associated with any other procedure performed on the kidney, renal pelvis or renal pedicle (Anaes.) (Assist.) **Fee:** $1,157.85 **Benefit:** 75% = $868.40
36579	URETERECTOMY, COMPLETE OR PARTIAL, with or without associated bladder repair, not being a service associated with a service to which item 37000 applies (Anaes.) (Assist.) **Fee:** $741.50 **Benefit:** 75% = $556.15
36585	URETER, transplantation of, into skin (Anaes.) (Assist.) **Fee:** $741.50 **Benefit:** 75% = $556.15
36588	URETER, reimplantation into bladder (Anaes.) (Assist.) **Fee:** $924.70 **Benefit:** 75% = $693.55
36591	URETER, reimplantation into bladder with psoas hitch or Boari flap or both (Anaes.) (Assist.) **Fee:** $1,107.95 **Benefit:** 75% = $831.00
36594	URETER, transplantation of, into intestine (Anaes.) (Assist.) **Fee:** $924.70 **Benefit:** 75% = $693.55
36597	URETER, transplantation of, into another ureter (Anaes.) (Assist.) **Fee:** $924.70 **Benefit:** 75% = $693.55
36600	URETER, transplantation of, into isolated intestinal segment, unilateral (Anaes.) (Assist.) **Fee:** $1,107.95 **Benefit:** 75% = $831.00 85% = $1,028.45
36603	URETERS, transplantation of, into isolated intestinal segment, bilateral (Anaes.) (Assist.) **Fee:** $1,291.10 **Benefit:** 75% = $968.35
36604	URETERIC STENT, passage of through percutaneous nephrostomy tube, using interventional imaging techniques (Anaes.) **Fee:** $267.65 **Benefit:** 75% = $200.75 85% = $227.55
36605	URETERIC STENT, insertion of, with removal of calculus from: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional imaging techniques (Anaes.) **Fee:** $690.70 **Benefit:** 75% = $518.05
36606	INTESTINAL URINARY RESERVOIR, continent, formation of, including formation of nonreturn valves and implantation of ureters (1 or both) into reservoir (Anaes.) (Assist.) **Fee:** $2,315.80 **Benefit:** 75% = $1,736.85
36607	URETERIC STENT insertion of, with baloon dilatation of: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional imaging techniques (Anaes.) **Fee:** $690.70 **Benefit:** 75% = $518.05
36608	URETERIC STENT, exchange of, percutaneously through either the ileal conduit or bladder, using interventional imaging techniques, not being a service associated with a service to which items 36811 to 36854 apply (Anaes.) **Fee:** $267.65 **Benefit:** 75% = $200.75
36609	INTESTINAL URINARY CONDUIT OR URETEROSTOMY, revision of (Anaes.) (Assist.) **Fee:** $741.50 **Benefit:** 75% = $556.15
36612	URETER, exploration of, with or without drainage of, as an independent procedure (Anaes.) (Assist.) **Fee:** $649.80 **Benefit:** 75% = $487.35
36615	URETEROLYSIS, with or without repositioning of the ureter, for obstruction of the ureter, evident either radiologically or by proximal ureteric dilatation at operation, secondary to retroperitoneal fibrosis, or similar condition (Anaes.) (Assist.) **Fee:** $741.50 **Benefit:** 75% = $556.15

36618	REDUCTION URETEROPLASTY (Anaes.) (Assist.) **Fee:** $649.80 **Benefit:** 75% = $487.35
36621	CLOSURE OF CUTANEOUS URETEROSTOMY (Anaes.) (Assist.) **Fee:** $464.50 **Benefit:** 75% = $348.40
36624	NEPHROSTOMY, percutaneous, using interventional imaging techniques (Anaes.) (Assist.) **Fee:** $558.10 **Benefit:** 75% = $418.60 85% = $478.60
36627	NEPHROSCOPY, percutaneous, with or without any 1 or more of; stone extraction, biopsy or diathermy, not being a service to which item 36639, 36642, 36645 or 36648 applies (Anaes.) **Fee:** $691.40 **Benefit:** 75% = $518.55
36630	NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36627 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (Anaes.) (Assist.) **Fee:** $341.50 **Benefit:** 75% = $256.15
36633	NEPHROSCOPY, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, not being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.) **Fee:** $741.50 **Benefit:** 75% = $556.15 85% = $662.00
36636	NEPHROSCOPY, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.) **Fee:** $399.90 **Benefit:** 75% = $299.95
36639	NEPHROSCOPY, percutaneous, with destruction and extraction of 1 or 2 stones using ultrasound or electrohydraulic shock waves or lasers (not being a service to which item 36645 or 36648 applies) (Anaes.) **Fee:** $833.10 **Benefit:** 75% = $624.85
36642	NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36639 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (Anaes.) (Assist.) **Fee:** $416.45 **Benefit:** 75% = $312.35
36645	NEPHROSCOPY, percutaneous, with removal or destruction of a stone greater than 3 cm in any dimension, or for 3 or more stones (Anaes.) (Assist.) **Fee:** $1,066.30 **Benefit:** 75% = $799.75
36648	NEPHROSCOPY, being a service to which item 36645 applies, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION (Anaes.) (Assist.) **Fee:** $949.60 **Benefit:** 75% = $712.20
36649	NEPHROSTOMY DRAINAGE TUBE, exchange of - but not including imaging (Anaes.) (Assist.) **Fee:** $267.65 **Benefit:** 75% = $200.75 85% = $227.55
36650	NEPHROSTOMY TUBE, removal of, if the ureter has been stented with a double J ureteric stent and that stent is left in place, using interventional imaging techniques (Anaes.) **Fee:** $149.70 **Benefit:** 75% = $112.30
36652	PYELOSCOPY, retrograde, of one collecting system, with or without any one or more of, cystoscopy, ureteric meatotomy, ureteric dilatation, not being a service associated with a service to which item 36803, 36812 or 36824 applies (Anaes.) (Assist.) **Fee:** $649.80 **Benefit:** 75% = $487.35
36654	PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, plus 1 or more of extraction of stone from the renal pelvis or calyces, or biopsy or diathermy of the renal pelvis or calyces, not being a service associated with a service to which item 36656 applies to a procedure performed in the same collecting system (Anaes.) (Assist.) **Fee:** $833.10 **Benefit:** 75% = $624.85
36656	PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, plus extraction of 2 or more stones in the renal pelvis or calyces or destruction of stone with ultrasound, electrohydraulic or kinetic lithotripsy, or laser in the renal pelvis or calyces, with or without extraction of fragments, not being a service associated with a service to which item 36654 applies to a procedure performed in the same collecting system (Anaes.) (Assist.) **Fee:** $1,066.30 **Benefit:** 75% = $799.75

36658	SACRAL NERVE STIMULATION for refractory urinary incontinence or urge retention, removal of pulse generator and leads *(See para T8.50 of explanatory notes to this Category)* **Fee:** $526.40 **Benefit:** 75% = $394.80 85% = $447.45
36660	SACRAL NERVE STIMULATION for refractory urinary incontinence or urge retention, removal and replacement of pulse generator *(See para T8.50 of explanatory notes to this Category)* **Fee:** $255.45 **Benefit:** 75% = $191.60 85% = $217.15
36662	SACRAL NERVE STIMULATION for refractory urinary incontinence or urge retention, removal and replacement of leads *(See para T8.50 of explanatory notes to this Category)* **Fee:** $610.30 **Benefit:** 75% = $457.75 85% = $530.80
	OPERATIONS ON BLADDER
36663	Sacral nerve lead(s), percutaneous placement using fluoroscopic guidance (or open placement) and intraoperative test stimulation, to manage: a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older. (Anaes.) **Fee:** $660.95 **Benefit:** 75% = $495.75
36664	Sacral nerve lead(s), percutaneous surgical repositioning of, using fluoroscopic guidance (or open surgical repositioning) and intraoperative test stimulation, to correct displacement or unsatisfactory positioning, if inserted for the management of: a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older, not being a service to which item 36663 applies (Anaes.) **Fee:** $593.55 **Benefit:** 75% = $445.20
36665	Sacral nerve electrode or electrodes, management and adjustment of the pulse generator by a medical practitioner, to manage detrusor overactivity or non obstructive urinary retention – each day **Fee:** $125.40 **Benefit:** 75% = $94.05 85% = $106.60
36666	Pulse generator, subcutaneous placement of, and placement and connection of extension wire(s) to sacral nerve electrode(s), for the management of a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older. (Anaes.) **Fee:** $334.00 **Benefit:** 75% = $250.50
36667	Sacral nerve lead(s), removal of, if the lead was inserted to manage: a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older. (Anaes.) **Fee:** $156.30 **Benefit:** 75% = $117.25
36668	Pulse generator, removal of, if the pulse generator was inserted to manage: a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older. (Anaes.) **Fee:** $156.30 **Benefit:** 75% = $117.25
36800	BLADDER, catheterisation of, where no other procedure is performed (Anaes.) **Fee:** $27.60 **Benefit:** 75% = $20.70 85% = $23.50
36803	URETEROSCOPY, of one ureter, with or without any one or more of; cystoscopy, ureteric meatotomy or ureteric dilatation, not being a service associated with a service to which item 36652, 36654, 36656, 36806, 36809, 36812, 36824, 36848 or 36857 applies (Anaes.) (Assist.) *(See para T8.52 of explanatory notes to this Category)* **Fee:** $466.35 **Benefit:** 75% = $349.80 85% = $396.40

36806	URETEROSCOPY, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus one or more of extraction of stone from the ureter, or biopsy or diathermy of the ureter, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36809, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Anaes.) (Assist.) **Fee:** $649.80 **Benefit:** 75% = $487.35
36809	URETEROSCOPY, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, PLUS destruction of stone in the ureter with ultrasound, electrohydraulic or kinetic lithotripsy, or laser, with or without extraction of fragments, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36806, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Anaes.) (Assist.) **Fee:** $833.10 **Benefit:** 75% = $624.85
36811	CYSTOSCOPY with insertion of urethral prosthesis (Anaes.) **Fee:** $323.40 **Benefit:** 75% = $242.55 85% = $274.90
36812	CYSTOSCOPY with urethroscopy with or without urethral dilatation, not being a service associated with any other urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies (Anaes.) **Fee:** $166.70 **Benefit:** 75% = $125.05 85% = $141.70
36815	CYSTOSCOPY, with or without urethroscopy, for the treatment of penile warts or uretheral warts, not being a service associated with a service to which item 30189 applies (Anaes.) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $237.90 **Benefit:** 75% = $178.45 85% = $202.25
36818	CYSTOSCOPY with ureteric catheterisation including fluoroscopic imaging of the upper urinary tract, unilateral or bilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes.) (Assist.) **Fee:** $276.60 **Benefit:** 75% = $207.45 85% = $235.15
36821	CYSTOSCOPY with 1 or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or renal pelvis, unilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes.) (Assist.) **Fee:** $323.20 **Benefit:** 75% = $242.40 85% = $274.75
36824	CYSTOSCOPY, with ureteric catheterisation, unilateral or bilateral, not being a service associated with a service to which item 36818 or 36821 applies (Anaes.) **Fee:** $213.15 **Benefit:** 75% = $159.90 85% = $181.20
36825	CYSTOSCOPY, with endoscopic incision of pelviureteric junction or ureteric stricture, including removal or replacement of ureteric stent, not being a service associated with a service to which item 36818, 36821, 36824, 36830 or 36833 applies (Anaes.) (Assist.) **Fee:** $581.30 **Benefit:** 75% = $436.00
36827	CYSTOSCOPY, with controlled hydrodilatation of the bladder (Anaes.) **Fee:** $229.85 **Benefit:** 75% = $172.40 85% = $195.40
36830	CYSTOSCOPY, with ureteric meatotomy (Anaes.) **Fee:** $203.25 **Benefit:** 75% = $152.45
36833	CYSTOSCOPY, with removal of ureteric stent or other foreign body (Anaes.) (Assist.) **Fee:** $276.60 **Benefit:** 75% = $207.45 85% = $235.15
36836	CYSTOSCOPY, with biopsy of bladder, not being a service associated with a service to which item 36812, 36830, 36840, 36845, 36848, 36854, 37203, 37206 or 37215 applies (Anaes.) **Fee:** $229.85 **Benefit:** 75% = $172.40 85% = $195.40
36840	CYSTOSCOPY, with resection, diathermy or visual laser destruction of bladder tumour or other lesion of the bladder, not being a service to which item 36845 applies (Anaes.) **Fee:** $323.20 **Benefit:** 75% = $242.40 85% = $274.75
36842	CYSTOSCOPY, with lavage of blood clots from bladder including any associated diathermy of prostate or bladder and not being a service associated with a service to which item 36812, 36827 to 36863, 37203 or 37206 apply (Anaes.) (Assist.) **Fee:** $325.20 **Benefit:** 75% = $243.90
36845	CYSTOSCOPY, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 quadrants of the bladder or solitary tumour greater than 2cm in diameter (Anaes.) **Fee:** $691.40 **Benefit:** 75% = $518.55 85% = $611.90

36848	CYSTOSCOPY, with resection of ureterocele (Anaes.) **Fee:** $229.85 **Benefit:** 75% = $172.40
36851	Cystoscopy, with injection into bladder wall, other than a service associated with a service to which item 18375 or 18379 applies (H) (Anaes.) *(See para T8.2 of explanatory notes to this Category)* **Fee:** $229.85 **Benefit:** 75% = $172.40
36854	CYSTOSCOPY, with endoscopic incision or resection of external sphincter, bladder neck or both (Anaes.) **Fee:** $466.35 **Benefit:** 75% = $349.80
36857	ENDOSCOPIC MANIPULATION OR EXTRACTION of ureteric calculus (Anaes.) **Fee:** $366.45 **Benefit:** 75% = $274.85
36860	ENDOSCOPIC EXAMINATION of intestinal conduit or reservoir (Anaes.) **Fee:** $166.70 **Benefit:** 75% = $125.05 85% = $141.70
36863	LITHOLAPAXY, with or without cystoscopy (Anaes.) (Assist.) **Fee:** $466.35 **Benefit:** 75% = $349.80
37000	BLADDER, partial excision of (Anaes.) (Assist.) **Fee:** $741.50 **Benefit:** 75% = $556.15
37004	BLADDER, repair of rupture (Anaes.) (Assist.) **Fee:** $649.80 **Benefit:** 75% = $487.35
37008	CYSTOSTOMY OR CYSTOTOMY, suprapubic, not being a service to which item 37011 applies and not being a service associated with other open bladder procedure (Anaes.) **Fee:** $416.45 **Benefit:** 75% = $312.35 85% = $354.00
37011	SUPRAPUBIC STAB CYSTOTOMY, not being a service associated with a service to which items 37200 to 37221 apply (Anaes.) **Fee:** $93.35 **Benefit:** 75% = $70.05 85% = $79.35
37014	BLADDER, total excision of (Anaes.) (Assist.) **Fee:** $1,066.30 **Benefit:** 75% = $799.75
37020	BLADDER DIVERTICULUM, excision or obliteration of (Anaes.) (Assist.) **Fee:** $741.50 **Benefit:** 75% = $556.15
37023	VESICAL FISTULA, cutaneous, operation for (Anaes.) **Fee:** $416.45 **Benefit:** 75% = $312.35
37026	CUTANEOUS VESICOSTOMY, establishment of (Anaes.) (Assist.) **Fee:** $416.45 **Benefit:** 75% = $312.35
37029	VESICOVAGINAL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.) **Fee:** $924.70 **Benefit:** 75% = $693.55
37038	VESICOINTESTINAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.) **Fee:** $691.75 **Benefit:** 75% = $518.85
37041	BLADDER ASPIRATION by needle **Fee:** $46.60 **Benefit:** 75% = $34.95 85% = $39.65
37042	BLADDER STRESS INCONTINENCE, sling procedure for, using autologous fascial sling, including harvesting of sling, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.) **Fee:** $911.30 **Benefit:** 75% = $683.50
37043	BLADDER STRESS INCONTINENCE, Stamey or similar type needle colposuspension, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.) **Fee:** $674.50 **Benefit:** 75% = $505.90
37044	BLADDER STRESS INCONTINENCE, suprapubic procedure for, eg Burch colposuspension, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.) **Fee:** $691.75 **Benefit:** 75% = $518.85

37045	CONTINENT CATHETERISATION BLADDER STOMAS (eg. Mitrofanoff), formation of (Anaes.) (Assist.) **Fee:** $1,428.75 **Benefit:** 75% = $1,071.60
37047	BLADDER ENLARGEMENT using intestine (Anaes.) (Assist.) **Fee:** $1,666.05 **Benefit:** 75% = $1,249.55
37050	BLADDER EXSTROPHY CLOSURE, not involving sphincter reconstruction (Anaes.) (Assist.) **Fee:** $741.50 **Benefit:** 75% = $556.15
37053	BLADDER TRANSECTION AND RE-ANASTOMOSIS TO TRIGONE (Anaes.) (Assist.) **Fee:** $856.70 **Benefit:** 75% = $642.55
	OPERATIONS ON PROSTATE
37200	PROSTATECTOMY, open (Anaes.) (Assist.) **Fee:** $1,016.30 **Benefit:** 75% = $762.25
37201	PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is, prostatectomy using diathermy or cold punch) and including services to which item 36854, 37203, 37206, 37207, 37208, 37245, 37303, 37321 or 37324 applies (Anaes.) *(See para T8.54 of explanatory notes to this Category)* **Fee:** $828.85 **Benefit:** 75% = $621.65
37202	PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is prostatectomy using diathermy or cold punch) and including services to which item 36854, 37245, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203 or 37207 which had to be discontinued for medical reasons (Anaes.) *(See para T8.54 of explanatory notes to this Category)* **Fee:** $416.05 **Benefit:** 75% = $312.05 85% = $353.65
37203	PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37201, 37202, 37207, 37208, 37245, 37303, 37321 or 37324 applies (Anaes.) **Fee:** $1,042.15 **Benefit:** 75% = $781.65
37206	PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203, 37207 or 37245 which had to be discontinued for medical reasons (Anaes.) **Fee:** $558.10 **Benefit:** 75% = $418.60
37207	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which items 36854, 37201, 37202, 37203, 37206, 37245, 37321 or 37324 applies (Anaes.) **Fee:** $866.45 **Benefit:** 75% = $649.85
37208	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by items 37201, 37203, 37207 or 37245 which had to be discontinued for medical reasons (Anaes.) **Fee:** $416.05 **Benefit:** 75% = $312.05
37209	PROSTATE, and/or SEMINAL VESICLE/AMPULLA OF VAS, unilateral or bilateral, total excision of, not being a service associated with a service to which item number 37210 or 37211 applies (Anaes.) (Assist.) **Fee:** $1,291.10 **Benefit:** 75% = $968.35
37210	PROSTATECTOMY, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Anaes.) (Assist.) **Fee:** $1,593.40 **Benefit:** 75% = $1,195.05
37211	PROSTATECTOMY, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, ***with pelvic lymphadenectomy***, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Anaes.) (Assist.) **Fee:** $1,935.20 **Benefit:** 75% = $1,451.40
37212	PROSTATE, open perineal biopsy or open drainage of abscess (Anaes.) (Assist.) **Fee:** $276.60 **Benefit:** 75% = $207.45

37215	PROSTATE, biopsy of, endoscopic, with or without cystoscopy (Anaes.) (Assist.) **Fee:** $416.45 **Benefit:** 75% = $312.35 85% = $354.00
37217	Prostate, implantation of radio-opaque fiducial markers into the prostate gland or prostate surgical bed (Anaes.) *(See para T8.2 and T8.55 of explanatory notes to this Category)* **Fee:** $138.30 **Benefit:** 75% = $103.75 85% = $117.60
37218	PROSTATE, needle biopsy of, or injection into, excluding for insertion of radiopaque markers (Anaes.) **Fee:** $138.30 **Benefit:** 75% = $103.75 85% = $117.60
37219	PROSTATE, needle biopsy of, using prostatic ultrasound techniques and obtaining 1 or more prostatic specimens, being a service associated with a service to which item 55600 or 55603 applies (Anaes.) (Assist.) **Fee:** $280.85 **Benefit:** 75% = $210.65 85% = $238.75
37220	PROSTATE, radioactive seed implantation of, urological component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate), with a Gleason score of less than or equal to 7 and a prostate specific antigen (PSA) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed by a urologist at an approved site in association with a radiation oncologist, and be associated with a service to which item 55603 applies. (Anaes.) *(See para T8.56 of explanatory notes to this Category)* **Fee:** $1,044.20 **Benefit:** 75% = $783.15
37221	PROSTATIC ABSCESS, endoscopic drainage of (Anaes.) (Assist.) **Fee:** $466.35 **Benefit:** 75% = $349.80
37223	PROSTATIC COIL, insertion of, under ultrasound control (Anaes.) **Fee:** $206.25 **Benefit:** 75% = $154.70
37224	PROSTATE, diathermy or visual laser destruction of lesion of, not being a service associated with a service to which item 37201, 37202, 37203, 37206, 37207, 37208 or 37215 applies (Anaes.) **Fee:** $323.20 **Benefit:** 75% = $242.40 85% = $274.75
37227	PROSTATE, transperineal insertion of catheters into, for high dose rate brachytherapy using ultrasound guidance including any associated cystoscopy. The procedure must be performed at an approved site in association with a radiation oncologist, and be associated with a service to which item 15331 or 15332 applies. (Anaes.) *(See para T8.57 of explanatory notes to this Category)* **Fee:** $565.85 **Benefit:** 75% = $424.40 85% = $486.35
37230	PROSTATE, high-energy transurethral microwave thermotherapy of, with or without cystoscopy and with or without urethroscopy and including services to which item 36854, 37203, 37206, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.) **Fee:** $1,042.15 **Benefit:** 75% = $781.65 85% = $962.65
37233	PROSTATE, high-energy transurethral microwave thermotherapy of, with or without cystoscopy and with or without urethroscopy and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203, 37207, 37230 which had to be discontinued for medical reasons (Anaes.) **Fee:** $558.10 **Benefit:** 75% = $418.60 85% = $478.60
37245	**Prostate**, endoscopic enucleation of, using high powered Holmium:YAG laser and an end-firing, non-contact fibre, with or without tissue morcellation, cystoscopy or urethroscopy, for the treatment of benign prostatic hyperplasia, **and other than a service associated with a service to which item 36854, 37201, 37202, 37203, 37206, 37207, 37208, 37303, 37321, or 37324 applies.** (Anaes.) **Fee:** $1,262.15 **Benefit:** 75% = $946.65
	OPERATIONS ON URETHRA, PENIS OR SCROTUM
37300	URETHRAL SOUNDS, passage of, as an independent procedure (Anaes.) **Fee:** $46.60 **Benefit:** 75% = $34.95 85% = $39.65
37303	URETHRAL STRICTURE, dilatation of (Anaes.) **Fee:** $74.05 **Benefit:** 75% = $55.55 85% = $62.95
37306	URETHRA, repair of rupture of distal section (Anaes.) (Assist.) **Fee:** $649.80 **Benefit:** 75% = $487.35
37309	URETHRA, repair of rupture of prostatic or membranous segment (Anaes.) (Assist.) **Fee:** $924.70 **Benefit:** 75% = $693.55

37315	URETHROSCOPY, as an independent procedure (Anaes.) **Fee:** $138.30 **Benefit:** 75% = $103.75 85% = $117.60
37318	URETHROSCOPY with any 1 or more of - biopsy, diathermy, visual laser destruction of stone or removal of foreign body or stone (Anaes.) (Assist.) **Fee:** $276.60 **Benefit:** 75% = $207.45 85% = $235.15
37321	URETHRAL MEATOTOMY, EXTERNAL (Anaes.) **Fee:** $93.35 **Benefit:** 75% = $70.05 85% = $79.35
37324	URETHROTOMY OR URETHROSTOMY, internal or external (Anaes.) **Fee:** $229.85 **Benefit:** 75% = $172.40
37327	URETHROTOMY, optical, for urethral stricture (Anaes.) (Assist.) **Fee:** $323.20 **Benefit:** 75% = $242.40
37330	URETHRECTOMY, partial or complete, for removal of tumour (Anaes.) (Assist.) **Fee:** $649.80 **Benefit:** 75% = $487.35
37333	URETHROVAGINAL FISTULA, closure of (Anaes.) (Assist.) **Fee:** $558.10 **Benefit:** 75% = $418.60
37336	URETHRORECTAL FISTULA, closure of (Anaes.) (Assist.) **Fee:** $741.50 **Benefit:** 75% = $556.15
37339	Periurethral or transurethral injection of materials for the treatment of urinary incontinence, including cystoscopy and urethroscopy, other than a service associated with a service to which item 18375 or 18379 applies (Anaes.) *(See para T8.2 of explanatory notes to this Category)* **Fee:** $239.85 **Benefit:** 75% = $179.90 85% = $203.90
37340	URETHRAL SLING, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, vaginal approach, not being a service associated with a service to which item number 37341 applies (Anaes.) (Assist.) **Fee:** $425.00 **Benefit:** 75% = $318.75
37341	URETHRAL SLING, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, suprapubic or combined suprapubic/vaginal approach, not being a service associated with a service to which item number 37340 applies (Anaes.) (Assist.) **Fee:** $911.30 **Benefit:** 75% = $683.50
37342	URETHROPLASTY single stage operation (Anaes.) (Assist.) **Fee:** $833.10 **Benefit:** 75% = $624.85
37343	URETHROPLASTY, single stage operation, transpubic approach via separate incisions above and below the symphysis pubis, excluding laparotomy, symphysectomy and suprapubic cystotomy, with or without re-routing of the urethra around the crura (Anaes.) (Assist.) **Fee:** $1,391.15 **Benefit:** 75% = $1,043.40
37345	URETHROPLASTY 2 stage operation first stage (Anaes.) (Assist.) **Fee:** $691.40 **Benefit:** 75% = $518.55
37348	URETHROPLASTY 2 stage operation second stage (Anaes.) (Assist.) **Fee:** $691.40 **Benefit:** 75% = $518.55
37351	URETHROPLASTY, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $276.60 **Benefit:** 75% = $207.45
37354	HYPOSPADIAS, meatotomy and hemicircumcision (Anaes.) (Assist.) **Fee:** $323.20 **Benefit:** 75% = $242.40
37369	URETHRA, excision of prolapse of (Anaes.) **Fee:** $186.60 **Benefit:** 75% = $139.95
37372	URETHRAL DIVERTICULUM, excision of (Anaes.) (Assist.) **Fee:** $466.35 **Benefit:** 75% = $349.80

37375	URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (Anaes.) (Assist.) **Fee:** $1,157.85 **Benefit:** 75% = $868.40
37381	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.) **Fee:** $741.50 **Benefit:** 75% = $556.15
37384	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.) **Fee:** $1,157.85 **Benefit:** 75% = $868.40
37387	ARTIFICIAL URINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.) (Assist.) **Fee:** $323.20 **Benefit:** 75% = $242.40
37390	ARTIFICIAL URINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.) (Assist.) **Fee:** $924.70 **Benefit:** 75% = $693.55
37393	PRIAPISM, decompression by glanular stab cavernosospongiosum shunt or penile aspiration with or without lavage (Anaes.) **Fee:** $229.85 **Benefit:** 75% = $172.40 85% = $195.40
37396	PRIAPISM, shunt operation for, not being a service to which item 37393 applies (Anaes.) (Assist.) **Fee:** $741.50 **Benefit:** 75% = $556.15
37402	PENIS, partial amputation of (Anaes.) (Assist.) **Fee:** $466.35 **Benefit:** 75% = $349.80
37405	PENIS, complete or radical amputation of (Anaes.) (Assist.) **Fee:** $924.70 **Benefit:** 75% = $693.55
37408	PENIS, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.) **Fee:** $466.35 **Benefit:** 75% = $349.80
37411	PENIS, repair of avulsion (Anaes.) (Assist.) **Fee:** $924.70 **Benefit:** 75% = $693.55 85% = $845.20
37415	PENIS, injection of, for the investigation and treatment of impotence - 2 services only in a period of 36 consecutive months **Fee:** $46.60 **Benefit:** 75% = $34.95 85% = $39.65
37417	PENIS, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting (Anaes.) (Assist.) **Fee:** $558.10 **Benefit:** 75% = $418.60
37418	PENIS, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting, involving mobilization of the urethra (Anaes.) (Assist.) **Fee:** $741.50 **Benefit:** 75% = $556.15 85% = $662.00
37420	PENIS, surgery to inhibit rapid penile drainage causing impotence, by ligation of veins deep to Buck's fascia including 1 or more deep cavernosal veins with or without pharmacological erection test (Anaes.) (Assist.) **Fee:** $366.45 **Benefit:** 75% = $274.85
37423	PENIS, lengthening by translocation of corpora (Anaes.) (Assist.) **Fee:** $924.70 **Benefit:** 75% = $693.55
37426	PENIS, artificial erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.) **Fee:** $974.55 **Benefit:** 75% = $730.95
37429	PENIS, artificial erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.) **Fee:** $323.20 **Benefit:** 75% = $242.40
37432	PENIS, artificial erection device, complete or partial revision or removal of components, with or without replacement (Anaes.) (Assist.) **Fee:** $924.70 **Benefit:** 75% = $693.55
37435	PENIS, frenuloplasty as an independent procedure (Anaes.) **Fee:** $93.35 **Benefit:** 75% = $70.05 85% = $79.35
37438	SCROTUM, partial excision of (Anaes.) (Assist.) **Fee:** $276.60 **Benefit:** 75% = $207.45 85% = $235.15

37444	URETEROLITHOTOMY COMPLICATED BY PREVIOUS SURGERY at the same site of the same ureter (Anaes.) (Assist.) **Fee:** $999.65 **Benefit:** 75% = $749.75 85% = $920.15
	OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES
37601	SPERMATOCELE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (Anaes.) **Fee:** $276.60 **Benefit:** 75% = $207.45 85% = $235.15
37604	EXPLORATION OF SCROTAL CONTENTS, with or without fixation and with or without biopsy, unilateral, not being a service associated with sperm harvesting for IVF (Anaes.) **Fee:** $276.60 **Benefit:** 75% = $207.45 85% = $235.15
37605	**Transcutaneous sperm retrieval**, unilateral, from either the testis or the epididymis, for the purposes of **intracytoplasmic sperm injection**, for male factor infertility, excluding a service to which item 13218 applies. (Anaes.) *(See para T8.59 of explanatory notes to this Category)* **Fee:** $373.45 **Benefit:** 75% = $280.10 85% = $317.45
37606	**Open surgical sperm retrieval**, unilateral, including the exploration of scrotal contents, with our without biopsy, for the purposes of **intracytoplasmic sperm injection**, for male factor infertility, performed in a hospital, excluding a service to which item 13218 or 37604 applies. (Anaes.) *(See para T8.60 of explanatory notes to this Category)* **Fee:** $554.55 **Benefit:** 75% = $415.95 85% = $475.05
37607	RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies (Anaes.) (Assist.) **Fee:** $924.70 **Benefit:** 75% = $693.55
37610	RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies, following previous similar retroperitoneal dissection, retroperitoneal irradiation or chemotherapy (Anaes.) (Assist.) **Fee:** $1,391.15 **Benefit:** 75% = $1,043.40
37613	EPIDIDYMECTOMY (Anaes.) **Fee:** $276.60 **Benefit:** 75% = $207.45 85% = $235.15
37616	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, using operating microscope, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) **Fee:** $691.40 **Benefit:** 75% = $518.55
37619	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) **Fee:** $276.60 **Benefit:** 75% = $207.45 85% = $235.15 **Extended Medicare Safety Net Cap:** $221.30
37622 G 37623 S	VASOTOMY OR VASECTOMY, unilateral or bilateral **NOTE:** ***Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim***. (Anaes.) *(See para T8.47 of explanatory notes to this Category)* **Fee:** $193.20 **Benefit:** 75% = $144.90 85% = $164.25 **Fee:** $229.85 **Benefit:** 75% = $172.40 85% = $195.40
	PAEDIATRIC GENITURINARY SURGERY
37800	PATENT URACHUS, excision of, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $521.25 **Benefit:** 75% = $390.95
37801	PATENT URACHUS, excision of, when performed on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $677.65 **Benefit:** 75% = $508.25
37803	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37806 applies, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $521.25 **Benefit:** 75% = $390.95
37804	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37807 applies, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $677.65 **Benefit:** 75% = $508.25

37806	UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $602.25 **Benefit:** 75% = $451.70 85% = $522.75
37807	UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $782.95 **Benefit:** 75% = $587.25 85% = $703.45
37809	UNDESCENDED TESTIS, revision orchidopexy for, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $602.25 **Benefit:** 75% = $451.70
37810	UNDESCENDED TESTIS, revision orchidopexy for, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $782.95 **Benefit:** 75% = $587.25
37812	IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37803, 37806 and 37809 applies, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $556.00 **Benefit:** 75% = $417.00
37813	IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37804, 37807 and 37810 applies, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $722.80 **Benefit:** 75% = $542.10
37815	HYPOSPADIAS, examination under anaesthesia with erection test on a person 10 years of age or over. (Anaes.) **Fee:** $92.75 **Benefit:** 75% = $69.60
37816	HYPOSPADIAS, examination under anaesthesia with erection test, on a person under 10 years of age (Anaes.) **Fee:** $120.60 **Benefit:** 75% = $90.45
37818	HYPOSPADIAS, glanuloplasty incorporating meatal advancement, on a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $491.45 **Benefit:** 75% = $368.60 85% = $417.75
37819	HYPOSPADIAS, glanuloplasty incorporating meatal advancement, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $638.90 **Benefit:** 75% = $479.20 85% = $559.40
37821	HYPOSPADIAS, distal, 1 stage repair, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $833.10 **Benefit:** 75% = $624.85
37822	HYPOSPADIAS, distal, 1 stage repair, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $1,083.05 **Benefit:** 75% = $812.30
37824	HYPOSPADIAS, proximal, 1 stage repair on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $1,158.30 **Benefit:** 75% = $868.75
37825	HYPOSPADIAS, proximal, 1 stage repair, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $1,505.80 **Benefit:** 75% = $1,129.35
37827	HYPOSPADIAS, staged repair, first stage, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $533.60 **Benefit:** 75% = $400.20
37828	HYPOSPADIAS, staged repair, first stage, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $693.70 **Benefit:** 75% = $520.30
37830	HYPOSPADIAS, staged repair, second stage, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $691.40 **Benefit:** 75% = $518.55 85% = $611.90
37831	HYPOSPADIAS, staged repair, second stage, on a person under 10 years of age. (Anaes.) (Assist.) **Fee:** $898.90 **Benefit:** 75% = $674.20 85% = $819.40
37833	HYPOSPADIAS, repair of post-operative urethral fistula, on a person 10 years of age or over. (Anaes.) (Assist.) **Fee:** $329.95 **Benefit:** 75% = $247.50
37834	HYPOSPADIAS, repair of post-operative urethral fistula, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $428.95 **Benefit:** 75% = $321.75
37836	EPISPADIAS, staged repair, first stage (Anaes.) (Assist.) **Fee:** $695.00 **Benefit:** 75% = $521.25

37839	EPISPADIAS, staged repair, second stage (Anaes.) (Assist.) **Fee:** $787.60 **Benefit:** 75% = $590.70
37842	EXSTROPHY OF BLADDER OR EPISPADIAS, secondary repair with bladder neck tightening, with or without ureteric reimplantation (Anaes.) (Assist.) **Fee:** $1,529.10 **Benefit:** 75% = $1,146.85
37845	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty, with or without endoscopy (Anaes.) (Assist.) **Fee:** $695.00 **Benefit:** 75% = $521.25
37848	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty with endoscopy and vaginoplasty (Anaes.) (Assist.) **Fee:** $1,251.05 **Benefit:** 75% = $938.30
37851	CONGENITAL ADRENAL HYPERPLASIA, mixed gonadal dysgenesis or similar condition, vaginoplasty for, with or without endoscopy (Anaes.) (Assist.) **Fee:** $926.80 **Benefit:** 75% = $695.10
37854	URETHRAL VALVE, destruction of, including cystoscopy and urethroscopy (Anaes.) (Assist.) **Fee:** $366.45 **Benefit:** 75% = $274.85
	SUBGROUP 6 - CARDIO-THORACIC
	CARDIOLOGY PROCEDURES
38200	RIGHT HEART CATHETERISATION, with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurement by any method, shunt detection or exercise stress test (Anaes.) **Fee:** $445.40 **Benefit:** 75% = $334.05 85% = $378.60
38203	LEFT HEART CATHETERISATION by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test (Anaes.) **Fee:** $531.55 **Benefit:** 75% = $398.70 85% = $452.05
38206	RIGHT HEART CATHETERISATION WITH LEFT HEART CATHETERISATION via the right heart or by any other procedure with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test (Anaes.) **Fee:** $642.65 **Benefit:** 75% = $482.00 85% = $563.15
38209	CARDIAC ELECTROPHYSIOLOGICAL STUDY up to and including 3 catheter investigation of any 1 or more of syncope, atrioventricular conduction, sinus node function or simple ventricular tachycardia studies, not being a service associated with a service to which item 38212 or 38213 applies (Anaes.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $825.15 **Benefit:** 75% = $618.90 85% = $745.65
38212	CARDIAC ELECTROPHYSIOLOGICAL STUDY 4 or more catheter supraventricular tachycardia investigation; or complex tachycardia inductions, or multiple catheter mapping, or acute intravenous antiarrhythmic drug testing with pre and post drug inductions; or catheter ablation to intentionally induce complete AV block; or intraoperative mapping; or electrophysiological services during defibrillator implantation not being a service associated with a service to which item 38209 or 38213 applies (Anaes.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $1,372.45 **Benefit:** 75% = $1,029.35 85% = $1,292.95
38213	CARDIAC ELECTROPHYSIOLOGICAL STUDY, for follow-up testing of implanted defibrillator - not being a service associated with a service to which item 38209 or 38212 applies (Anaes.) **Fee:** $408.70 **Benefit:** 75% = $306.55 85% = $347.40
38215	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries, not being a service associated with a service to which item 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.53 of explanatory notes to this Category)* **Fee:** $354.90 **Benefit:** 75% = $266.20 85% = $301.70

38218	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography, not being a service associated with a service to which item 38215, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.53 of explanatory notes to this Category)* **Fee:** $532.25 **Benefit:** 75% = $399.20 85% = $452.75
38220	SELECTIVE CORONARY GRAFT ANGIOGRAPHY placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.53 of explanatory notes to this Category)* **Fee:** $177.40 **Benefit:** 75% = $133.05 85% = $150.80
38222	SELECTIVE CORONARY GRAFT ANGIOGRAPHY, placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.53 of explanatory notes to this Category)* **Fee:** $354.90 **Benefit:** 75% = $266.20 85% = $301.70
38225	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.53 of explanatory notes to this Category)* **Fee:** $532.35 **Benefit:** 75% = $399.30 85% = $452.85
38228	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.53 of explanatory notes to this Category)* **Fee:** $709.90 **Benefit:** 75% = $532.45 85% = $630.40
38231	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into the free coronary graft(s) attached to the aorta (irrespective of the number of grafts), and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.53 of explanatory notes to this Category)* **Fee:** $887.25 **Benefit:** 75% = $665.45 85% = $807.75
38234	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.53 of explanatory notes to this Category)* **Fee:** $709.75 **Benefit:** 75% = $532.35 85% = $630.25
38237	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38240 or 38246 applies (Anaes.) *(See para T8.53 of explanatory notes to this Category)* **Fee:** $887.20 **Benefit:** 75% = $665.40 85% = $807.70
38240	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts) and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237 or 38246 applies (Anaes.) *(See para T8.53 of explanatory notes to this Category)* **Fee:** $1,064.60 **Benefit:** 75% = $798.45 85% = $985.10

38241	USE OF A CORONARY PRESSURE WIRE during selective coronary angiography to measure fractional flow reserve (FFR) and coronary flow reserve (CFR) in one or more intermediate coronary artery or graft lesions (stenosis of 30-70%), to determine whether revascularisation should be performed where previous stress testing has either not been performed or the results are inconclusive (Anaes.) **Fee:** $469.70 **Benefit:** 75% = $352.30 85% = $399.25
38243	PLACEMENT OF CATHETER(S) and injection of opaque material into any coronary vessel(s) or graft(s) prior to any coronary interventional procedure, not being a service associated with a service to which item 38246 applies (Anaes.) *(See para T8.53 of explanatory notes to this Category)* **Fee:** $443.60 **Benefit:** 75% = $332.70 85% = $377.10
38246	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography followed by placement of catheters prior to any coronary interventional procedure, not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243 applies (Anaes.) *(See para T8.53 of explanatory notes to this Category)* **Fee:** $887.20 **Benefit:** 75% = $665.40 85% = $807.70
38256	TEMPORARY TRANSVENOUS PACEMAKING ELECTRODE, insertion of (Anaes.) **Fee:** $267.25 **Benefit:** 75% = $200.45 85% = $227.20
38270	BALLOON VALVULOPLASTY OR ISOLATED ATRIAL SEPTOSTOMY, including cardiac catheterisations before and after balloon dilatation (Anaes.) (Assist.) **Fee:** $912.30 **Benefit:** 75% = $684.25 85% = $832.80
38272	ATRIAL SEPTAL DEFECT closure, with septal occluder or other similar device, by transcatheter approach (Anaes.) (Assist.) **Fee:** $912.30 **Benefit:** 75% = $684.25 85% = $832.80
38273	Patent ductus arteriosus, transcatheter closure of, including cardiac catheterisation and any imaging associated with the service (Anaes.) (Assist.) **Fee:** $912.30 **Benefit:** 75% = $684.25
38274	Ventricular septal defect, transcatheter closure of, with imaging and cardiac catheterisation (Anaes.) (Assist.) **Fee:** $912.30 **Benefit:** 75% = $684.25
38275	MYOCARDIAL BIOPSY, by cardiac catheterisation (Anaes.) **Fee:** $298.20 **Benefit:** 75% = $223.65 85% = $253.50
38285	IMPLANTABLE ECG LOOP RECORDER, insertion of, for diagnosis of primary disorder in patients with recurrent unexplained syncope where: - a diagnosis has not been achieved through all other available cardiac investigations; and - a neurogenic cause is not suspected; and - it has been determined that the patient does not have structural heart disease associated with a high risk of sudden cardiac death. including initial programming and testing, as an admitted patient in an approved hospital (Anaes.) *(See para T8.62 of explanatory notes to this Category)* **Fee:** $192.90 **Benefit:** 75% = $144.70 85% = $164.00
38286	IMPLANTABLE ECG LOOP RECORDER, removal of, as an admitted patient in an approved hospital (Anaes.) **Fee:** $173.75 **Benefit:** 75% = $130.35 85% = $147.70
	CATHETER BASED ARRHYTHMIA ABLATION
38287	ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation procedure involving 1 atrial chamber (Anaes.) (Assist.) **Fee:** $2,098.45 **Benefit:** 75% = $1,573.85 85% = $2,018.95
38290	ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.) (Assist.) **Fee:** $2,671.95 **Benefit:** 75% = $2,004.00
38293	VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.) **Fee:** $2,868.05 **Benefit:** 75% = $2,151.05 85% = $2,788.55

	ENDOVASCULAR INTERVENTIONAL PROCEDURES
38300	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $515.35 **Benefit:** 75% = $386.55 85% = $438.05
38303	TRANSLUMINAL BALLOON ANGIOPLASTY of more than 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation and excluding aftercare (Anaes.) (Assist.) **Fee:** $660.80 **Benefit:** 75% = $495.60 85% = $581.30
38306	TRANSLUMINAL INSERTION OF STENT OR STENTS into 1 occlusional site, including associated balloon dilatation for coronary artery, percutaneous or by open exposure, excluding associated radiological services and preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.63 of explanatory notes to this Category)* **Fee:** $762.35 **Benefit:** 75% = $571.80 85% = $682.85
38309	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with no stent insertion, where: - no lesion of the coronary artery has been stented; and - each lesion of the coronary artery is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.42 of explanatory notes to this Category)* **Fee:** $885.45 **Benefit:** 75% = $664.10 85% = $805.95
38312	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with insertion of 1 or more stents, where: - no lesion of the coronary artery has been stented; and - each lesion of the coronary artery is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.42 of explanatory notes to this Category)* **Fee:** $1,132.35 **Benefit:** 75% = $849.30 85% = $1,052.85
38315	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty with no stent insertion, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.42 of explanatory notes to this Category)* **Fee:** $1,215.85 **Benefit:** 75% = $911.90 85% = $1,136.35
38318	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.42 of explanatory notes to this Category)* **Fee:** $1,586.35 **Benefit:** 75% = $1,189.80 85% = $1,506.85
	MISCELLANEOUS CARDIAC PROCEDURES
38350	SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $638.65 **Benefit:** 75% = $479.00
38353	PERMANENT CARDIAC PACEMAKER, insertion, removal or replacement of, not for cardiac resynchronisation therapy, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $255.45 **Benefit:** 75% = $191.60

38356	DUAL CHAMBER PERMANENT TRANSVENOUS ELECTRODES, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $837.35 **Benefit:** 75% = $628.05
38358	Extraction of chronically implanted transvenous pacing or defibrillator lead or leads, by percutaneous method where the leads have been in situ for greater than six months and require removal with locking stylets, snares and/or extraction sheaths in a facility where cardiac surgery is available, in association with item 61109 or 60509 (Anaes.) (Assist.) *(See para T8.65 of explanatory notes to this Category)* **Fee:** $2,868.05 **Benefit:** 75% = $2,151.05
38359	PERICARDIUM, paracentesis of (excluding aftercare) (Anaes.) **Fee:** $133.55 **Benefit:** 75% = $100.20 85% = $113.55
38362	INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (Anaes.) **Fee:** $384.95 **Benefit:** 75% = $288.75 85% = $327.25
38365	Permanent cardiac synchronisation device (including a cardiac synchronisation device that is capable of defibrillation), insertion, removal or replacement of, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) satisfied the requirements mentioned in paragraph (a) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Anaes.) *(See para T8.64 of explanatory notes to this Category)* **Fee:** $255.45 **Benefit:** 75% = $191.60
38368	Permanent transvenous left ventricular electrode, insertion, removal or replacement of through the coronary sinus, for the purpose of cardiac resynchronisation therapy, including right heart catheterisation and any associated venogram of left ventricular veins, other than a service associated with a service to which item 35200 or 38200 applies, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 150 ms; or (c) satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Anaes.) *(See para T8.64 of explanatory notes to this Category)* **Fee:** $1,224.60 **Benefit:** 75% = $918.45
38371	Permanent cardiac synchronisation device capable of defibrillation, insertion, removal or replacement of, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association ((NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 150 ms (Anaes.) *(See para T8.66 of explanatory notes to this Category)* **Fee:** $287.85 **Benefit:** 75% = $215.90

38384	AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for, primary prevention of sudden cardiac death in: - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct when the patient has received optimised medical therapy; or - patients with chronic heart failure associated with mild to moderate symptoms (NYHA II and III) and a left ventricular ejection fraction less than or equal to 35% when the patient has received optimised medical therapy. Not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.) **Fee:** $1,052.65 **Benefit:** 75% = $789.50 85% = $973.15
38387	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of for, primary prevention of sudden cardiac death in: - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct when the patient has received optimised medical therapy; or - patients with chronic heart failure associated with mild to moderate symptoms (NYHA II and III) and a left ventricular ejection fraction less than or equal to 35% when the patient has received optimised medical therapy. Not being a service associated with a service to which item 38213 applies, not for defibrillators capable of cardiac resynchronisation therapy (Anaes.) (Assist.) **Fee:** $287.85 **Benefit:** 75% = $215.90 85% = $244.70
38390	AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.) **Fee:** $1,052.65 **Benefit:** 75% = $789.50 85% = $973.15
38393	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies. (Anaes.) (Assist.) **Fee:** $287.85 **Benefit:** 75% = $215.90 85% = $244.70
	THORACIC SURGERY
38415	EMPYEMA, radical operation for, involving resection of rib (Anaes.) (Assist.) **Fee:** $399.35 **Benefit:** 75% = $299.55 85% = $339.45
38418	THORACOTOMY, exploratory, with or without biopsy (Anaes.) (Assist.) **Fee:** $958.40 **Benefit:** 75% = $718.80
38421	THORACOTOMY, with pulmonary decortication (Anaes.) (Assist.) **Fee:** $1,532.00 **Benefit:** 75% = $1,149.00
38424	THORACOTOMY, with pleurectomy or pleurodesis, OR ENUCLEATION OF HYDATID cysts (Anaes.) (Assist.) **Fee:** $958.40 **Benefit:** 75% = $718.80
38427	THORACOPLASTY (complete) - 3 or more ribs (Anaes.) (Assist.) **Fee:** $1,183.40 **Benefit:** 75% = $887.55
38430	THORACOPLASTY (in stages) each stage (Anaes.) (Assist.) **Fee:** $609.90 **Benefit:** 75% = $457.45
38436	THORACOSCOPY, with or without division of pleural adhesions, including insertion of intercostal catheter where necessary, with or without biopsy (Anaes.) **Fee:** $249.75 **Benefit:** 75% = $187.35
38438	PNEUMONECTOMY or LOBECTOMY or SEGMENTECTOMY not being a service associated with a service to which Item 38418 applies (Anaes.) (Assist.) **Fee:** $1,532.00 **Benefit:** 75% = $1,149.00
38440	LUNG, wedge resection of (Anaes.) (Assist.) **Fee:** $1,147.20 **Benefit:** 75% = $860.40

38441	RADICAL LOBECTOMY or PNEUMONECTOMY including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (Anaes.) (Assist.) **Fee:** $1,815.20 **Benefit:** 75% = $1,361.40
38446	THORACOTOMY or STERNOTOMY, for removal of thymus or mediastinal tumour (Anaes.) (Assist.) **Fee:** $1,183.40 **Benefit:** 75% = $887.55
38447	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $1,532.00 **Benefit:** 75% = $1,149.00
38448	MEDIASTINUM, cervical exploration of, with or without biopsy (Anaes.) (Assist.) **Fee:** $363.05 **Benefit:** 75% = $272.30
38449	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $2,143.20 **Benefit:** 75% = $1,607.40
38450	PERICARDIUM, transthoracic open surgical drainage of (Anaes.) (Assist.) **Fee:** $856.65 **Benefit:** 75% = $642.50
38452	PERICARDIUM, sub-xyphoid drainage of (Anaes.) (Assist.) **Fee:** $573.70 **Benefit:** 75% = $430.30
38453	TRACHEAL excision and repair without cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $1,720.90 **Benefit:** 75% = $1,290.70
38455	TRACHEAL EXCISION AND REPAIR OF, with cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $2,327.70 **Benefit:** 75% = $1,745.80
38456	INTRATHORACIC OPERATION on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than 1 of those organs, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $1,532.00 **Benefit:** 75% = $1,149.00
38457	PECTUS EXCAVATUM or PECTUS CARINATUM, repair or radical correction of (Anaes.) (Assist.) **Fee:** $1,430.25 **Benefit:** 75% = $1,072.70
38458	PECTUS EXCAVATUM, repair of, with implantation of subcutaneous prosthesis (Anaes.) (Assist.) **Fee:** $762.35 **Benefit:** 75% = $571.80
38460	STERNAL WIRE OR WIRES, removal of (Anaes.) **Fee:** $275.40 **Benefit:** 75% = $206.55
38462	STERNOTOMY WOUND, debridement of, not involving reopening of the mediastinum (Anaes.) **Fee:** $326.45 **Benefit:** 75% = $244.85
38464	STERNOTOMY WOUND, debridement of, involving curettage of infected bone with or without removal of wires but not involving reopening of the mediastinum (Anaes.) **Fee:** $354.80 **Benefit:** 75% = $266.10
38466	STERNUM, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (Anaes.) (Assist.) **Fee:** $958.00 **Benefit:** 75% = $718.50
38468	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps or greater omentum (Anaes.) (Assist.) **Fee:** $1,476.15 **Benefit:** 75% = $1,107.15
38469	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps and greater omentum (Anaes.) (Assist.) **Fee:** $1,720.90 **Benefit:** 75% = $1,290.70
	CARDIAC SURGERY PROCEDURES
38470	PERMANENT MYOCARDIAL ELECTRODE, insertion of, by thoracotomy or sternotomy (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $958.40 **Benefit:** 75% = $718.80

38473	PERMANENT PACEMAKER ELECTRODE, insertion by open surgical approach (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $573.70 **Benefit:** 75% = $430.30
	VALVULAR PROCEDURES
38475	VALVE ANNULOPLASTY without insertion of ring, not being a service associated with a service to which item 38480 or 38481 applies (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $831.75 **Benefit:** 75% = $623.85
38477	VALVE ANNULOPLASTY with insertion of ring not being a service to which item 38478 applies (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,003.35 **Benefit:** 75% = $1,502.55
38478	VALVE ANNULOPLASTY with insertion of ring performed in conjunction with item 38480 or 38481 (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $970.40 **Benefit:** 75% = $727.80
38480	VALVE REPAIR, 1 leaflet (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,003.35 **Benefit:** 75% = $1,502.55
38481	VALVE REPAIR, 2 or more leaflets (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,280.65 **Benefit:** 75% = $1,710.50
38483	AORTIC VALVE LEAFLET OR LEAFLETS, decalcification of, not being a service to which item 38475, 38477, 38480, 38481, 38488 or 38489 applies (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,720.90 **Benefit:** 75% = $1,290.70
38485	MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with valve surgery (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $817.10 **Benefit:** 75% = $612.85
38487	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,720.90 **Benefit:** 75% = $1,290.70
38488	VALVE REPLACEMENT with BIOPROSTHESIS OR MECHANICAL PROSTHESIS (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,909.60 **Benefit:** 75% = $1,432.20
38489	VALVE REPLACEMENT with allograft (subcoronary or cylindrical implant), or unstented xenograft (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,271.05 **Benefit:** 75% = $1,703.30
38490	SUB-VALVULAR STRUCTURES, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $554.55 **Benefit:** 75% = $415.95
38493	OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,957.60 **Benefit:** 75% = $1,468.20
	SURGERY FOR ISCHAEMIC HEART DISEASE
38496	ARTERY HARVESTING (other than internal mammary), for coronary artery bypass (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $623.95 **Benefit:** 75% = $468.00

38497	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, not being a service asociated with a service to which items 38498, 38500, 38501, 38503 or 38504 apply (Anaes.) (Assist.) *(See para T8.68 and T8.69 of explanatory notes to this Category)* **Fee:** $2,047.60 **Benefit:** 75% = $1,535.70
38498	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, **performed without cardiopulmonary bypass**, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38500, 38501, 38503, 38504 or 38600 apply (Anaes.) (Assist.) *(See para T8.68 and T8.69 of explanatory notes to this Category)* **Fee:** $2,047.60 **Benefit:** 75% = $1,535.70
38500	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38501, 38503 or 38504 apply (Anaes.) (Assist.) *(See para T8.68 and T8.69 of explanatory notes to this Category)* **Fee:** $2,200.00 **Benefit:** 75% = $1,650.00
38501	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, **performed without cardiopulmonary bypass**, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38498, 38500, 38503, 38504 or 38600 apply (Anaes.) (Assist.) *(See para T8.68 and T8.69 of explanatory notes to this Category)* **Fee:** $2,200.00 **Benefit:** 75% = $1,650.00
38503	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38500, 38501 or 38504 apply (Anaes.) (Assist.) *(See para T8.68 and T8.69 of explanatory notes to this Category)* **Fee:** $2,388.70 **Benefit:** 75% = $1,791.55
38504	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, **performed without cardiopulmonary bypass**, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38498, 38500, 38501, 38503 or 38600 apply (Anaes.) (Assist.) *(See para T8.68 and T8.69 of explanatory notes to this Category)* **Fee:** $2,388.70 **Benefit:** 75% = $1,791.55
38505	CORONARY ENDARTERECTOMY, by open operation, including repair with 1 or more patch grafts, each vessel (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $277.25 **Benefit:** 75% = $207.95
38506	LEFT VENTRICULAR ANEURYSM, plication of (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,626.25 **Benefit:** 75% = $1,219.70
38507	LEFT VENTRICULAR ANEURYSM resection with primary repair (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,909.20 **Benefit:** 75% = $1,431.90
38508	LEFT VENTRICULAR ANEURYSM resection with patch reconstruction of the left ventricle (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,388.70 **Benefit:** 75% = $1,791.55
38509	ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,388.70 **Benefit:** 75% = $1,791.55
	ARRHYTHMIA SURGERY
38512	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,098.45 **Benefit:** 75% = $1,573.85

38515	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,671.95 **Benefit:** 75% = $2,004.00
38518	VENTRICULAR ARRHYTHMIA with mapping and muscle ablation, with or without aneurysmeotomy (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,868.05 **Benefit:** 75% = $2,151.05
	PROCEDURES ON THORACIC AORTA
38550	ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,146.15 **Benefit:** 75% = $1,609.65
38553	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,719.75 **Benefit:** 75% = $2,039.85
38556	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $3,104.70 **Benefit:** 75% = $2,328.55
38559	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,531.00 **Benefit:** 75% = $1,898.25
38562	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $3,104.70 **Benefit:** 75% = $2,328.55
38565	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $3,482.25 **Benefit:** 75% = $2,611.70
38568	DESCENDING THORACIC AORTA, repair or replacement of, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endvascular means (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,862.95 **Benefit:** 75% = $1,397.25
38571	DESCENDING THORACIC AORTA, repair or replacement of, using shunt or cardiopulmonary bypass (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,051.75 **Benefit:** 75% = $1,538.85
38572	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISSECTION, in conjunction with procedures on the thoracic aorta (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,987.05 **Benefit:** 75% = $1,490.30
38577	CANNULATION FOR, and supervision and monitoring of, the administration of retrograde cerebral perfusion during deep hypothermic arrest (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $554.55 **Benefit:** 75% = $415.95
	TECHNIQUES FOR PRESERVATION OF ARRESTED HEART
38588	CANNULATION of the coronary sinus for, and supervision of, the retrograde administration of blood or crystalloid for cardioplegia, including pressure monitoring (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $416.05 **Benefit:** 75% = $312.05

	CIRCULATORY SUPPORT PROCEDURES
38600	CENTRAL CANNULATION for cardiopulmonary bypass excluding post-operative management, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,532.00 **Benefit:** 75% = $1,149.00
38603	PERIPHERAL CANNULATION for cardiopulmonary bypass excluding post-operative management (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $958.40 **Benefit:** 75% = $718.80
38609	INTRA-AORTIC BALLOON PUMP, insertion of, by arteriotomy (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $479.15 **Benefit:** 75% = $359.40
38612	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by direct suture (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $537.10 **Benefit:** 75% = $402.85 85% = $457.60
38613	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by patch graft (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $674.05 **Benefit:** 75% = $505.55
38615	Insertion of a left or right ventricular assist device, for use as: (a) a bridge to cardiac transplantation in patients with refractory heart failure who are: (i) currently on a heart transplant waiting list, or (ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or (b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or (c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks; not being a service associated with the use of a ventricular assist device as destination therapy in the management of patients with heart failure who are not expected to be suitable candidates for cardiac transplantation (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,532.00 **Benefit:** 75% = $1,149.00
38618	Insertion of a left and right ventricular assist device, for use as: (a) a bridge to cardiac transplantation in patients with refractory heart failure who are: (i) currently on a heart transplant waiting list, or (ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or (b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or (c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks; not being a service associated with the use of a ventricular assist device as destination therapy in the management of patients with heart failure who are not expected to be suitable candidates for cardiac transplantation (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,909.60 **Benefit:** 75% = $1,432.20
38621	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $762.35 **Benefit:** 75% = $571.80
38624	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $856.65 **Benefit:** 75% = $642.50
38627	EXTRA-CORPOREAL MEMBRANE OXYGENATION, BYPASS OR VENTRICULAR ASSIST DEVICE CANNULAE, adjustment and re-positioning of, by open operation, in patients supported by these devices (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $669.60 **Benefit:** 75% = $502.20
	RE-OPERATION
38637	PATENT DISEASED coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $554.55 **Benefit:** 75% = $415.95

38640	RE-OPERATION via median sternotomy, for any procedure, including any divisions of adhesions where the time taken to divide the adhesions is 45 minutes or less (Anaes.) (Assist.) *(See para T8.68 and T8.70 of explanatory notes to this Category)* **Fee:** $958.40 **Benefit:** 75% = $718.80
	MISCELLANEOUS CARDIOTHORACIC SURGICAL PROCEDURES
38643	THORACOTOMY OR STERNOTOMY involving division of adhesions where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,067.40 **Benefit:** 75% = $800.55
38647	THORACOTOMY OR STERNOTOMY involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,134.50 **Benefit:** 75% = $1,600.90
38650	MYOMECTOMY or MYOTOMY for hypertrophic obstructive cardiomyopathy (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,909.60 **Benefit:** 75% = $1,432.20
38653	OPEN HEART SURGERY, not being a service to which another item in this Group applies (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,909.60 **Benefit:** 75% = $1,432.20
38654	Permanent left ventricular electrode, insertion, removal or replacement of via open thoracotomy, for the purpose of cardiac resynchronisation therapy, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 150 ms; or (c) satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Anaes.) (Assist.) *(See para T8.64 and T8.68 of explanatory notes to this Category)* **Fee:** $1,224.60 **Benefit:** 75% = $918.45
38656	THORACOTOMY or median sternotomy for post-operative bleeding (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $958.40 **Benefit:** 75% = $718.80
	CARDIAC TUMOURS
38670	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,909.20 **Benefit:** 75% = $1,431.90
38673	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,148.85 **Benefit:** 75% = $1,611.65
38677	CARDIAC TUMOUR arising from ventricular myocardium, partial thickness excision of (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,010.35 **Benefit:** 75% = $1,507.80

38680	CARDIAC TUMOUR arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Anaes.) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $2,384.55 **Benefit:** 75% = $1,788.45 85% = $2,305.05
	CONGENITAL CARDIAC SURGERY
38700	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,067.40 **Benefit:** 75% = $800.55
38703	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,924.10 **Benefit:** 75% = $1,443.10
38706	AORTA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,822.40 **Benefit:** 75% = $1,366.80
38709	AORTA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,134.50 **Benefit:** 75% = $1,600.90
38712	AORTIC INTERRUPTION, repair of, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,563.15 **Benefit:** 75% = $1,922.40
38715	MAIN PULMONARY ARTERY, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,706.30 **Benefit:** 75% = $1,279.75
38718	MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,134.50 **Benefit:** 75% = $1,600.90
38721	VENA CAVA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,495.80 **Benefit:** 75% = $1,121.85
38724	VENA CAVA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,134.50 **Benefit:** 75% = $1,600.90
38727	INTRATHORACIC VESSELS, anastomosis or repair of, without cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,495.80 **Benefit:** 75% = $1,121.85
38730	INTRATHORACIC VESSELS, anastomosis or repair of, with cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.) **Fee:** $2,134.50 **Benefit:** 75% = $1,600.90
38733	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,495.80 **Benefit:** 75% = $1,121.85
38736	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,134.50 **Benefit:** 75% = $1,600.90

38739	ATRIAL SEPTECTOMY, with or without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,924.10 **Benefit:** 75% = $1,443.10
38742	ATRIAL SEPTAL DEFECT, closure by open exposure direct suture or patch, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $1,924.10 **Benefit:** 75% = $1,443.10
38745	INTRA-ATRIAL BAFFLE, insertion of, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,134.50 **Benefit:** 75% = $1,600.90
38748	VENTRICULAR SEPTECTOMY, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,134.50 **Benefit:** 75% = $1,600.90
38751	Ventricular septal defect, closure by direct suture or patch (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,134.50 **Benefit:** 75% = $1,600.90
38754	INTRAVENTRICULAR BAFFLE OR CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,671.95 **Benefit:** 75% = $2,004.00
38757	EXTRACARDIAC CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,134.50 **Benefit:** 75% = $1,600.90
38760	EXTRACARDIAC CONDUIT, replacement of, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,134.50 **Benefit:** 75% = $1,600.90
38763	VENTRICULAR MYECTOMY, for relief of ventricular obstruction, right or left, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,134.50 **Benefit:** 75% = $1,600.90
38766	VENTRICULAR AUGMENTATION, right or left, for congenital heart disease (Anaes.) (Assist.) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $2,134.50 **Benefit:** 75% = $1,600.90
	MISCELLANEOUS PROCEDURES ON THE CHEST
38800	THORACIC CAVITY, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38803 applies **Fee:** $38.50 **Benefit:** 75% = $28.90 85% = $32.75
38803	THORACIC CAVITY, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample **Fee:** $76.90 **Benefit:** 75% = $57.70 85% = $65.40
38806	INTERCOSTAL DRAIN, insertion of, not involving resection of rib (excluding aftercare) (Anaes.) **Fee:** $133.55 **Benefit:** 75% = $100.20 85% = $113.55
38809	INTERCOSTAL DRAIN, insertion of, with pleurodesis and not involving resection of rib (excluding aftercare) (Anaes.) **Fee:** $164.55 **Benefit:** 75% = $123.45 85% = $139.90
38812	PERCUTANEOUS NEEDLE BIOPSY of lung (Anaes.) **Fee:** $209.15 **Benefit:** 75% = $156.90 85% = $177.80
	SUBGROUP 7 - NEUROSURGICAL
	GENERAL
39000	LUMBAR PUNCTURE (Anaes.) **Fee:** $75.30 **Benefit:** 75% = $56.50 85% = $64.05
39003	CISTERNAL PUNCTURE (Anaes.) **Fee:** $85.65 **Benefit:** 75% = $64.25 85% = $72.85

39006	VENTRICULAR PUNCTURE (not including burr-hole) (Anaes.) **Fee:** $159.40 **Benefit:** 75% = $119.55 85% = $135.50
39009	SUBDURAL HAEMORRHAGE, tap for, each tap (Anaes.) **Fee:** $59.35 **Benefit:** 75% = $44.55
39012	BURR-HOLE, single, preparatory to ventricular puncture or for inspection purpose - not being a service to which another item applies (Anaes.) **Fee:** $237.60 **Benefit:** 75% = $178.20
39013	INJECTION UNDER IMAGE INTENSIFICATION with 1 or more of contrast media, local anaesthetic or corticosteroid into 1 or more zygo-apophyseal or costo-transverse joints or 1 or more primary posterior rami of spinal nerves (Anaes.) **Fee:** $109.15 **Benefit:** 75% = $81.90 85% = $92.80
39015	VENTRICULAR RESERVOIR, EXTERNAL VENTRICULAR DRAIN or INTRACRANIAL PRESSURE MONITORING DEVICE, insertion of - including burr-hole (excluding after-care) (Anaes.) (Assist.) **Fee:** $376.00 **Benefit:** 75% = $282.00
39018	CEREBROSPINAL FLUID reservoir, insertion of (Anaes.) (Assist.) **Fee:** $376.00 **Benefit:** 75% = $282.00
	PAIN RELIEF
39100	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.) **Fee:** $237.60 **Benefit:** 75% = $178.20 85% = $202.00
39106	NEURECTOMY, INTRACRANIAL, for trigeminal neuralgia (Anaes.) (Assist.) **Fee:** $1,188.20 **Benefit:** 75% = $891.15
39109	TRIGEMINAL GANGLIOTOMY by radiofrequency, balloon or glycerol (Anaes.) **Fee:** $443.70 **Benefit:** 75% = $332.80 85% = $377.15
39112	CRANIAL NERVE, intracranial decompression of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,541.50 **Benefit:** 75% = $1,156.15
39115	PERCUTANEOUS NEUROTOMY of posterior divisions (or rami) of spinal nerves by any method, including any associated spinal, epidural or regional nerve block (payable once only in a 30 day period) (Anaes.) **Fee:** $75.30 **Benefit:** 75% = $56.50 85% = $64.05
39118	PERCUTANEOUS NEUROTOMY for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.) (Assist.) **Fee:** $297.85 **Benefit:** 75% = $223.40 85% = $253.20
39121	PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.) **Fee:** $631.75 **Benefit:** 75% = $473.85 85% = $552.25
39124	CORDOTOMY OR MYELOTOMY, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.) **Fee:** $1,616.80 **Benefit:** 75% = $1,212.60
39125	Intrathecal or epidural SPINAL CATHETER insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $298.05 **Benefit:** 75% = $223.55
39126	INFUSION PUMP, subcutaneous implantation or replacement of, and connection of the pump to an intrathecal or epidural catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $361.90 **Benefit:** 75% = $271.45
39127	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of chronic intractable pain (Anaes.) **Fee:** $473.65 **Benefit:** 75% = $355.25
39128	INFUSION PUMP, subcutaneous implantation of, AND intrathecal or epidural SPINAL CATHETER insertion of, and connection of pump to catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $659.95 **Benefit:** 75% = $495.00

39130	EPIDURAL LEAD, percutaneous placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.) **Fee:** $674.15 **Benefit:** 75% = $505.65
39131	ELECTRODES, epidural or peripheral nerve, management of patient and adjustment or reprogramming of neurostimulator by a medical practitioner, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris - each day **Fee:** $127.80 **Benefit:** 75% = $95.85 85% = $108.65
39133	Removal of subcutaneously IMPLANTED INFUSION PUMP OR removal or repositioning of intrathecal or epidural SPINAL CATHETER, for the management of chronic intractable pain (Anaes.) **Fee:** $159.40 **Benefit:** 75% = $119.55
39134	NEUROSTIMULATOR or RECEIVER, subcutaneous placement of, including placement and connection of extension wires to epidural or peripheral nerve electrodes, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris (Anaes.) (Assist.) **Fee:** $340.60 **Benefit:** 75% = $255.45
39135	NEUROSTIMULATOR or RECEIVER, that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.) **Fee:** $159.40 **Benefit:** 75% = $119.55 85% = $135.50
39136	LEAD, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.) **Fee:** $159.40 **Benefit:** 75% = $119.55
39137	LEAD, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, surgical repositioning to correct displacement or unsatisfactory positioning, including intraoperative test stimulation, not being a service to which item 39130, 39138 or 39139 applies (Anaes.) **Fee:** $605.35 **Benefit:** 75% = $454.05
39138	PERIPHERAL NERVE LEAD, surgical placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.) (Assist.) **Fee:** $674.15 **Benefit:** 75% = $505.65
39139	EPIDURAL LEAD, surgical placement of one or more by partial or total laminectomy, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris (Anaes.) (Assist.) **Fee:** $905.10 **Benefit:** 75% = $678.85
39140	EPIDURAL CATHETER, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.) **Fee:** $292.85 **Benefit:** 75% = $219.65 85% = $248.95
	PERIPHERAL NERVES
39300	CUTANEOUS NERVE (including digital nerve), primary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $353.35 **Benefit:** 75% = $265.05
39303	CUTANEOUS NERVE (including digital nerve), secondary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $466.10 **Benefit:** 75% = $349.60
39306	NERVE TRUNK, primary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $676.80 **Benefit:** 75% = $507.60
39309	NERVE TRUNK, secondary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $714.35 **Benefit:** 75% = $535.80
39312	NERVE TRUNK, (interfascicular), neurolysis of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $398.55 **Benefit:** 75% = $298.95
39315	NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,030.20 **Benefit:** 75% = $772.65
39318	CUTANEOUS NERVE (including digital nerve), nerve graft to, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $639.20 **Benefit:** 75% = $479.40

39321	NERVE, transposition of (Anaes.) (Assist.) **Fee:** $473.65 **Benefit:** 75% = $355.25
39323	PERCUTANEOUS NEUROTOMY by cryotherapy or radiofrequency lesion generator, not being a service to which another item applies (Anaes.) (Assist.) **Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30
39324	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation (Anaes.) (Assist.) **Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30
39327	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral or cranial nerve, by open operation, not being a service to which item 41575, 41576, 41578 or 41579 applies (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35
39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item 39312 applies (Anaes.) (Assist.) **Fee:** $276.80 **Benefit:** 75% = $207.60
39331	CARPAL TUNNEL RELEASE (division of transverse carpal ligament), by any method (Anaes.) **Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30
39333	BRACHIAL PLEXUS, exploration of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $398.55 **Benefit:** 75% = $298.95 85% = $338.80
	CRANIAL NERVES
39500	VESTIBULAR NERVE, section of, via posterior fossa (Anaes.) (Assist.) **Fee:** $1,270.90 **Benefit:** 75% = $953.20
39503	FACIO-HYPOGLOSSAL nerve or FACIO-ACCESSORY nerve, anastomosis of (Anaes.) (Assist.) **Fee:** $955.00 **Benefit:** 75% = $716.25
	CRANIO-CEREBRAL INJURIES
39600	INTRACRANIAL HAEMORRHAGE, burr-hole craniotomy for - including burr-holes (Anaes.) (Assist.) **Fee:** $473.65 **Benefit:** 75% = $355.25
39603	INTRACRANIAL HAEMORRHAGE, osteoplastic craniotomy or extensive craniectomy and removal of haematoma (Anaes.) (Assist.) **Fee:** $1,195.70 **Benefit:** 75% = $896.80
39606	FRACTURED SKULL, depressed or comminuted, operation for (Anaes.) (Assist.) **Fee:** $797.10 **Benefit:** 75% = $597.85
39609	FRACTURED SKULL, compound, without dural penetration, operation for (Anaes.) (Assist.) **Fee:** $955.00 **Benefit:** 75% = $716.25
39612	FRACTURED SKULL, compound, depressed or complicated, with dural penetration and brain laceration, operation for (Anaes.) (Assist.) **Fee:** $1,120.45 **Benefit:** 75% = $840.35
39615	FRACTURED SKULL with rhinorrhoea or otorrhoea, repair of by cranioplasty or endoscopic approach (Anaes.) (Assist.) **Fee:** $1,195.70 **Benefit:** 75% = $896.80
	SKULL BASE SURGERY
39640	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving craniotomy, radical excision of the skull base, and dural repair (Anaes.) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $3,031.65 **Benefit:** 75% = $2,273.75
39642	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy for clearance of paranasal sinus extension (intracranial procedure) (Anaes.) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $3,187.25 **Benefit:** 75% = $2,390.45

39646	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy and radical clearance of paranasal sinus and orbital fossa extensions, with intracranial decompression of the optic nerve, (intracranial procedure) (Anaes.) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $3,653.60 **Benefit:** 75% = $2,740.20
39650	TUMOUR INVOLVING MIDDLE CRANIAL FOSSA AND INFRA-TEMPORAL FOSSA, removal of, craniotomy and radical or sub-total radical excision, with division and reconstruction of zygomatic arch, (intracranial procedure) (Anaes.) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $2,642.95 **Benefit:** 75% = $1,982.25
39653	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision (intracranial procedure), not being a service to which item 39654 or 39656 applies (Anaes.) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $4,703.15 **Benefit:** 75% = $3,527.40
39654	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure), conjoint surgery, principal surgeon (Anaes.) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $3,420.50 **Benefit:** 75% = $2,565.40
39656	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure) conjoint surgery, co-surgeon (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $2,565.30 **Benefit:** 75% = $1,924.00
39658	TUMOUR INVOLVING THE CLIVUS, radical or sub-total radical excision of, involving transoral or transmaxillary approach (Anaes.) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $3,031.65 **Benefit:** 75% = $2,273.75
39660	TUMOUR OR VASCULAR LESION OF CAVERNOUS SINUS, radical excision of, involving craniotomy with or without intracranial carotid artery exposure (Anaes.) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $3,031.65 **Benefit:** 75% = $2,273.75
39662	TUMOUR OR VASCULAR LESION OF FORAMEN MAGNUM, radical excision of, via transcondylar or far lateral suboccipital approach (Anaes.) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $3,031.65 **Benefit:** 75% = $2,273.75
	INTRA-CRANIAL NEOPLASMS
39700	SKULL TUMOUR, benign or malignant, excision of, excluding cranioplasty (Anaes.) (Assist.) **Fee:** $556.60 **Benefit:** 75% = $417.45
39703	INTRACRANIAL tumour, cyst or other brain tissue, burr-hole and biopsy of, or drainage of, or both (Anaes.) (Assist.) **Fee:** $519.00 **Benefit:** 75% = $389.25
39706	INTRACRANIAL tumour, biopsy or decompression of via osteoplastic flap OR biopsy and decompression of via osteoplastic flap (Anaes.) (Assist.) **Fee:** $1,112.85 **Benefit:** 75% = $834.65
39709	CRANIOTOMY for removal of glioma, metastatic carcinoma or any other tumour in cerebrum, cerebellum or brain stem - not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,586.75 **Benefit:** 75% = $1,190.10
39712	CRANIOTOMY FOR REMOVAL OF MENINGIOMA, pinealoma, cranio-pharyngioma, intraventricular tumour or any other intracranial tumour, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $2,865.00 **Benefit:** 75% = $2,148.75
39715	PITUITARY TUMOUR, removal of, by transcranial or transphenoidal approach (Anaes.) (Assist.) **Fee:** $1,985.30 **Benefit:** 75% = $1,489.00
39718	ARACHNOIDAL CYST, craniotomy for (Anaes.) (Assist.) **Fee:** $872.30 **Benefit:** 75% = $654.25

39721	CRANIOTOMY, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling, etc (Anaes.) (Assist.) **Fee:** $797.10 **Benefit:** 75% = $597.85
	CEREBROVASCULAR DISEASE
39800	ANEURYSM, clipping or reinforcement of sac (Anaes.) (Assist.) **Fee:** $2,857.55 **Benefit:** 75% = $2,143.20
39803	INTRACRANIAL ARTERIOVENOUS MALFORMATION, excision of (Anaes.) (Assist.) **Fee:** $2,857.55 **Benefit:** 75% = $2,143.20
39806	ANEURYSM, or arteriovenous malformation, intracranial proximal artery clipping of (Anaes.) (Assist.) **Fee:** $1,285.75 **Benefit:** 75% = $964.35
39812	INTRACRANIAL ANEURYSM or arteriovenous fistula, ligation of cervical vessel or vessels (Anaes.) (Assist.) **Fee:** $631.75 **Benefit:** 75% = $473.85
39815	CAROTID-CAVERNOUS FISTULA, obliteration of - combined cervical and intracranial procedure (Anaes.) (Assist.) **Fee:** $1,827.25 **Benefit:** 75% = $1,370.45 85% = $1,747.75
39818	EXTRACRANIAL TO INTRACRANIAL BYPASS using superficial temporal artery (Anaes.) (Assist.) **Fee:** $1,827.25 **Benefit:** 75% = $1,370.45
39821	EXTRACRANIAL TO INTRACRANIAL BYPASS using saphenous vein graft (Anaes.) (Assist.) **Fee:** $2,169.75 **Benefit:** 75% = $1,627.35
	INFECTION
39900	INTRACRANIAL INFECTION, drainage of, via burr-hole - including burr-hole (Anaes.) (Assist.) **Fee:** $519.00 **Benefit:** 75% = $389.25
39903	INTRACRANIAL ABSCESS, excision of (Anaes.) (Assist.) **Fee:** $1,586.75 **Benefit:** 75% = $1,190.10
39906	OSTEOMYELITIS OF SKULL or removal of infected bone flap, craniectomy for (Anaes.) (Assist.) **Fee:** $797.10 **Benefit:** 75% = $597.85
	CEREBROSPINAL FLUID CIRCULATION DISORDERS
40000	VENTRICULO-CISTERNOSTOMY (Torkildsen's operation) (Anaes.) (Assist.) **Fee:** $917.40 **Benefit:** 75% = $688.05
40003	CRANIAL OR CISTERNAL SHUNT DIVERSION, insertion of (Anaes.) (Assist.) **Fee:** $917.40 **Benefit:** 75% = $688.05
40006	LUMBAR SHUNT DIVERSION, insertion of (Anaes.) (Assist.) **Fee:** $721.95 **Benefit:** 75% = $541.50
40009	CRANIAL, CISTERNAL OR LUMBAR SHUNT, revision or removal of (Anaes.) (Assist.) **Fee:** $526.40 **Benefit:** 75% = $394.80
40012	THIRD VENTRICULOSTOMY (open or endoscopic) with or without endoscopic septum pellucidotomy (Anaes.) (Assist.) **Fee:** $1,030.20 **Benefit:** 75% = $772.65
40015	SUBTEMPORAL DECOMPRESSION (Anaes.) (Assist.) **Fee:** $638.65 **Benefit:** 75% = $479.00
40018	LUMBAR CEREBROSPINAL FLUID DRAIN, insertion of (Anaes.) **Fee:** $159.40 **Benefit:** 75% = $119.55 85% = $135.50
	CONGENITAL DISORDERS
40100	MENINGOCELE, excision and closure of (Anaes.) (Assist.) **Fee:** $691.75 **Benefit:** 75% = $518.85
40103	MYELOMENINGOCELE, excision and closure of, including skin flaps or Z plasty where performed (Anaes.) (Assist.) **Fee:** $1,015.25 **Benefit:** 75% = $761.45

40106	ARNOLD-CHIARI MALFORMATION, decompression of (Anaes.) (Assist.) **Fee:** $1,030.20 **Benefit:** 75% = $772.65
40109	ENCEPHALOCOELE, excision and closure of (Anaes.) (Assist.) **Fee:** $1,112.85 **Benefit:** 75% = $834.65
40112	TETHERED CORD, release of, including lipomeningocele or diastematomyelia (Anaes.) (Assist.) **Fee:** $1,428.75 **Benefit:** 75% = $1,071.60
40115	CRANIOSTENOSIS, operation for - single suture (Anaes.) (Assist.) **Fee:** $721.95 **Benefit:** 75% = $541.50
40118	CRANIOSTENOSIS, operation for - more than 1 suture (Anaes.) (Assist.) **Fee:** $955.00 **Benefit:** 75% = $716.25
	SPINAL DISORDERS
40300	INTERVERTEBRAL DISC OR DISCS, partial or total laminectomy for removal of (Anaes.) (Assist.) **Fee:** $955.00 **Benefit:** 75% = $716.25
40301	INTERVERTEBRAL DISC OR DISCS, microsurgical partial or total discectomy of (Anaes.) (Assist.) **Fee:** $958.00 **Benefit:** 75% = $718.50
40303	RECURRENT DISC LESION OR SPINAL STENOSIS, or both, partial or total laminectomy for - 1 level (Anaes.) (Assist.) **Fee:** $1,090.35 **Benefit:** 75% = $817.80
40306	SPINAL STENOSIS, partial or total laminectomy for, involving more than 1 vertebral interspace (disc level) (Anaes.) (Assist.) **Fee:** $1,436.30 **Benefit:** 75% = $1,077.25
40309	EEXTRADURAL TUMOUR OR ABSCESS, partial or total laminectomy for (Anaes.) (Assist.) **Fee:** $1,090.35 **Benefit:** 75% = $817.80
40312	INTRADURAL LESION, partial or total laminectomy for, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $1,466.30 **Benefit:** 75% = $1,099.75
40315	CRANIOCERVICAL JUNCTION LESION, transoral approach for (Anaes.) (Assist.) **Fee:** $1,586.75 **Benefit:** 75% = $1,190.10
40316	ODONTOID screw fixation (Anaes.) (Assist.) **Fee:** $2,079.75 **Benefit:** 75% = $1,559.85
40318	INTRAMEDULLARY TUMOUR OR ARTERIOVENOUS MALFORMATION, partial or total laminectomy and radical excision of (Anaes.) (Assist.) **Fee:** $1,985.30 **Benefit:** 75% = $1,489.00
40321	POSTERIOR SPINAL FUSION, not being a service to which items 40324 and 40327 apply (Anaes.) (Assist.) **Fee:** $1,090.35 **Benefit:** 75% = $817.80
40324	PARTIAL OR TOTAL LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together – laminectomy, including aftercare (Anaes.) (Assist.) **Fee:** $639.20 **Benefit:** 75% = $479.40
40327	PARTIAL OR TOTAL LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together – posterior fusion, including aftercare (Assist.) **Fee:** $639.20 **Benefit:** 75% = $479.40
40330	SPINAL RHIZOLYSIS involving exposure of spinal nerve roots – for lateral recess, exit foraminal stenosis, adhesive radiculopathy or extensive epidural fibrosis, at 1 or more levels – with or without partial or total laminectomy (Anaes.) (Assist.) **Fee:** $955.00 **Benefit:** 75% = $716.25
40331	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, without fusion, 1 level, by any approach, not being a service to which item 40330 applies (Anaes.) (Assist.) **Fee:** $955.00 **Benefit:** 75% = $716.25

40332	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, including anterior fusion, 1 level, not being a service to which item 40330 applies (Anaes.) (Assist.) **Fee:** $1,558.30 **Benefit:** 75% = $1,168.75
40333	CERVICAL PARTIAL OR TOTAL DISCECTOMY (ANTERIOR), without fusion (Anaes.) (Assist.) **Fee:** $797.10 **Benefit:** 75% = $597.85
40334	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, without fusion, more than 1 level, by any approach, not being a service to which item 40330 applies (Anaes.) (Assist.) **Fee:** $1,053.90 **Benefit:** 75% = $790.45
40335	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, including anterior fusion, more than 1 level, by any approach, not being a service to which item 40330 applies (Anaes.) (Assist.) **Fee:** $1,935.60 **Benefit:** 75% = $1,451.70
40336	INTRADISCAL INJECTION OF CHYMOPAPAIN (DISCASE) - 1 disc (Anaes.) (Assist.) *(See para T8.72 of explanatory notes to this Category)* **Fee:** $315.90 **Benefit:** 75% = $236.95
40339	HYDROMYELIA, plugging of obex for, with or without duroplasty (Anaes.) (Assist.) **Fee:** $1,586.75 **Benefit:** 75% = $1,190.10
40342	HYDROMYELIA, craniotomy and partial or total laminectomy for, with cavity packing and CSF shunt (Anaes.) (Assist.) **Fee:** $1,466.30 **Benefit:** 75% = $1,099.75
40345	THORACIC DECOMPRESSION of spinal cord with or without involvement of nerve roots, via pedicle or costotransversectomy (Anaes.) (Assist.) **Fee:** $1,365.00 **Benefit:** 75% = $1,023.75
40348	THORACIC DECOMPRESSION of spinal cord via thoracotomy with vertebrectomy, not including stabilisation procedure (Anaes.) (Assist.) **Fee:** $1,733.10 **Benefit:** 75% = $1,299.85
40351	THORACO-LUMBAR or high lumbar anterior decompression of spinal cord, not including stabilisation procedure (Anaes.) (Assist.) **Fee:** $1,733.10 **Benefit:** 75% = $1,299.85
	SKULL RECONSTRUCTION
40600	CRANIOPLASTY, reconstructive (Anaes.) (Assist.) **Fee:** $955.00 **Benefit:** 75% = $716.25
	EPILEPSY
40700	CORPUS CALLOSUM, anterior section of, for epilepsy (Anaes.) (Assist.) **Fee:** $1,744.65 **Benefit:** 75% = $1,308.50
40703	CORTICECTOMY, TOPECTOMY or PARTIAL LOBECTOMY for epilepsy (Anaes.) (Assist.) **Fee:** $1,466.30 **Benefit:** 75% = $1,099.75
40706	HEMISPHERECTOMY for intractable epilepsy (Anaes.) (Assist.) **Fee:** $2,143.10 **Benefit:** 75% = $1,607.35 85% = $2,063.60
40709	BURR-HOLE PLACEMENT of intracranial depth or surface electrodes (Anaes.) (Assist.) **Fee:** $519.00 **Benefit:** 75% = $389.25
40712	INTRACRANIAL ELECTRODE PLACEMENT via craniotomy (Anaes.) (Assist.) **Fee:** $1,045.20 **Benefit:** 75% = $783.90
	STEREOTACTIC PROCEDURES
40800	STEREOTACTIC ANATOMICAL LOCALISATION, as an independent procedure (Anaes.) (Assist.) **Fee:** $638.65 **Benefit:** 75% = $479.00 85% = $559.15

40801	FUNCTIONAL STEREOTACTIC procedure including computer assisted anatomical localisation, physiological localisation, and lesion production in the basal ganglia, brain stem or deep white matter tracts, not being a service associated with deep brain stimulation for Parkinson's disease, essential tremor or dystonia (Anaes.) (Assist.) **Fee:** $1,745.80 **Benefit:** 75% = $1,309.35
40803	INTRACRANIAL STEREOTACTIC PROCEDURE BY ANY METHOD, not being a service to which item 40800 or 40801 applies (Anaes.) (Assist.) **Fee:** $1,195.70 **Benefit:** 75% = $896.80 85% = $1,116.20
40850	DEEP BRAIN STIMULATION (unilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability (Anaes.) (Assist.) **Fee:** $2,264.45 **Benefit:** 75% = $1,698.35
40851	DEEP BRAIN STIMULATION (bilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) (Assist.) **Fee:** $3,963.00 **Benefit:** 75% = $2,972.25
40852	DEEP BRAIN STIMULATION (unilateral) subcutaneous placement of neurostimulator receiver or pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) (Assist.) **Fee:** $340.60 **Benefit:** 75% = $255.45
40854	DEEP BRAIN STIMULATION (unilateral) revision or removal of brain electrode for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $526.40 **Benefit:** 75% = $394.80
40856	DEEP BRAIN STIMULATION (unilateral) removal or replacement of neurostimulator receiver or pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $255.45 **Benefit:** 75% = $191.60
40858	DEEP BRAIN STIMULATION (unilateral) placement, removal or replacement of extension lead for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $526.40 **Benefit:** 75% = $394.80
40860	DEEP BRAIN STIMULATION (unilateral) target localisation incorporating anatomical and physiological techniques, including intra-operative clinical evaluation, for the insertion of a single neurostimulation wire for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $2,022.70 **Benefit:** 75% = $1,517.05

40862	DEEP BRAIN STIMULATION (unilateral) electronic analysis and programming of neurostimulator pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $189.70 **Benefit:** 75% = $142.30 85% = $161.25
	MISCELLANEOUS
40903	NEUROENDOSCOPY, for inspection of an intraventricular lesion, with or without biopsy including burr hole (Anaes.) (Assist.) **Fee:** $554.55 **Benefit:** 75% = $415.95
40905	CRANIOTOMY, performed in association with items 45767, 45776, 45782 and 45785 for the correction of craniofacial abnormalities (Anaes.) **Fee:** $601.70 **Benefit:** 75% = $451.30 85% = $522.20
	SUBGROUP 8 - EAR, NOSE AND THROAT
41500	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.) *(See para T8.73 of explanatory notes to this Category)* **Fee:** $82.50 **Benefit:** 75% = $61.90 85% = $70.15
41503	EAR, foreign body in, removal of, involving incision of external auditory canal (Anaes.) **Fee:** $238.80 **Benefit:** 75% = $179.10 85% = $203.00
41506	AURAL POLYP, removal of (Anaes.) **Fee:** $144.00 **Benefit:** 75% = $108.00 85% = $122.40
41509	EXTERNAL AUDITORY MEATUS, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (Anaes.) **Fee:** $162.95 **Benefit:** 75% = $122.25 85% = $138.55
41512	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes.) (Assist.) **Fee:** $585.90 **Benefit:** 75% = $439.45
41515	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, being a service associated with a service to which item 41530, 41548, 41557, 41560 or 41563 applies (Anaes.) (Assist.) *(See para T8.74 of explanatory notes to this Category)* **Fee:** $384.55 **Benefit:** 75% = $288.45
41518	EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.) **Fee:** $928.75 **Benefit:** 75% = $696.60
41521	Correction of AUDITORY CANAL STENOSIS, including meatoplasty, with or without grafting (Anaes.) (Assist.) **Fee:** $988.85 **Benefit:** 75% = $741.65
41524	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL, being a service associated with a service to which items 41557, 41560 and 41563 apply (Anaes.) (Assist.) *(See para T8.75 of explanatory notes to this Category)* **Fee:** $285.70 **Benefit:** 75% = $214.30
41527	MYRINGOPLASTY, transcanal approach (Rosen incision) (Anaes.) (Assist.) **Fee:** $587.60 **Benefit:** 75% = $440.70
41530	MYRINGOPLASTY, postaural or endaural approach with or without mastoid inspection (Anaes.) **Fee:** $957.30 **Benefit:** 75% = $718.00
41533	ATTICOTOMY without reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.) **Fee:** $1,144.30 **Benefit:** 75% = $858.25
41536	ATTICOTOMY with reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.) **Fee:** $1,281.70 **Benefit:** 75% = $961.30
41539	OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.) **Fee:** $1,089.90 **Benefit:** 75% = $817.45

41542	OSSICULAR CHAIN RECONSTRUCTION AND MYRINGOPLASTY (Anaes.) (Assist.) **Fee:** $1,194.25 **Benefit:** 75% = $895.70
41545	MASTOIDECTOMY (CORTICAL) (Anaes.) (Assist.) **Fee:** $521.25 **Benefit:** 75% = $390.95
41548	OBLITERATION OF THE MASTOID CAVITY (Anaes.) (Assist.) **Fee:** $691.75 **Benefit:** 75% = $518.85
41551	MASTOIDECTOMY, intact wall technique, with myringoplasty (Anaes.) (Assist.) **Fee:** $1,593.05 **Benefit:** 75% = $1,194.80
41554	MASTOIDECTOMY, intact wall technique, with myringoplasty and ossicular chain reconstruction (Anaes.) (Assist.) **Fee:** $1,876.95 **Benefit:** 75% = $1,407.75
41557	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) (Anaes.) (Assist.) **Fee:** $1,089.90 **Benefit:** 75% = $817.45
41560	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) AND MYRINGOPLASTY (Anaes.) **Fee:** $1,194.25 **Benefit:** 75% = $895.70
41563	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), MYRINGOPLASTY AND OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.) **Fee:** $1,478.40 **Benefit:** 75% = $1,108.80
41564	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), OBLITERATION OF THE MASTOID CAVITY, BLIND SAC CLOSURE OF EXTERNAL AUDITORY CANAL AND OBLITERATION OF EUSTACHIAN TUBE (Anaes.) (Assist.) **Fee:** $1,911.80 **Benefit:** 75% = $1,433.85
41566	REVISION OF MASTOIDECTOMY (radical, modified radical or intact wall), including myringoplasty (Anaes.) (Assist.) **Fee:** $1,089.90 **Benefit:** 75% = $817.45
41569	DECOMPRESSION OF FACIAL NERVE in its mastoid portion (Anaes.) (Assist.) **Fee:** $1,194.25 **Benefit:** 75% = $895.70
41572	LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (Anaes.) (Assist.) **Fee:** $1,033.20 **Benefit:** 75% = $774.90
41575	CEREBELLO PONTINE ANGLE TUMOUR, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach transmastoid, translabyrinthine or retromastoid procedure (including aftercare) (Anaes.) (Assist.) **Fee:** $2,435.70 **Benefit:** 75% = $1,826.80
41576	CEREBELLO - PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach - intracranial procedure (including aftercare) not being a service to which item 41578 or 41579 applies (Anaes.) (Assist.) **Fee:** $3,653.60 **Benefit:** 75% = $2,740.20
41578	CEREBELLO PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $2,435.70 **Benefit:** 75% = $1,826.80
41579	CEREBELLO-PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,826.75 **Benefit:** 75% = $1,370.10
41581	TUMOUR INVOLVING INFRA-TEMPORAL FOSSA, removal of, involving craniotomy and radical excision of (Anaes.) (Assist.) **Fee:** $2,801.55 **Benefit:** 75% = $2,101.20
41584	PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes.) (Assist.) **Fee:** $1,922.65 **Benefit:** 75% = $1,442.00
41587	TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes.) (Assist.) **Fee:** $2,618.60 **Benefit:** 75% = $1,963.95
41590	ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (Anaes.) (Assist.) **Fee:** $1,194.25 **Benefit:** 75% = $895.70

41593	TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (Anaes.) (Assist.) **Fee:** $1,556.50 **Benefit:** 75% = $1,167.40
41596	RETROLABYRINTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTION, or BOTH (Anaes.) (Assist.) **Fee:** $1,739.50 **Benefit:** 75% = $1,304.65
41599	INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes.) (Assist.) **Fee:** $1,739.50 **Benefit:** 75% = $1,304.65
41603	OSSEO-INTEGRATION PROCEDURE – implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients: - With a permanent or long term hearing loss; and - Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and - With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted. Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.) **Fee:** $503.85 **Benefit:** 75% = $377.90 85% = $428.30
41604	OSSEO-INTEGRATION PROCEDURE – fixation of transcutaneous abutment implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients: - With a permanent or long term hearing loss; and - Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and - With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted. Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.) **Fee:** $186.50 **Benefit:** 75% = $139.90 85% = $158.55
41608	STAPEDECTOMY (Anaes.) (Assist.) **Fee:** $1,089.90 **Benefit:** 75% = $817.45
41611	STAPES MOBILISATION (Anaes.) (Assist.) **Fee:** $701.30 **Benefit:** 75% = $526.00
41614	ROUND WINDOW SURGERY including repair of cochleotomy (Anaes.) (Assist.) **Fee:** $1,089.90 **Benefit:** 75% = $817.45 85% = $1,010.40
41615	OVAL WINDOW SURGERY, including repair of fistula, not being a service associated with a service to which any other item in this Group applies (Anaes.) (Assist.) **Fee:** $1,089.90 **Benefit:** 75% = $817.45 85% = $1,010.40
41617	COCHLEAR IMPLANT, insertion of, including mastoidectomy (Anaes.) (Assist.) **Fee:** $1,895.20 **Benefit:** 75% = $1,421.40
41620	GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.) **Fee:** $824.55 **Benefit:** 75% = $618.45
41623	GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.) **Fee:** $1,194.25 **Benefit:** 75% = $895.70
41626	ABSCESS OR INFLAMMATION OF MIDDLE EAR, operation for (excluding aftercare) (Anaes.) **Fee:** $144.00 **Benefit:** 75% = $108.00 85% = $122.40
41629	MIDDLE EAR, EXPLORATION OF (Anaes.) (Assist.) **Fee:** $521.25 **Benefit:** 75% = $390.95
41632	MIDDLE EAR, insertion of tube for DRAINAGE OF (including myringotomy) (Anaes.) **Fee:** $238.80 **Benefit:** 75% = $179.10 85% = $203.00
41635	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty (Anaes.) (Assist.) **Fee:** $1,144.30 **Benefit:** 75% = $858.25 85% = $1,064.80
41638	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty with ossicular chain reconstruction (Anaes.) (Assist.) **Fee:** $1,428.35 **Benefit:** 75% = $1,071.30

41641	PERFORATION OF TYMPANUM, cauterisation or diathermy of (Anaes.) **Fee:** $47.45 **Benefit:** 75% = $35.60 85% = $40.35
41644	EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (Anaes.) **Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40
41647	EAR TOILET requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (Anaes.) **Fee:** $109.90 **Benefit:** 75% = $82.45 85% = $93.45
41650	TYMPANIC MEMBRANE, microinspection of 1 or both ears under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $109.90 **Benefit:** 75% = $82.45 85% = $93.45
41653	EXAMINATION OF NASAL CAVITY or POSTNASAL SPACE, or NASAL CAVITY AND POSTNASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $71.95 **Benefit:** 75% = $54.00 85% = $61.20
41656	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) **Fee:** $122.85 **Benefit:** 75% = $92.15 85% = $104.45
41659	NOSE, removal of FOREIGN BODY IN, other than by simple probing (Anaes.) **Fee:** $77.55 **Benefit:** 75% = $58.20 85% = $65.95
41662	NASAL POLYP OR POLYPI (SIMPLE), removal of *(See para T8.76 of explanatory notes to this Category)* **Fee:** $82.50 **Benefit:** 75% = $61.90 85% = $70.15
41665 G 41668 S	NASAL POLYP OR POLYPI (requiring admission to hospital), removal of (Anaes.) *(See para T8.76 of explanatory notes to this Category)* **Fee:** $172.50 **Benefit:** 75% = $129.40 **Fee:** $219.95 **Benefit:** 75% = $165.00
41671	NASAL SEPTUM, SEPTOPLASTY, SUBMUCOUS RESECTION or closure of septal perforation (Anaes.) **Fee:** $483.25 **Benefit:** 75% = $362.45
41672	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.) **Fee:** $602.85 **Benefit:** 75% = $452.15
41674	CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES OR PHARYNX - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
41677	NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50
41680	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes.) **Fee:** $162.95 **Benefit:** 75% = $122.25 85% = $138.55
41683	DIVISION OF NASAL ADHESIONS, with or without stenting not being a service associated with any other operation on the nose and not performed during the postoperative period of a nasal operation (Anaes.) **Fee:** $117.20 **Benefit:** 75% = $87.90 85% = $99.65
41686	DISLOCATION OF TURBINATE OR TURBINATES, 1 or both sides, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $71.95 **Benefit:** 75% = $54.00 85% = $61.20
41689	TURBINECTOMY or turbinectomies, partial or total, unilateral (Anaes.) **Fee:** $136.50 **Benefit:** 75% = $102.40
41692	TURBINATES, submucous resection of, unilateral (Anaes.) **Fee:** $178.05 **Benefit:** 75% = $133.55
41695	TURBINATES, cryotherapy to (Anaes.) **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00

41698	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.) **Fee:** $32.55 **Benefit:** 75% = $24.45 85% = $27.70
41701	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $91.90 **Benefit:** 75% = $68.95
41704	MAXILLARY ANTRUM, LAVAGE OF each attendance at which the procedure is performed, including any associated consultation (Anaes.) **Fee:** $36.30 **Benefit:** 75% = $27.25 85% = $30.90
41707	MAXILLARY ARTERY, transantral ligation of (Anaes.) (Assist.) **Fee:** $448.55 **Benefit:** 75% = $336.45
41710	ANTROSTOMY (RADICAL) (Anaes.) (Assist.) **Fee:** $521.25 **Benefit:** 75% = $390.95
41713	ANTROSTOMY (RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy (Anaes.) (Assist.) **Fee:** $606.50 **Benefit:** 75% = $454.90
41716	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) **Fee:** $295.70 **Benefit:** 75% = $221.80
41719	ANTRUM, drainage of, through tooth socket (Anaes.) **Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95
41722	OROANTRAL FISTULA, plastic closure of (Anaes.) (Assist.) **Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $508.10
41725	ETHMOIDAL ARTERY OR ARTERIES, transorbital ligation of (unilateral) (Anaes.) (Assist.) **Fee:** $448.55 **Benefit:** 75% = $336.45
41728	LATERAL RHINOTOMY with removal of tumour (Anaes.) (Assist.) **Fee:** $897.30 **Benefit:** 75% = $673.00
41729	DERMOID OF NOSE, excision of, with intranasal extension (Anaes.) (Assist.) **Fee:** $568.65 **Benefit:** 75% = $426.50
41731	FRONTONASAL ETHMOIDECTOMY by external approach with or without sphenoidectomy (Anaes.) (Assist.) **Fee:** $777.10 **Benefit:** 75% = $582.85
41734	RADICAL FRONTOETHMOIDECTOMY with osteoplastic flap (Anaes.) (Assist.) **Fee:** $1,014.05 **Benefit:** 75% = $760.55
41737	FRONTAL SINUS, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on (Anaes.) (Assist.) **Fee:** $483.25 **Benefit:** 75% = $362.45
41740	FRONTAL SINUS, catheterisation of (Anaes.) **Fee:** $58.80 **Benefit:** 75% = $44.10
41743	FRONTAL SINUS, trephine of (Anaes.) (Assist.) **Fee:** $337.45 **Benefit:** 75% = $253.10
41746	FRONTAL SINUS, radical obliteration of (Anaes.) (Assist.) **Fee:** $777.10 **Benefit:** 75% = $582.85 85% = $697.60
41749	ETHMOIDAL SINUSES, external operation on (Anaes.) (Assist.) **Fee:** $606.50 **Benefit:** 75% = $454.90
41752	SPHENOIDAL SINUS, intranasal operation on (Anaes.) (Assist.) **Fee:** $295.70 **Benefit:** 75% = $221.80
41755	EUSTACHIAN TUBE, catheterisation of (Anaes.) **Fee:** $46.50 **Benefit:** 75% = $34.90 85% = $39.55
41758	DIVISION OF PHARYNGEAL ADHESIONS (Anaes.) **Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95

41761	POSTNASAL SPACE, direct examination of, with or without biopsy (Anaes.) **Fee:** $122.85 **Benefit:** 75% = $92.15 85% = $104.45
41764	NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX and LARYNX, one or more of these procedures, unilateral or bilateral examination (Anaes.) **Fee:** $122.85 **Benefit:** 75% = $92.15 85% = $104.45
41767	NASOPHARYNGEAL ANGIOFIBROMA, removal of (Anaes.) (Assist.) **Fee:** $737.00 **Benefit:** 75% = $552.75 85% = $657.50
41770	PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.) **Fee:** $701.30 **Benefit:** 75% = $526.00
41773	PHARYNGEAL POUCH, ENDOSCOPIC RESECTION OF (Dohlman's operation) (Anaes.) (Assist.) **Fee:** $587.60 **Benefit:** 75% = $440.70
41776	CRICOPHARYNGEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes.) (Assist.) **Fee:** $585.90 **Benefit:** 75% = $439.45
41779	PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes.) (Assist.) **Fee:** $701.30 **Benefit:** 75% = $526.00
41782	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY (Anaes.) (Assist.) **Fee:** $952.10 **Benefit:** 75% = $714.10 85% = $872.60
41785	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes.) (Assist.) **Fee:** $1,181.15 **Benefit:** 75% = $885.90
41786	UVULOPALATOPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.) (Assist.) **Fee:** $737.00 **Benefit:** 75% = $552.75
41787	UVULECTOMY AND PARTIAL PALATECTOMY WITH LASER INCISION OF THE PALATE, with or without tonsillectomy, 1 or more stages, including any revision procedures within 12 months (Anaes.) (Assist.) **Fee:** $568.65 **Benefit:** 75% = $426.50 85% = $489.15
41788 G 41789 S	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person aged LESS THAN 12 YEARS (Anaes.) **Fee:** $219.95 **Benefit:** 75% = $165.00 **Fee:** $295.70 **Benefit:** 75% = $221.80
41792 G 41793 S	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person 12 YEARS OF AGE OR OVER (Anaes.) **Fee:** $276.80 **Benefit:** 75% = $207.60 **Fee:** $371.50 **Benefit:** 75% = $278.65
41796 G 41797 S	TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (Anaes.) **Fee:** $113.70 **Benefit:** 75% = $85.30 **Fee:** $144.00 **Benefit:** 75% = $108.00
41800 G 41801 S	ADENOIDS, removal of (Anaes.) **Fee:** $117.55 **Benefit:** 75% = $88.20 **Fee:** $162.95 **Benefit:** 75% = $122.25
41804	LINGUAL TONSIL OR LATERAL PHARYNGEAL BANDS, removal of (Anaes.) **Fee:** $90.00 **Benefit:** 75% = $67.50
41807	PERITONSILLAR ABSCESS (quinsy), incision of (Anaes.) **Fee:** $70.10 **Benefit:** 75% = $52.60 85% = $59.60
41810	UVULOTOMY or UVULECTOMY (Anaes.) **Fee:** $35.60 **Benefit:** 75% = $26.70 85% = $30.30
41813	VALLECULAR OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.) **Fee:** $356.35 **Benefit:** 75% = $267.30
41816	OESOPHAGOSCOPY (with rigid oesophagoscope) (Anaes.) **Fee:** $185.60 **Benefit:** 75% = $139.20 85% = $157.80

41819	DILATATION OF STRICTURE OF UPPER GASTRO-INTESTINAL TRACT using bougie or balloon over endoscopically inserted guidewire, including endoscopy with flexible or rigid endoscope (Anaes.) **Fee:** $348.95 **Benefit:** 75% = $261.75 85% = $296.65
41820	DILATATION OF STRICTURE OF UPPER GASTRO-INTESTINAL TRACT using bougie or balloon over endoscopically inserted guidewire, including endoscopy with flexible or rigid endoscope, where the use of imaging intensification is clinically indicated (Anaes.) **Fee:** $418.75 **Benefit:** 75% = $314.10 85% = $355.95
41822	OESOPHAGOSCOPY (with rigid oesophagoscope), with biopsy (Anaes.) **Fee:** $238.80 **Benefit:** 75% = $179.10
41825	OESOPHAGOSCOPY (with rigid oesophagoscope), with removal of foreign body (Anaes.) (Assist.) **Fee:** $356.35 **Benefit:** 75% = $267.30
41828	OESOPHAGEAL STRICTURE, dilatation of, without oesophagoscopy (Anaes.) **Fee:** $52.20 **Benefit:** 75% = $39.15 85% = $44.40
41831	OESOPHAGUS, endoscopic pneumatic dilatation of (Anaes.) (Assist.) **Fee:** $357.00 **Benefit:** 75% = $267.75 85% = $303.45
41832	OESOPHAGUS, balloon dilatation of, using interventional imaging techniques (Anaes.) **Fee:** $228.50 **Benefit:** 75% = $171.40 85% = $194.25
41834	LARYNGECTOMY (TOTAL) (Anaes.) (Assist.) **Fee:** $1,289.15 **Benefit:** 75% = $966.90
41837	VERTICAL HEMILARYNGECTOMY including tracheostomy (Anaes.) (Assist.) **Fee:** $1,236.05 **Benefit:** 75% = $927.05
41840	SUPRAGLOTTIC LARYNGECTOMY including tracheostomy (Anaes.) (Assist.) **Fee:** $1,519.80 **Benefit:** 75% = $1,139.85
41843	LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.) **Fee:** $1,336.45 **Benefit:** 75% = $1,002.35
41846	LARYNX, direct examination of the supraglottic, glottic and subglottic regions, not being a service associated with any other procedure on the larynx or with the administration of a general anaesthetic (Anaes.) *(See para T8.77 of explanatory notes to this Category)* **Fee:** $185.60 **Benefit:** 75% = $139.20 85% = $157.80
41849	LARYNX, direct examination of, with biopsy (Anaes.) (Assist.) **Fee:** $272.90 **Benefit:** 75% = $204.70
41852	LARYNX, direct examination of, WITH REMOVAL OF TUMOUR (Anaes.) (Assist.) **Fee:** $295.70 **Benefit:** 75% = $221.80
41855	MICROLARYNGOSCOPY (Anaes.) (Assist.) **Fee:** $288.20 **Benefit:** 75% = $216.15
41858	MICROLARYNGOSCOPY with removal of juvenile papillomata (Anaes.) (Assist.) *(See para T8.78 of explanatory notes to this Category)* **Fee:** $494.15 **Benefit:** 75% = $370.65
41861	MICROLARYNGOSCOPY with removal of benign lesions of the larynx by laser surgery (Anaes.) (Assist.) **Fee:** $604.30 **Benefit:** 75% = $453.25
41864	MICROLARYNGOSCOPY WITH REMOVAL OF TUMOUR (Anaes.) (Assist.) **Fee:** $407.50 **Benefit:** 75% = $305.65
41867	MICROLARYNGOSCOPY with arytenoidectomy (Anaes.) (Assist.) **Fee:** $613.40 **Benefit:** 75% = $460.05
41868	LARYNGEAL WEB, division of, using microlarygoscopic techniques (Anaes.) **Fee:** $388.70 **Benefit:** 75% = $291.55

41870	INJECTION OF VOCAL CORD BY TEFLON, FAT, COLLAGEN OR GELFOAM (Anaes.) (Assist.) **Fee:** $454.85 **Benefit:** 75% = $341.15
41873	LARYNX, FRACTURED, operation for (Anaes.) (Assist.) **Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $508.10
41876	LARYNX, external operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes.) (Assist.) **Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $508.10
41879	LARYNGOPLASTY or TRACHEOPLASTY, including tracheostomy (Anaes.) (Assist.) **Fee:** $952.10 **Benefit:** 75% = $714.10
41880	TRACHEOSTOMY by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (Anaes.) **Fee:** $254.15 **Benefit:** 75% = $190.65
41881	TRACHEOSTOMY by open exposure of the trachea, including separation of the strap muscles or division of the thyroid isthmus, where performed (Anaes.) (Assist.) **Fee:** $401.75 **Benefit:** 75% = $301.35
41884	CRICOTHYROSTOMY by direct stab or Seldinger technique, using mini tracheostomy device (Anaes.) *(See para T8.2 of explanatory notes to this Category)* **Fee:** $91.05 **Benefit:** 75% = $68.30
41885	TRACHE-OESOPHAGEAL FISTULA, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $287.90 **Benefit:** 75% = $215.95 85% = $244.75
41886	TRACHEA, removal of foreign body in (Anaes.) **Fee:** $178.05 **Benefit:** 75% = $133.55 85% = $151.35
41889	BRONCHOSCOPY, as an independent procedure (Anaes.) **Fee:** $178.05 **Benefit:** 75% = $133.55 85% = $151.35
41892	BRONCHOSCOPY with 1 or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.) **Fee:** $235.05 **Benefit:** 75% = $176.30 85% = $199.80
41895	BRONCHUS, removal of foreign body in (Anaes.) (Assist.) **Fee:** $367.75 **Benefit:** 75% = $275.85
41898	FIBREOPTIC BRONCHOSCOPY with 1 or more transbronchial lung biopsies, with or without bronchial or bronchoalveolar lavage, with or without the use of interventional imaging (Anaes.) (Assist.) **Fee:** $256.95 **Benefit:** 75% = $192.75 85% = $218.45
41901	ENDOSCOPIC LASER RESECTION OF ENDOBRONCHIAL TUMOURS for relief of obstruction including any associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $604.30 **Benefit:** 75% = $453.25
41904	BRONCHOSCOPY with dilatation of tracheal stricture (Anaes.) **Fee:** $246.50 **Benefit:** 75% = $184.90 85% = $209.55
41905	TRACHEA OR BRONCHUS, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assist.) **Fee:** $453.35 **Benefit:** 75% = $340.05
41907	NASAL SEPTUM BUTTON, insertion of (Anaes.) **Fee:** $122.85 **Benefit:** 75% = $92.15 85% = $104.45
41910	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) **Fee:** $390.25 **Benefit:** 75% = $292.70
	SUBGROUP 9 - OPHTHALMOLOGY
42503	OPHTHALMOLOGICAL EXAMINATION under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $102.50 **Benefit:** 75% = $76.90

42506	EYE, ENUCLEATION OF, with or without sphere implant (Anaes.) (Assist.) **Fee:** $481.25 **Benefit:** 75% = $360.95 85% = $409.10
42509	EYE, ENUCLEATION OF, with insertion of integrated implant (Anaes.) (Assist.) **Fee:** $609.05 **Benefit:** 75% = $456.80
42510	EYE, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.) (Assist.) **Fee:** $702.05 **Benefit:** 75% = $526.55
42512	GLOBE, EVISCERATION OF (Anaes.) (Assist.) **Fee:** $481.25 **Benefit:** 75% = $360.95 85% = $409.10
42515	GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE (Anaes.) (Assist.) **Fee:** $609.05 **Benefit:** 75% = $456.80
42518	ANOPHTHALMIC ORBIT, INSERTION OF CARTILAGE OR ARTIFICIAL IMPLANT as a delayed procedure, or REMOVAL OF IMPLANT FROM SOCKET, or PLACEMENT OF A MOTILITY INTEGRATING PEG by drilling into an existing orbital implant (Anaes.) (Assist.) **Fee:** $353.35 **Benefit:** 75% = $265.05
42521	ANOPHTHALMIC SOCKET, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Anaes.) (Assist.) **Fee:** $1,203.20 **Benefit:** 75% = $902.40
42524	ORBIT, SKIN GRAFT TO, as a delayed procedure (Anaes.) **Fee:** $204.60 **Benefit:** 75% = $153.45 85% = $173.95
42527	CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTING AND STENT MOULD (Anaes.) (Assist.) **Fee:** $406.05 **Benefit:** 75% = $304.55
42530	ORBIT, EXPLORATION with or without biopsy, requiring REMOVAL OF BONE (Anaes.) (Assist.) **Fee:** $631.75 **Benefit:** 75% = $473.85
42533	ORBIT, EXPLORATION OF, with drainage or biopsy not requiring removal of bone (Anaes.) (Assist.) **Fee:** $406.05 **Benefit:** 75% = $304.55
42536	ORBIT, EXENTERATION OF, with or without skin graft and with or without temporalis muscle transplant (Anaes.) (Assist.) **Fee:** $834.60 **Benefit:** 75% = $625.95
42539	ORBIT, EXPLORATION OF, with removal of tumour or foreign body, requiring removal of bone (Anaes.) (Assist.) **Fee:** $1,188.20 **Benefit:** 75% = $891.15
42542	ORBIT, exploration of anterior aspect with removal of tumour or foreign body (Anaes.) (Assist.) **Fee:** $503.85 **Benefit:** 75% = $377.90
42543	ORBIT, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.) **Fee:** $883.85 **Benefit:** 75% = $662.90
42545	ORBIT, decompression of, for dysthyroid eye disease, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, 1 eye (Anaes.) (Assist.) **Fee:** $1,278.35 **Benefit:** 75% = $958.80
42548	OPTIC NERVE MENINGES, incision of (Anaes.) (Assist.) **Fee:** $759.40 **Benefit:** 75% = $569.55
42551	EYE, PENETRATING WOUND OR RUPTURE OF, not involving intraocular structures repair involving suture of cornea or sclera, or both, not being a service to which item 42632 applies (Anaes.) (Assist.) **Fee:** $631.75 **Benefit:** 75% = $473.85 85% = $552.25
42554	EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration or prolapse of uveal tissue repair (Anaes.) (Assist.) **Fee:** $737.00 **Benefit:** 75% = $552.75
42557	EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration of lens or vitreous repair (Anaes.) (Assist.) **Fee:** $1,030.20 **Benefit:** 75% = $772.65

42563	INTRAOCULAR FOREIGN BODY, removal from anterior segment (Anaes.) (Assist.) **Fee:** $519.00 **Benefit:** 75% = $389.25 85% = $441.15
42569	INTRAOCULAR FOREIGN BODY, removal from posterior segment (Anaes.) (Assist.) **Fee:** $1,030.20 **Benefit:** 75% = $772.65
42572	ORBITAL ABSCESS OR CYST, drainage of (Anaes.) **Fee:** $117.35 **Benefit:** 75% = $88.05 85% = $99.75
42573	DERMOID, periorbital, excision of, on a person 10 years of age or over (Anaes.) **Fee:** $227.45 **Benefit:** 75% = $170.60 85% = $193.35
42574	DERMOID, orbital, excision of (Anaes.) (Assist.) **Fee:** $483.25 **Benefit:** 75% = $362.45 85% = $410.80
42575	TARSAL CYST, extirpation of (Anaes.) **Fee:** $82.75 **Benefit:** 75% = $62.10 85% = $70.35
42576	DERMOID, periorbital, excision of, on a person under 10 years of age (Anaes.) **Fee:** $295.70 **Benefit:** 75% = $221.80 85% = $251.35
42581	ECTROPION OR ENTROPION, tarsal cauterisation of (Anaes.) **Fee:** $117.35 **Benefit:** 75% = $88.05 85% = $99.75
42584	TARSORRHAPHY (Anaes.) (Assist.) **Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30
42587	TRICHIASIS, treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.) **Fee:** $51.95 **Benefit:** 75% = $39.00 85% = $44.20
42590	CANTHOPLASTY, medial or lateral (Anaes.) (Assist.) **Fee:** $338.35 **Benefit:** 75% = $253.80 85% = $287.60 **Extended Medicare Safety Net Cap:** $270.70
42593	LACRIMAL GLAND, excision of palpebral lobe (Anaes.) **Fee:** $204.60 **Benefit:** 75% = $153.45
42596	LACRIMAL SAC, excision of, or operation on (Anaes.) (Assist.) **Fee:** $503.85 **Benefit:** 75% = $377.90 85% = $428.30
42599	LACRIMAL CANALICULAR SYSTEM, establishment of patency by closed operation using silicone tubes or similar, 1 eye (Anaes.) (Assist.) **Fee:** $631.75 **Benefit:** 75% = $473.85 85% = $552.25
42602	LACRIMAL CANALICULAR SYSTEM, establishment of patency by open operation, 1 eye (Anaes.) (Assist.) **Fee:** $631.75 **Benefit:** 75% = $473.85 85% = $552.25
42605	LACRIMAL CANALICULUS, immediate repair of (Anaes.) (Assist.) **Fee:** $466.10 **Benefit:** 75% = $349.60 85% = $396.20
42608	LACRIMAL DRAINAGE by insertion of glass tube, as an independent procedure (Anaes.) (Assist.) **Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65
42610	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (Anaes.) **Fee:** $96.25 **Benefit:** 75% = $72.20 85% = $81.85
42611	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (Anaes.) **Fee:** $144.35 **Benefit:** 75% = $108.30 85% = $122.70
42614	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing to establish patency of the lacrimal passage and/or site of obstruction, unilateral, including lavage, not being a service associated with a service to which item 42610 applies (excluding aftercare) **Fee:** $48.30 **Benefit:** 75% = $36.25 85% = $41.10

42615	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing to establish patency of the lacrimal passage and/or site of obstruction, bilateral, including lavage, not being a service associated with a service to which item 42611 applies (excluding aftercare) **Fee:** $72.25	**Benefit:** 75% = $54.20	85% = $61.45
42617	PUNCTUM SNIP operation (Anaes.) **Fee:** $136.95	**Benefit:** 75% = $102.75	85% = $116.45
42620	PUNCTUM, occlusion of, by use of a plug (Anaes.) **Fee:** $52.65	**Benefit:** 75% = $39.50	85% = $44.80
42622	PUNCTUM, permanent occlusion of, by use of electrical cautery (Anaes.) **Fee:** $82.75	**Benefit:** 75% = $62.10	85% = $70.35
42623	DACRYOCYSTORHINOSTOMY (Anaes.) (Assist.) **Fee:** $699.45	**Benefit:** 75% = $524.60	
42626	DACRYOCYSTORHINOSTOMY where a previous dacryocystorhinostomy has been performed (Anaes.) (Assist.) **Fee:** $1,128.05	**Benefit:** 75% = $846.05	85% = $1,048.55
42629	CONJUNCTIVORHINOSTOMY including dacryocystorhinostomy and fashioning of conjunctival flaps (Anaes.) (Assist.) **Fee:** $849.70	**Benefit:** 75% = $637.30	
42632	CONJUNCTIVAL PERITOMY OR REPAIR OF CORNEAL LACERATION by conjunctival flap (Anaes.) **Fee:** $117.35	**Benefit:** 75% = $88.05	85% = $99.75
42635	CORNEAL PERFORATIONS, sealing of, with tissue adhesive (Anaes.) (Assist.) **Fee:** $300.75	**Benefit:** 75% = $225.60	85% = $255.65
42638	CONJUNCTIVAL GRAFT OVER CORNEA (Anaes.) (Assist.) **Fee:** $376.00	**Benefit:** 75% = $282.00	85% = $319.60
42641	AUTOCONJUNCTIVAL TRANSPLANT, or mucous membrane graft (Anaes.) (Assist.) **Fee:** $488.75	**Benefit:** 75% = $366.60	85% = $415.45
42644	CORNEA OR SCLERA, complete removal of embedded foreign body from - not more than once on the same day by the same practitioner (excluding aftercare) (Anaes.) *(See para T8.79 of explanatory notes to this Category)* **Fee:** $72.15	**Benefit:** 75% = $54.15	85% = $61.35
42647	CORNEAL SCARS, removal of, by partial keratectomy, not being a service associated with a service to which item 42686 applies (Anaes.) **Fee:** $204.60	**Benefit:** 75% = $153.45	85% = $173.95
42650	CORNEA, epithelial debridement for corneal ulcer or corneal erosion (excluding aftercare) (Anaes.) **Fee:** $72.15	**Benefit:** 75% = $54.15	85% = $61.35
42651	CORNEA, epithelial debridement for eliminating band keratopathy (Anaes.) **Fee:** $160.80	**Benefit:** 75% = $120.60	85% = $136.70
42653	CORNEA transplantation of (Anaes.) (Assist.) **Fee:** $1,307.75	**Benefit:** 75% = $980.85	
42656	CORNEA, transplantation of, second and subsequent procedures (Anaes.) (Assist.) **Fee:** $1,669.45	**Benefit:** 75% = $1,252.10	
42662	SCLERA, transplantation of, full thickness, including collection of donor material (Anaes.) (Assist.) **Fee:** $902.30	**Benefit:** 75% = $676.75	
42665	SCLERA, transplantation of, superficial or lamellar, including collection of donor material (Anaes.) (Assist.) **Fee:** $601.65	**Benefit:** 75% = $451.25	85% = $522.15
42667	RUNNING CORNEAL SUTURE, manipulation of, performed within 4 months of corneal grafting, to reduce astigmatism where a reduction of 2 dioptres of astigmatism is obtained, including any associated consultation **Fee:** $141.95	**Benefit:** 75% = $106.50	85% = $120.70

42668	CORNEAL SUTURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.) **Fee:** $75.30 **Benefit:** 75% = $56.50 85% = $64.05
42672	CORNEAL INCISONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres following anterior segment surgery, including appropriate measurements and calculations, performed as an independent procedure (Anaes.) (Assist.) *(See para T8.80 of explanatory notes to this Category)* **Fee:** $902.30 **Benefit:** 75% = $676.75 85% = $822.80
42673	ADDITIONAL CORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, including appropriate measurements and calculations, performed in conjunction with other anterior segment surgery (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35 85% = $383.45
42676	CONJUNCTIVA, biopsy of, as an independent procedure **Fee:** $115.70 **Benefit:** 75% = $86.80 85% = $98.35
42677	CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at which treatment is given including any associated consultation (Anaes.) **Fee:** $60.95 **Benefit:** 75% = $45.75 85% = $51.85
42680	CONJUNCTIVA, cryotherapy to, for melanotic lesions or similar using CO^2 or N^20 (Anaes.) **Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65
42683	CONJUNCTIVAL CYSTS, removal of, requiring admission to hospital or approved day-hospital facility (Anaes.) **Fee:** $120.35 **Benefit:** 75% = $90.30
42686	PTERYGIUM, removal of (Anaes.) **Fee:** $273.65 **Benefit:** 75% = $205.25 85% = $232.65
42689	PINGUECULA, removal of, not being a service associated with the fitting of contact lenses (Anaes.) **Fee:** $117.35 **Benefit:** 75% = $88.05 85% = $99.75
42692	LIMBIC TUMOUR, removal of, excluding Pterygium (Anaes.) (Assist.) **Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30
42695	LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35 85% = $383.45
42698	LENS EXTRACTION, excluding surgery performed for the correction of refractive error ***except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye*** (Anaes.) *(See para T8.81 of explanatory notes to this Category)* **Fee:** $594.75 **Benefit:** 75% = $446.10 85% = $515.25
42701	INTRAOCULAR LENS, insertion of, excluding surgery performed for the correction of refractive error ***except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye*** (Anaes.) *(See para T8.81 of explanatory notes to this Category)* **Fee:** $331.70 **Benefit:** 75% = $248.80 85% = $281.95
42702	LENS EXTRACTION AND INSERTION OF INTRAOCULAR LENS, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.) **Fee:** $760.65 **Benefit:** 75% = $570.50 85% = $681.15 **Extended Medicare Safety Net Cap:** $114.10
42703	INTRAOCULAR LENS or IRIS PROSTHESIS insertion of, into the posterior chamber with fixation to the iris or sclera (Anaes.) (Assist.) **Fee:** $572.05 **Benefit:** 75% = $429.05 85% = $492.55
42704	INTRAOCULAR LENS, REMOVAL or REPOSITIONING of by open operation, not being a service associated with a service to which item 42701 applies (Anaes.) **Fee:** $466.10 **Benefit:** 75% = $349.60 85% = $396.20
42707	INTRAOCULAR LENS, REMOVAL of and REPLACEMENT with a different lens, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.) **Fee:** $797.10 **Benefit:** 75% = $597.85 85% = $717.60

42710	INTRAOCULAR LENS, removal of, and replacement with a lens inserted into the posterior chamber and fixated to the iris or sclera (Anaes.) (Assist.) **Fee:** $902.30 **Benefit:** 75% = $676.75 85% = $822.80
42713	IRIS SUTURING, McCannell technique or similar, for fixation of intraocular lens or repair of iris defect (Anaes.) (Assist.) **Fee:** $376.00 **Benefit:** 75% = $282.00 85% = $319.60
42716	CATARACT, JUVENILE, removal of, including subsequent needlings (Anaes.) (Assist.) **Fee:** $1,195.70 **Benefit:** 75% = $896.80 85% = $1,116.20
42719	REMOVAL OF VITREOUS, and/or CAPSULAR or LENS MATERIAL, via a limbal approach, not being a service associated with a service to which item 42698, 42702, 42716, 42725 or 42731 applies (Anaes.) (Assist.) **Fee:** $519.00 **Benefit:** 75% = $389.25 85% = $441.15
42725	VITRECTOMY via pars plana sclerotomies including the removal of vitreous, division of bands or removal of epiretinal membranes (Anaes.) (Assist.) **Fee:** $1,338.45 **Benefit:** 75% = $1,003.85
42731	LIMBAL OR PARS PLANA LENSECTOMY combined with vitrectomy, not being a service associated with items 42698, 42702, 42719, or 42725 (Anaes.) (Assist.) **Fee:** $1,519.00 **Benefit:** 75% = $1,139.25
42734	CAPSULOTOMY, other than by laser (Anaes.) (Assist.) **Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65
42738	PARACENTESIS OF ANTERIOR CHAMBER OR VITREOUS CAVITY, or both, for the injection of therapeutic substances, or the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes, 1 or more of, as an independent procedure. *(See para T8.123 of explanatory notes to this Category)* **Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65 **Extended Medicare Safety Net Cap:** $240.60
42739	PARACENTESIS OF ANTERIOR CHAMBER OR VITREOUS CAVITY, or both, for the injection of therapeutic substances, or the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes, 1 or more of, as an independent procedure, for a patient requiring anaesthetic services. (Anaes.) *(See para T8.123 of explanatory notes to this Category)* **Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65 **Extended Medicare Safety Net Cap:** $240.60
42740	INTRAVITREAL INJECTION OF THERAPEUTIC SUBSTANCES, or the removal of vitreous humour for diagnostic purposes, 1 or more of, as a procedure associated with other intraocular surgery. (Anaes.) *(See para T8.123 of explanatory notes to this Category)* **Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65 **Extended Medicare Safety Net Cap:** $240.60
42741	Posterior juxtascleral depot injection of a therapeutic substance, for the treatment of subfoveal choroidal neovascularisation due to age-related macular degeneration, 1 or more of (Anaes.) *(See para T8.82 of explanatory notes to this Category)* **Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65
42743	ANTERIOR CHAMBER, IRRIGATION OF BLOOD FROM, as an independent procedure (Anaes.) (Assist.) **Fee:** $631.75 **Benefit:** 75% = $473.85 85% = $552.25
42744	Needle revision of glaucoma filtration bleb, following glaucoma filtering procedure (Anaes.) **Fee:** $300.55 **Benefit:** 75% = $225.45 85% = $255.50
42746	GLAUCOMA, filtering operation for, where conservative therapies have failed, are likely to fail, or are contraindicated (Anaes.) (Assist.) **Fee:** $955.00 **Benefit:** 75% = $716.25
42749	GLAUCOMA, filtering operation for, where previous filtering operation has been performed (Anaes.) (Assist.) **Fee:** $1,195.70 **Benefit:** 75% = $896.80
42752	GLAUCOMA, insertion of drainage device incorporating an extraocular reservoir for, such as a Molteno device (Anaes.) (Assist.) *(See para T8.84 of explanatory notes to this Category)* **Fee:** $1,338.45 **Benefit:** 75% = $1,003.85

42755	GLAUCOMA, removal of drainage device incorporating an extraocular reservoir for, such as a Molteno device (Anaes.) **Fee:** $165.45 **Benefit:** 75% = $124.10 85% = $140.65
42758	GONIOTOMY (Anaes.) (Assist.) **Fee:** $699.45 **Benefit:** 75% = $524.60
42761	DIVISION OF ANTERIOR OR POSTERIOR SYNECHIAE, as an independent procedure, other than by laser (Anaes.) (Assist.) **Fee:** $519.00 **Benefit:** 75% = $389.25 85% = $441.15
42764	IRIDECTOMY (including excision of tumour of iris) OR IRIDOTOMY, as an independent procedure, other than by laser (Anaes.) (Assist.) **Fee:** $519.00 **Benefit:** 75% = $389.25 85% = $441.15
42767	TUMOUR, INVOLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes.) (Assist.) **Fee:** $1,090.35 **Benefit:** 75% = $817.80
42770	CYCLODESTRUCTIVE procedures for the treatment of intractable glaucoma, treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) *(See para T8.83 of explanatory notes to this Category)* **Fee:** $294.80 **Benefit:** 75% = $221.10 85% = $250.60
42773	DETACHED RETINA, pneumatic retinopexy for, not being a service associated with a service to which item 42776 applies (Anaes.) (Assist.) **Fee:** $902.30 **Benefit:** 75% = $676.75 85% = $822.80
42776	DETACHED RETINA, buckling or resection operation for (Anaes.) (Assist.) **Fee:** $1,338.45 **Benefit:** 75% = $1,003.85
42779	DETACHED RETINA, revision of scleral buckling operation for (Anaes.) (Assist.) **Fee:** $1,669.45 **Benefit:** 75% = $1,252.10
42782	LASER TRABECULOPLASTY, for the treatment of glaucoma. Each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.) (Assist.) *(See para T8.85 of explanatory notes to this Category)* **Fee:** $451.10 **Benefit:** 75% = $338.35 85% = $383.45
42783	LASER TRABECULOPLASTY, for the treatment of glaucoma. Each treatment to 1 eye – *where it can be demonstrated that a 5th or subsequent treatment to that eye (including any treatments to which item 42782 applies*) is indicated in a 2 year period (Anaes.) (Assist.) *(See para T8.85 of explanatory notes to this Category)* **Fee:** $451.10 **Benefit:** 75% = $338.35 85% = $383.45
42785	LASER IRIDOTOMY - each treatment episode to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) *(See para T8.86 of explanatory notes to this Category)* **Fee:** $353.35 **Benefit:** 75% = $265.05 85% = $300.35
42786	LASER IRIDOTOMY - each treatment episode to 1 eye ***- where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42785 applies) is indicated in a 2 year period*** (Anaes.) (Assist.) *(See para T8.86 of explanatory notes to this Category)* **Fee:** $353.35 **Benefit:** 75% = $265.05 85% = $300.35
42788	LASER CAPSULOTOMY - each treatment episode to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) *(See para T8.87 of explanatory notes to this Category)* **Fee:** $353.35 **Benefit:** 75% = $265.05 85% = $300.35
42789	LASER CAPSULOTOMY - each treatment episode to 1 eye ***- where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42788 applies) is indicated in a 2 year period*** (Anaes.) (Assist.) *(See para T8.87 of explanatory notes to this Category)* **Fee:** $353.35 **Benefit:** 75% = $265.05 85% = $300.35
42791	LASER VITREOLYSIS OR CORTICOLYSIS OF LENS MATERIAL OR FIBRINOLYSIS -each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) *(See para T8.88 of explanatory notes to this Category)* **Fee:** $353.35 **Benefit:** 75% = $265.05 85% = $300.35

42792	LASER VITREOLYSIS OR CORTICOLYSIS OF LENS MATERIAL OR FIBRINOLYSIS - each treatment to 1 eye ***- where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42791 applies) is indicated in a 2 year period*** (Anaes.) (Assist.) *(See para T8.88 of explanatory notes to this Category)* **Fee:** $353.35 **Benefit:** 75% = $265.05 85% = $300.35
42794	DIVISION OF SUTURE BY LASER following glaucoma filtration surgery, each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) *(See para T8.89 of explanatory notes to this Category)* **Fee:** $67.65 **Benefit:** 75% = $50.75 85% = $57.55
42801	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (Anaes.) (Assist.) **Fee:** $1,049.70 **Benefit:** 75% = $787.30
42802	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, removal of (Anaes.) (Assist.) **Fee:** $524.70 **Benefit:** 75% = $393.55
42805	TANTALUM MARKERS, surgical insertion to the sclera to localise the tumour base to assist in planning of radiotherapy of choroidal melanomas, 1 or more (Anaes.) (Assist.) **Fee:** $586.50 **Benefit:** 75% = $439.90 85% = $507.00
42806	IRIS TUMOUR, laser photocoagulation of (Anaes.) (Assist.) **Fee:** $353.35 **Benefit:** 75% = $265.05 85% = $300.35
42807	PHOTOMYDRIASIS, laser **Fee:** $355.80 **Benefit:** 75% = $266.85 85% = $302.45
42808	Laser peripheral iridoplasty **Fee:** $355.80 **Benefit:** 75% = $266.85 85% = $302.45
42809	RETINA, photocoagulation of, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35 85% = $383.45
42810	PHOTOTHERAPEUTIC KERATECTOMY, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.) **Fee:** $567.70 **Benefit:** 75% = $425.80 85% = $488.20
42811	TRANSPUPILLARY THERMOTHERAPY, for treatment of choroidal and retinal tumours or vascular malformations (Anaes.) **Fee:** $451.10 **Benefit:** 75% = $338.35 85% = $383.45
42812	Removal of scleral buckling material, from an eye having undergone previous scleral buckling surgery (Anaes.) **Fee:** $165.45 **Benefit:** 75% = $124.10 85% = $140.65
42815	VITREOUS CAVITY, removal of silicone oil or other liquid vitreous substitutes from, during a procedure other than that in which the vitreous substitute is inserted (Anaes.) (Assist.) **Fee:** $631.75 **Benefit:** 75% = $473.85
42818	RETINA, CRYOTHERAPY TO, as an independent procedure, or when performed in conjunction with item 42809 or 42770 (Anaes.) **Fee:** $586.50 **Benefit:** 75% = $439.90 85% = $507.00
42821	OCULAR TRANSILLUMINATION, for the diagnosis and measurement of intraocular tumours (Anaes.) **Fee:** $90.35 **Benefit:** 75% = $67.80 85% = $76.80
42824	RETROBULBAR INJECTION OF ALCOHOL OR OTHER DRUG, as an independent procedure **Fee:** $69.90 **Benefit:** 75% = $52.45 85% = $59.45
42833	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.) **Fee:** $586.50 **Benefit:** 75% = $439.90
42836	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.) **Fee:** $729.45 **Benefit:** 75% = $547.10

42839	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 OR MORE MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.) **Fee:** $699.45 **Benefit:** 75% = $524.60
42842	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 or MORE MUSCLES, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.) **Fee:** $872.30 **Benefit:** 75% = $654.25
42845	READJUSTMENT OF ADJUSTABLE SUTURES, 1 or both eyes, as an independent procedure following an operation for correction of squint (Anaes.) *(See para T8.91 of explanatory notes to this Category)* **Fee:** $189.40 **Benefit:** 75% = $142.05 85% = $161.00
42848	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 15 years or over (Anaes.) (Assist.) **Fee:** $699.45 **Benefit:** 75% = $524.60
42851	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.) **Fee:** $872.30 **Benefit:** 75% = $654.25
42854	RUPTURED MEDIAL PALPEBRAL LIGAMENT or ruptured EXTRAOCULAR MUSCLE, repair of (Anaes.) (Assist.) **Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15
42857	RESUTURING OF WOUND FOLLOWING INTRAOCULAR PROCEDURES with or without excision of prolapsed iris (Anaes.) (Assist.) **Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15
42860	EYELID (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Anaes.) (Assist.) **Fee:** $902.30 **Benefit:** 75% = $676.75 85% = $822.80
42863	EYELID, recession of (Anaes.) (Assist.) **Fee:** $774.55 **Benefit:** 75% = $580.95 85% = $695.05
42866	ENTROPION or TARSAL ECTROPION, repair of, by tightening, shortening or repair of inferior retractors by open operation across the entire width of the eyelid (Anaes.) (Assist.) **Fee:** $751.85 **Benefit:** 75% = $563.90 85% = $672.35
42869	EYELID closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.) **Fee:** $549.00 **Benefit:** 75% = $411.75 85% = $469.50
42872	EYEBROW, elevation of, for paretic states (Anaes.) **Fee:** $240.70 **Benefit:** 75% = $180.55 85% = $204.60
43021	Photodynamic therapy, one eye, including the infusion of Verteporfin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689nm, for the treatment of choroidal neovascularisation. **Fee:** $455.05 **Benefit:** 75% = $341.30 85% = $386.80
43022	Photodynamic therapy, both eyes, including the infusion of Verteporfin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689nm, for the treatment of choroidal neovascularisation. **Fee:** $546.15 **Benefit:** 75% = $409.65 85% = $466.65
43023	Infusion of Verteporfin for discontinued photodynamic therapy, where a session of therapy which would have been provided under item 43021 or 43022 has been discontinued on medical grounds. **Fee:** $88.50 **Benefit:** 75% = $66.40 85% = $75.25
	SUBGROUP 10 - OPERATIONS FOR OSTEOMYELITIS
	ACUTE
43500	OPERATION ON PHALANX (Anaes.) **Fee:** $123.35 **Benefit:** 75% = $92.55

43503	OPERATION ON STERNUM, CLAVICLE, RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, TARSUS, SKULL, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE (Anaes.) **Fee:** $204.70 **Benefit:** 75% = $153.55
43506	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.) **Fee:** $356.35 **Benefit:** 75% = $267.30
43509	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.) **Fee:** $356.35 **Benefit:** 75% = $267.30
	CHRONIC
43512	OPERATION ON SCAPULA, STERNUM, CLAVICLE, RIB, ULNA, RADIUS, METACARPUS, CARPUS, PHALANX, TIBIA, FIBULA, METATARSUS, TARSUS, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE or ANY COMBINATION OF ADJOINING BONES (Anaes.) (Assist.) **Fee:** $356.35 **Benefit:** 75% = $267.30
43515	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.) **Fee:** $356.35 **Benefit:** 75% = $267.30 85% = $302.90
43518	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.) **Fee:** $587.60 **Benefit:** 75% = $440.70
43521	OPERATION ON SKULL (Anaes.) (Assist.) **Fee:** $464.50 **Benefit:** 75% = $348.40
43524	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 43515, 43518 or 43521 (Anaes.) (Assist.) **Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $508.10
	SUBGROUP 11 - PAEDIATRIC
	SURGERY IN NEONATE OR YOUNG CHILD
43801	INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes.) (Assist.) **Fee:** $957.30 **Benefit:** 75% = $718.00
43804	INTESTINAL MALROTATION with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Anaes.) (Assist.) **Fee:** $1,019.25 **Benefit:** 75% = $764.45
43805	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, on a person under 10 years of age (Anaes.) **Fee:** $356.35 **Benefit:** 75% = $267.30
43807	DUODENAL ATRESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes.) (Assist.) **Fee:** $1,112.00 **Benefit:** 75% = $834.00
43810	JEJUNAL ATRESIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.) **Fee:** $1,297.35 **Benefit:** 75% = $973.05
43813	MECONIUM ILEUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intesinal perforation with or without meconium peritonitis (Anaes.) (Assist.) **Fee:** $1,297.35 **Benefit:** 75% = $973.05
43816	ILEAL ATRESIA, COLONIC ATRESIA OR MECONIUM ILEUS not being a service associated with a service to which item 43813 applies, laparotomy for (Anaes.) (Assist.) **Fee:** $1,204.60 **Benefit:** 75% = $903.45
43819	Agangliosis Coli, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes.) (Assist.) **Fee:** $972.95 **Benefit:** 75% = $729.75
43822	ANORECTAL MALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.) **Fee:** $972.95 **Benefit:** 75% = $729.75
43825	NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $1,112.00 **Benefit:** 75% = $834.00

43828	ACUTE NEONATAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes.) (Assist.) **Fee:** $1,228.55 **Benefit:** 75% = $921.45
43831	ACUTE NEONATAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, laparotomy for (Anaes.) (Assist.) **Fee:** $957.30 **Benefit:** 75% = $718.00
43832	BRANCHIAL FISTULA, on a person under 10 years of age. Removal of, (Anaes.) (Assist.) **Fee:** $652.95 **Benefit:** 75% = $489.75
43834	BOWEL RESECTION for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Anaes.) (Assist.) **Fee:** $1,112.00 **Benefit:** 75% = $834.00
43835	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel resection, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $677.65 **Benefit:** 75% = $508.25
43837	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Anaes.) (Assist.) **Fee:** $1,389.90 **Benefit:** 75% = $1,042.45
43838	Diaphragmatic hernia, congential repair of, by thoracic or abdominal approach, not being a service to which any of items 31569 to 31581 apply, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $1,244.50 **Benefit:** 75% = $933.40
43840	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, diagnosed after the first day of life and before 20 days of age (Anaes.) (Assist.) **Fee:** $1,204.60 **Benefit:** 75% = $903.45
43841	FEMORAL OR INGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to which item 30403 or 43835 applies, on a person under 10 years of age (Anaes.) (Assist.) **Fee:** $603.85 **Benefit:** 75% = $452.90
43843	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, not being a service to which item 43846 applies (Anaes.) (Assist.) **Fee:** $1,853.35 **Benefit:** 75% = $1,390.05
43846	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, in infant of birth weight less than 1500 grams (Anaes.) (Assist.) **Fee:** $1,992.30 **Benefit:** 75% = $1,494.25
43849	OESOPHAGEAL ATRESIA, gastrostomy for (Anaes.) (Assist.) **Fee:** $509.65 **Benefit:** 75% = $382.25
43852	OESOPHAGEAL ATRESIA, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.) (Assist.) **Fee:** $1,621.55 **Benefit:** 75% = $1,216.20
43855	OESOPHAGEAL ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.) **Fee:** $1,714.35 **Benefit:** 75% = $1,285.80
43858	OESOPHAGEAL ATRESIA, cervical oesophagostomy for (Anaes.) (Assist.) **Fee:** $602.25 **Benefit:** 75% = $451.70
43861	CONGENITAL CYSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR EMPHYSEMA, thoracotomy and lung resection for (Anaes.) (Assist.) **Fee:** $1,668.05 **Benefit:** 75% = $1,251.05
43864	GASTROSCHISIS, operation for (Anaes.) (Assist.) **Fee:** $1,251.05 **Benefit:** 75% = $938.30
43867	GASTROSCHISIS or Exomphalos, secondary operation for, with removal of silo (Anaes.) (Assist.) **Fee:** $695.00 **Benefit:** 75% = $521.25
43870	EXOMPHALOS containing small bowel only, operation for (Anaes.) (Assist.) **Fee:** $972.95 **Benefit:** 75% = $729.75

43873	EXOMPHALOS containing small bowel and other viscera, operation for (Anaes.) (Assist.) **Fee:** $1,297.35 **Benefit:** 75% = $973.05
43876	SACROCOCCYGEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assist.) **Fee:** $1,112.00 **Benefit:** 75% = $834.00
43879	SACROCOCCYGEAL TERATOMA, excision of, by combined posterior and abdominal approach (Anaes.) (Assist.) **Fee:** $1,297.35 **Benefit:** 75% = $973.05
43882	CLOACAL EXSTROPHY, operation for (Anaes.) (Assist.) **Fee:** $1,668.05 **Benefit:** 75% = $1,251.05 85% = $1,588.55
	THORACIC SURGERY
43900	TRACHEO-OESOPHAGEAL FISTULA without atresia, division and repair of (Anaes.) (Assist.) **Fee:** $1,112.00 **Benefit:** 75% = $834.00
43903	OESOPHAGEAL ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes.) (Assist.) **Fee:** $1,853.35 **Benefit:** 75% = $1,390.05
43906	OESOPHAGUS, resection of congenital, anastomic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Anaes.) (Assist.) **Fee:** $1,621.55 **Benefit:** 75% = $1,216.20
43909	TRACHEOMALACIA, aortopexy for (Anaes.) (Assist.) **Fee:** $1,621.55 **Benefit:** 75% = $1,216.20
43912	THORACOTOMY and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Anaes.) (Assist.) **Fee:** $1,532.00 **Benefit:** 75% = $1,149.00
43915	EVENTRATION, plication of diaphragm for (Anaes.) (Assist.) **Fee:** $1,158.30 **Benefit:** 75% = $868.75
	ABDOMINAL SURGERY
43930	HYPERTROPHIC PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.) **Fee:** $445.40 **Benefit:** 75% = $334.05
43933	IDIOPATHIC INTUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.) **Fee:** $521.40 **Benefit:** 75% = $391.05
43936	INTUSSUSCEPTION, laparotomy and resection with anastomosis (Anaes.) (Assist.) **Fee:** $972.95 **Benefit:** 75% = $729.75
43939	VENTRAL HERNIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.) (Assist.) **Fee:** $741.30 **Benefit:** 75% = $556.00
43942	ABDOMINAL WALL VITELLO INTESTINAL REMNANT, excision of (Anaes.) **Fee:** $231.70 **Benefit:** 75% = $173.80
43945	PATENT VITELLO INTESTINAL DUCT, excision of (Anaes.) (Assist.) **Fee:** $972.95 **Benefit:** 75% = $729.75
43948	UMBILICAL GRANULOMA, excision of, under general anaesthesia (Anaes.) **Fee:** $139.10 **Benefit:** 75% = $104.35
43951	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Anaes.) (Assist.) **Fee:** $871.30 **Benefit:** 75% = $653.50
43954	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes.) (Assist.) **Fee:** $1,065.75 **Benefit:** 75% = $799.35

43957	GASTRO-OESOPHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.) **Fee:** $1,158.30 **Benefit:** 75% = $868.75
43960	ANORECTAL MALFORMATION, perineal anoplasty of (Anaes.) (Assist.) **Fee:** $407.50 **Benefit:** 75% = $305.65
43963	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.) **Fee:** $1,621.55 **Benefit:** 75% = $1,216.20
43966	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.) (Assist.) **Fee:** $1,853.35 **Benefit:** 75% = $1,390.05
43969	PERSISTENT CLOACA, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Anaes.) (Assist.) **Fee:** $2,548.35 **Benefit:** 75% = $1,911.30
43972	CHOLEDOCHAL CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.) **Fee:** $1,853.35 **Benefit:** 75% = $1,390.05
43975	CHOLEDOCHAL CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.) **Fee:** $2,177.70 **Benefit:** 75% = $1,633.30
43978	BILIARY ATRESIA, portoenterostomy for (Anaes.) (Assist.) **Fee:** $1,853.35 **Benefit:** 75% = $1,390.05
43981	NEPHROBLASTOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.) **Fee:** $509.65 **Benefit:** 75% = $382.25
43984	NEPHROBLASTOMA, radical nephrectomy for (Anaes.) (Assist.) **Fee:** $1,297.35 **Benefit:** 75% = $973.05
43987	NEUROBLASTOMA, radical excision of (Anaes.) (Assist.) **Fee:** $1,436.40 **Benefit:** 75% = $1,077.30
43990	Aganglionosis Coli, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends to sigmoid colon (Anaes.) (Assist.) **Fee:** $1,760.75 **Benefit:** 75% = $1,320.60
43993	Aganglionosis Coli, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends into descending or transverse colon with or without resiting of stoma (Anaes.) (Assist.) **Fee:** $1,899.65 **Benefit:** 75% = $1,424.75
43996	Aganglionosis Coli, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolic anastomosis (Anaes.) (Assist.) **Fee:** $2,131.35 **Benefit:** 75% = $1,598.55
43999	Aganglionosis Coli, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.) **Fee:** $266.55 **Benefit:** 75% = $199.95
44101	RECTUM, examination of, on a person under 2 years of age, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.) **Fee:** $334.05 **Benefit:** 75% = $250.55
44102	RECTUM, examination of, on a person 2 years of age or over, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.) **Fee:** $256.95 **Benefit:** 75% = $192.75
44104	RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, on a person under 2 years of age, under general anaesthesia (Anaes.) **Fee:** $58.65 **Benefit:** 75% = $44.00 85% = $49.90
44105	RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, on a person 2 years of age or over, under general anaesthesia (Anaes.) **Fee:** $45.10 **Benefit:** 75% = $33.85 85% = $38.35

44108	INGUINAL HERNIA repair at age less than 12 months (Anaes.) (Assist.) **Fee:** $491.45 **Benefit:** 75% = $368.60
44111	OBSTRUCTED OR STRANGULATED INGUINAL HERNIA, repair, at age, less than 12 months including orchidopexy when performed (Anaes.) (Assist.) **Fee:** $575.65 **Benefit:** 75% = $431.75 85% = $496.15
44114	INGUINAL HERNIA repair at age less than 12 months when orchidopexy also required (Anaes.) (Assist.) **Fee:** $575.65 **Benefit:** 75% = $431.75
	MISCELLANEOUS SURGERY
44130	LYMPHADENECTOMY, for atypical mycobacterial infection or other granulomatous disease (Anaes.) (Assist.) **Fee:** $463.30 **Benefit:** 75% = $347.50 85% = $393.85
44133	TORTICOLLIS, open division of sternomastoid muscle for (Anaes.) (Assist.) **Fee:** $367.75 **Benefit:** 75% = $275.85
44136	INGROWN TOE NAIL, operation for, under general anaesthesia (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
	SUBGROUP 12 - AMPUTATIONS
44325	HAND, MIDCARPAL OR TRANSMETACARPAL, amputation of (Anaes.) (Assist.) **Fee:** $295.70 **Benefit:** 75% = $221.80 85% = $251.35
44328	HAND, FOREARM OR THROUGH ARM, amputation of (Anaes.) (Assist.) **Fee:** $356.35 **Benefit:** 75% = $267.30
44331	AMPUTATION AT SHOULDER (Anaes.) (Assist.) **Fee:** $587.60 **Benefit:** 75% = $440.70
44334	INTERSCAPULOTHORACIC AMPUTATION (Anaes.) (Assist.) **Fee:** $1,194.25 **Benefit:** 75% = $895.70 85% = $1,114.75
44338	1 DIGIT of foot, amputation of (Anaes.) **Fee:** $144.00 **Benefit:** 75% = $108.00 85% = $122.40
44342	2 DIGITS of 1 foot, amputation of (Anaes.) **Fee:** $219.95 **Benefit:** 75% = $165.00
44346	3 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) **Fee:** $254.00 **Benefit:** 75% = $190.50
44350	4 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) **Fee:** $288.20 **Benefit:** 75% = $216.15 85% = $245.00
44354	5 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) **Fee:** $329.80 **Benefit:** 75% = $247.35
44358	TOE, including metatarsal or part of metatarsal each toe , amputation of (Anaes.) **Fee:** $183.90 **Benefit:** 75% = $137.95
44359	ONE OR MORE TOES OF ONE FOOT, amputation of, including if performed, excision of 1 or more metatarsal bones of the foot, performed for diabetic or other microvascular disease, excluding aftercare (Anaes.) (Assist.) **Fee:** $263.95 **Benefit:** 75% = $198.00
44361	FOOT AT ANKLE (Syme, Pirogoff types), amputation of (Anaes.) (Assist.) **Fee:** $356.35 **Benefit:** 75% = $267.30
44364	FOOT, MIDTARSAL OR TRANSMETATARSAL, amputation of (Anaes.) (Assist.) **Fee:** $295.70 **Benefit:** 75% = $221.80
44367	AMPUTATION THROUGH THIGH, AT KNEE OR BELOW KNEE (Anaes.) (Assist.) **Fee:** $521.95 **Benefit:** 75% = $391.50

44370	AMPUTATION AT HIP (Anaes.) (Assist.) **Fee:** $720.20 **Benefit:** 75% = $540.15
44373	HINDQUARTER, amputation of (Anaes.) (Assist.) **Fee:** $1,478.40 **Benefit:** 75% = $1,108.80 85% = $1,398.90
44376	AMPUTATION STUMP, reamputation of, to provide adequate skin and muscle cover (Assist.) **Derived Fee:** 75% of the original amputation fee
	SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY
	GENERAL
	METICULOUS REPAIR DESIGNED TO OBTAIN MAXIMUM FUNCTIONAL RESULTS INCLUDING THE PREPARATION OF THE DEFECT REQUIRING REPAIR *(Note: See Explanatory notes to this Category for definition of "Local skin flap")*
45000	SINGLE STAGE LOCAL MUSCLE FLAP REPAIR, on eyelid, nose, lip, neck, hand, thumb, finger or genitals (Anaes.) **Fee:** $541.35 **Benefit:** 75% = $406.05 85% = $461.85
45003	SINGLE STAGE LOCAL MYOCUTANEOUS FLAP REPAIR to 1 defect, simple and small (Anaes.) **Fee:** $601.65 **Benefit:** 75% = $451.25 85% = $522.15 **Extended Medicare Safety Net Cap:** $481.35
45006	SINGLE STAGE LARGE MYOCUTANEOUS FLAP REPAIR to 1 defect, (pectoralis major, latissimus dorsi, or similar large muscle) (Anaes.) (Assist.) **Fee:** $1,037.65 **Benefit:** 75% = $778.25
45009	SINGLE STAGE LOCAL muscle flap repair to 1 defect, simple and small (Anaes.) (Assist.) **Fee:** $379.05 **Benefit:** 75% = $284.30
45012	SINGLE STAGE LARGE MUSCLE FLAP REPAIR to 1 defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle) (Anaes.) (Assist.) **Fee:** $635.00 **Benefit:** 75% = $476.25
45015	MUSCLE OR MYOCUTANEOUS FLAP, delay of (Anaes.) **Fee:** $300.75 **Benefit:** 75% = $225.60
45018	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) (Anaes.) (Assist.) **Fee:** $473.65 **Benefit:** 75% = $355.25 85% = $402.65
45019	FULL FACE CHEMICAL PEEL **for severely sun-damaged skin,** ***where it can be demonstrated that the damage affects 75% of the facial skin surface area involving photodamage (dermatoheliosis) typically consisting of solar keratoses, solar lentigines, freckling, yellowing and leathering of the skin,*** where at least medium depth peeling agents are used, performed in the operating theatre of a hospital by a specialist in the practice of his or her specialty - ***1 session only in a 12 month period*** (Anaes.) *(See para T8.92 of explanatory notes to this Category)* **Fee:** $396.70 **Benefit:** 75% = $297.55
45020	FULL FACE CHEMICAL PEEL **for severe chloasma or melasma refractory to all other treatments**, ***where it can be demonstrated that the chloasma or melasma affects 75% of the facial skin surface area involving diffuse pigmentation visible at a distance of 4 metres***, where at least medium depth peeling agents are used, performed in the operating theatre of a hospital by a specialist in the practice of his or her specialty - ***1 session only in a 12 month period*** (Anaes.) *(See para T8.92 of explanatory notes to this Category)* **Fee:** $396.70 **Benefit:** 75% = $297.55 85% = $337.20
45021	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.) *(See para T8.93 of explanatory notes to this Category)* **Fee:** $177.35 **Benefit:** 75% = $133.05 85% = $150.75
45024	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.) *(See para T8.93 of explanatory notes to this Category)* **Fee:** $398.55 **Benefit:** 75% = $298.95 85% = $338.80

45025	CARBON DIOXIDE LASER OR ERBIUM LASER (not including fractional laser therapy) resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.) *(See para T8.93 of explanatory notes to this Category)* **Fee:** $177.35 **Benefit:** 75% = $133.05 85% = $150.75 **Extended Medicare Safety Net Cap:** $141.90
45026	CARBON DIOXIDE LASER OR ERBIUM LASER (not including fractional laser therapy) resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.) *(See para T8.93 of explanatory notes to this Category)* **Fee:** $398.55 **Benefit:** 75% = $298.95 85% = $338.80 **Extended Medicare Safety Net Cap:** $318.85
45027	ANGIOMA, cauterisation of or injection into, where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $120.35 **Benefit:** 75% = $90.30 85% = $102.30
45030	ANGIOMA (haemangioma or lymphangioma or both) of skin and subcutaneous tissue (excluding facial muscle or breast) or mucous surface, small, excision and suture of (Anaes.) **Fee:** $129.25 **Benefit:** 75% = $96.95 85% = $109.90
45033	ANGIOMA, (haemangioma or lymphangioma or both), large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes.) **Fee:** $240.70 **Benefit:** 75% = $180.55 85% = $204.60
45035	ANGIOMA (haemangioma or lymphangioma or both), large and deep, involving muscles or nerves, excision of (Anaes.) (Assist.) **Fee:** $702.05 **Benefit:** 75% = $526.55
45036	ANGIOMA (haemangioma or lymphangioma or both) of neck, deep, excision of (Anaes.) (Assist.) **Fee:** $1,128.05 **Benefit:** 75% = $846.05
45039	ARTERIOVENOUS MALFORMATION (3 centimetres or less) of superficial tissue, excision of (Anaes.) **Fee:** $240.70 **Benefit:** 75% = $180.55 85% = $204.60
45042	ARTERIOVENOUS MALFORMATION, (greater than 3 centimetres), excision of (Anaes.) (Assist.) **Fee:** $308.40 **Benefit:** 75% = $231.30 85% = $262.15
45045	ARTERIOVENOUS MALFORMATION on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.) **Fee:** $308.40 **Benefit:** 75% = $231.30 85% = $262.15
45048	LYMPHOEDEMATOUS tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (Anaes.) (Assist.) **Fee:** $774.55 **Benefit:** 75% = $580.95
45051	Contour reconstruction for open repair of contour defects, due to deformity, requiring insertion of a non-biological implant, if it can be demonstrated that contour reconstructive surgery is indicated because the deformity is secondary to congenital absence of tissue or has arisen from trauma (other than trauma from previous cosmetic surgery), excluding the following: (a) insertion of a non-biological implant that is a component of another service listed in Group T8; (b) injection of liquid or semisolid material; (c) oral and maxillofacial implant services provided under item 52321; (d) services to insert mesh (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35
45054	LIMB OR CHEST, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Anaes.) (Assist.) *(See para T8.94 of explanatory notes to this Category)* **Fee:** $246.10 **Benefit:** 75% = $184.60
	SKIN FLAP SURGERY
45200	*(Note: See Explanatory notes to this Category for definition of "Local skin flap")* SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, simple and small, excluding flap for male pattern baldness and excluding H-flap or double advancement flap (Anaes.) *(See para T8.95 of explanatory notes to this Category)* **Fee:** $284.35 **Benefit:** 75% = $213.30 85% = $241.70 **Extended Medicare Safety Net Cap:** $227.50

45203	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, complicated or large, excluding flap for male pattern baldness and excluding H-flap or double advancement flap (Anaes.) (Assist.) *(See para T8.95 of explanatory notes to this Category)* **Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15 **Extended Medicare Safety Net Cap:** $324.85
45206	SINGLE STAGE LOCAL FLAP where indicated to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, and excluding H-flap or double advancement flap (Anaes.) *(See para T8.95 of explanatory notes to this Category)* **Fee:** $383.55 **Benefit:** 75% = $287.70 85% = $326.05 **Extended Medicare Safety Net Cap:** $306.85
45207	H-FLAP OR DOUBLE ADVANCEMENT FLAP where indicated to repair 1 defect, on eyelid, eyebrow or forehead (Anaes.) **Fee:** $383.55 **Benefit:** 75% = $287.70 85% = $326.05
45209	DIRECT FLAP REPAIR (cross arm, abdominal or similar), first stage (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70
45212	DIRECT FLAP REPAIR (cross arm, abdominal or similar), second stage (Anaes.) **Fee:** $235.05 **Benefit:** 75% = $176.30 85% = $199.80
45215	DIRECT FLAP REPAIR, cross leg, first stage (Anaes.) (Assist.) **Fee:** $1,014.05 **Benefit:** 75% = $760.55
45218	DIRECT FLAP REPAIR, cross leg, second stage (Anaes.) (Assist.) **Fee:** $454.85 **Benefit:** 75% = $341.15
45221	DIRECT FLAP REPAIR, small (cross finger or similar), first stage (Anaes.) **Fee:** $261.55 **Benefit:** 75% = $196.20 85% = $222.35
45224	DIRECT FLAP REPAIR, small (cross finger or similar), second stage (Anaes.) **Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95
45227	INDIRECT FLAP OR TUBED PEDICLE, formation of (Anaes.) (Assist.) **Fee:** $445.40 **Benefit:** 75% = $334.05 85% = $378.60
45230	DIRECT OR INDIRECT FLAP OR TUBED PEDICLE, delay of (Anaes.) **Fee:** $222.75 **Benefit:** 75% = $167.10 85% = $189.35
45233	INDIRECT FLAP OR TUBED PEDICLE, preparation of intermediate or final site and attachment to the site (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70
45236	INDIRECT FLAP OR TUBED PEDICLE, spreading of pedicle, as a separate procedure (Anaes.) **Fee:** $371.50 **Benefit:** 75% = $278.65
45239	DIRECT, INDIRECT OR LOCAL FLAP, revision of, by incision and suture, not being a service to which item 45240 applies (Anaes.) **Fee:** $261.55 **Benefit:** 75% = $196.20 85% = $222.35
45240	DIRECT, INDIRECT OR LOCAL FLAP, revision of, by liposuction, not being a service to which item 45239, 45497, 45498 or 45499 applies (Anaes.) **Fee:** $261.55 **Benefit:** 75% = $196.20 85% = $222.35
	FREE GRAFTS
45400	FREE GRAFTING (split skin) of a granulating area, small (Anaes.) **Fee:** $204.70 **Benefit:** 75% = $153.55 85% = $174.00
45403	FREE GRAFTING (split skin) of a granulating area, extensive (Anaes.) (Assist.) **Fee:** $407.50 **Benefit:** 75% = $305.65 85% = $346.40
45406	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving not more than 3 per cent of total body surface (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $451.10 **Benefit:** 75% = $338.35 85% = $383.45

45409	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 3 per cent or more but less than 6 per cent of total body surface (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $601.65 **Benefit:** 75% = $451.25
45412	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 6 per cent or more but less than 9 per cent of total body surface (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $827.30 **Benefit:** 75% = $620.50
45415	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 9 per cent or more but less than 12 per cent of total body surface (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $902.30 **Benefit:** 75% = $676.75
45418	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 12 per cent or more but less than 15 per cent of total body surface (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $977.55 **Benefit:** 75% = $733.20
45439	FREE GRAFTING (split skin) to 1 defect, including elective dissection, small (Anaes.) **Fee:** $284.35 **Benefit:** 75% = $213.30 85% = $241.70
45442	FREE GRAFTING (split skin) to 1 defect, including elective dissection, extensive (Anaes.) (Assist.) **Fee:** $586.50 **Benefit:** 75% = $439.90 85% = $507.00
45445	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of, and removal of mould) (Anaes.) (Assist.) **Fee:** $556.60 **Benefit:** 75% = $417.45 85% = $477.10
45448	FREE GRAFTING (split skin) to 1 defect, including elective dissection on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, not being a service to which item 45442 or 45445 applies (Anaes.) **Fee:** $376.00 **Benefit:** 75% = $282.00 85% = $319.60
45451	FREE GRAFTING (full thickness), to 1 defect, excluding grafts for male pattern baldness (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70
45460	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **one surgeon** (Anaes.) (Assist.) **Fee:** $1,253.30 **Benefit:** 75% = $940.00
45461	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $893.25 **Benefit:** 75% = $669.95
45462	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **conjoint surgery, co- surgeon** (Assist.) **Fee:** $674.05 **Benefit:** 75% = $505.55
45464	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **one surgeon** (Anaes.) (Assist.) **Fee:** $1,913.10 **Benefit:** 75% = $1,434.85
45465	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $1,363.00 **Benefit:** 75% = $1,022.25 85% = $1,283.50
45466	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $1,027.95 **Benefit:** 75% = $771.00 85% = $948.45
45468	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***30 percent or more but less than 40 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $1,832.65 **Benefit:** 75% = $1,374.50

45469	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***30 percent or more but less than 40 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $1,382.70 **Benefit:** 75% = $1,037.05 85% = $1,303.20
45471	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***40 percent or more but less than 50 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $2,303.65 **Benefit:** 75% = $1,727.75 85% = $2,224.15
45472	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***40 percent or more but less than 50 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $1,737.60 **Benefit:** 75% = $1,303.20 85% = $1,658.10
45474	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***50 percent or more but less than 60 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $2,773.30 **Benefit:** 75% = $2,080.00 85% = $2,693.80
45475	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***50 percent or more but less than 60 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $2,092.45 **Benefit:** 75% = $1,569.35 85% = $2,012.95
45477	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***60 percent or more but less than 70 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $3,243.00 **Benefit:** 75% = $2,432.25 85% = $3,163.50
45478	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***60 percent or more but less than 70 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $2,446.05 **Benefit:** 75% = $1,834.55 85% = $2,366.55
45480	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***70 percent or more but less than 80 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $3,712.60 **Benefit:** 75% = $2,784.45 85% = $3,633.10
45481	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***70 percent or more but less than 80 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $2,801.10 **Benefit:** 75% = $2,100.85 85% = $2,721.60
45483	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***80 percent or more*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $4,229.95 **Benefit:** 75% = $3,172.50 85% = $4,150.45
45484	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***80 percent or more*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $3,191.50 **Benefit:** 75% = $2,393.65 85% = $3,112.00
45485	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - upper eyelid, nose, lip, ear or palm of the hand (Anaes.) (Assist.) **Fee:** $527.70 **Benefit:** 75% = $395.80
45486	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - forehead, cheek, anterior aspect of the neck, chin, plantar aspect of the foot, heel or genitalia (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35
45487	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of toe (Anaes.) (Assist.) **Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15
45488	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the hand (Anaes.) (Assist.) **Fee:** $451.10 **Benefit:** 75% = $338.35
45489	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the hand (Anaes.) (Assist.) **Fee:** $676.80 **Benefit:** 75% = $507.60 85% = $597.30
45490	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the hand (Anaes.) (Assist.) **Fee:** $902.50 **Benefit:** 75% = $676.90
45491	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the hand (Anaes.) (Assist.) **Fee:** $1,128.05 **Benefit:** 75% = $846.05

45492	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the hand (Anaes.) (Assist.) **Fee:** $1,353.60 **Benefit:** 75% = $1,015.20
45493	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - portion of digit of hand (Anaes.) (Assist.) **Fee:** $406.05 **Benefit:** 75% = $304.55
45494	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of face (excluding ears) (Anaes.) (Assist.) **Fee:** $1,638.70 **Benefit:** 75% = $1,229.05 85% = $1,559.20
	OTHER GRAFTS AND MISCELLANEOUS PROCEDURES
45496	FLAP, free tissue transfer using microvascular techniques - ***revision of***, by open operation (Anaes.) **Fee:** $416.05 **Benefit:** 75% = $312.05
45497	FLAP, free tissue transfer using microvascular techniques, *or* any autogenous breast reconstruction - ***complete revision of***, by liposuction (Anaes.) **Fee:** $324.95 **Benefit:** 75% = $243.75
45498	FLAP, free tissue transfer using microvascular techniques, *or* any autogenous breast reconstruction - ***staged revision of***, by liposuction - first stage (Anaes.) **Fee:** $261.55 **Benefit:** 75% = $196.20
45499	FLAP, free tissue transfer using microvascular techniques, *or* any autogenous breast reconstruction - ***staged revision of***, by liposuction - second stage (Anaes.) **Fee:** $195.00 **Benefit:** 75% = $146.25
45500	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.) **Fee:** $1,090.35 **Benefit:** 75% = $817.80
45501	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.) **Fee:** $1,774.70 **Benefit:** 75% = $1,331.05
45502	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.) **Fee:** $1,774.70 **Benefit:** 75% = $1,331.05
45503	MICRO-ARTERIAL OR MICRO-VENOUS GRAFT using microsurgical techniques (Anaes.) (Assist.) **Fee:** $2,030.35 **Benefit:** 75% = $1,522.80
45504	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.) **Fee:** $1,774.70 **Benefit:** 75% = $1,331.05
45505	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.) **Fee:** $1,774.70 **Benefit:** 75% = $1,331.05
45506	SCAR, of face or neck, not more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.) *(See para T8.97 of explanatory notes to this Category)* **Fee:** $219.95 **Benefit:** 75% = $165.00 85% = $187.00
45512	SCAR, of face or neck, more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.) *(See para T8.97 of explanatory notes to this Category)* **Fee:** $295.70 **Benefit:** 75% = $221.80 85% = $251.35
45515	SCAR, other than on face or neck, not more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or where performed by a specialist in the practice of his or her specialty (Anaes.) *(See para T8.97 of explanatory notes to this Category)* **Fee:** $186.50 **Benefit:** 75% = $139.90 85% = $158.55

45518	SCAR, other than on face or neck, more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her speciality (Anaes.) *(See para T8.97 of explanatory notes to this Category)* **Fee:** $225.70 **Benefit:** 75% = $169.30 85% = $191.85
45519	EXTENSIVE BURN SCARS OF SKIN (more than 1 percent of body surface area), excision of, for correction of scar contracture (Anaes.) (Assist.) **Fee:** $429.05 **Benefit:** 75% = $321.80
45520	REDUCTION MAMMAPLASTY (unilateral) with surgical repositioning of nipple (Anaes.) (Assist.) **Fee:** $900.45 **Benefit:** 75% = $675.35
45522	REDUCTION MAMMAPLASTY (unilateral) without surgical repositioning of nipple, excluding the treatment of gynaecomastia (H) (Anaes.) (Assist.) **Fee:** $631.75 **Benefit:** 75% = $473.85
45524	MAMMAPLASTY, AUGMENTATION, for significant breast asymmetry where the augmentation is limited to 1 breast (Anaes.) (Assist.) *(See para T8.98 of explanatory notes to this Category)* **Fee:** $741.65 **Benefit:** 75% = $556.25
45527	MAMMAPLASTY, AUGMENTATION, (unilateral), following mastectomy (Anaes.) (Assist.) *(See para T8.98 of explanatory notes to this Category)* **Fee:** $741.65 **Benefit:** 75% = $556.25
45528	MAMMAPLASTY, AUGMENTATION, bilateral, not being a service to which Item 45527 applies, ***where it can be demonstrated*** that surgery is indicated because of malformation of breast tissue (excluding hypomastia), disease or trauma of the breast (other than trauma resulting from previous elective cosmetic surgery) (Anaes.) (Assist.) *(See para T8.98 of explanatory notes to this Category)* **Fee:** $1,112.35 **Benefit:** 75% = $834.30
45530	BREAST RECONSTRUCTION (unilateral) using a latissimus dorsi or other large muscle or myocutaneous flap, including repair of secondary skin defect, if required, excluding repair of muscular aponeurotic layer, not being a service associated with a service to which items 30165, 30168, 30171, 30174 or 30177 applies (Anaes.) (Assist.) *(See para T8.99 of explanatory notes to this Category)* **Fee:** $1,099.40 **Benefit:** 75% = $824.55
45533	BREAST RECONSTRUCTION using breast sharing technique (first stage) including breast reduction, transfer of complex skin and breast tissue flap, split skin graft to pedicle of flap or other similar procedure (Anaes.) (Assist.) **Fee:** $1,245.10 **Benefit:** 75% = $933.85
45536	BREAST RECONSTRUCTION using breast sharing technique (second stage) including division of pedicle, insetting of breast flap, with closure of donor site or other similar procedure (Anaes.) (Assist.) **Fee:** $457.85 **Benefit:** 75% = $343.40
45539	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.) **Fee:** $1,071.20 **Benefit:** 75% = $803.40
45542	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (Anaes.) (Assist.) **Fee:** $613.40 **Benefit:** 75% = $460.05
45545	NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes.) (Assist.) *(See para T8.102 of explanatory notes to this Category)* **Fee:** $622.55 **Benefit:** 75% = $466.95 85% = $543.05 **Extended Medicare Safety Net Cap:** $498.05
45546	NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple *(See para T8.102 of explanatory notes to this Category)* **Fee:** $197.85 **Benefit:** 75% = $148.40 85% = $168.20
45548	BREAST PROSTHESIS, removal of, as an independent procedure (Anaes.) **Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30

45551	BREAST PROSTHESIS, removal of, with excision of fibrous capsule (Anaes.) (Assist.) **Fee:** $443.70 **Benefit:** 75% = $332.80
45552	BREAST PROSTHESIS, removal of, with excision of fibrous capsule and replacement of prosthesis (Anaes.) (Assist.) *(See para T8.100 of explanatory notes to this Category)* **Fee:** $638.65 **Benefit:** 75% = $479.00 85% = $559.15
45553	BREAST PROSTHESIS, removal and replacement with another prosthesis, following medical complications (such as rupture, migration of prosthetic material, or capsule formation). (Anaes.) (Assist.) *(See para T8.100 of explanatory notes to this Category)* **Fee:** $638.65 **Benefit:** 75% = $479.00 85% = $559.15
45554	BREAST PROSTHESIS, removal and replacement with another prosthesis, following medical complications (such as rupture, migration of prosthetic material, or capsule formation), where new pocket is formed, including excision of fibrous capsule (Anaes.) (Assist.) *(See para T8.100 of explanatory notes to this Category)* **Fee:** $699.45 **Benefit:** 75% = $524.60 85% = $619.95
45555	SILICONE BREAST PROSTHESIS, removal of and replacement with prosthesis other than silicone gel prosthesis (Anaes.) (Assist.) *(See para T8.100 of explanatory notes to this Category)* **Fee:** $638.65 **Benefit:** 75% = $479.00
45556	BREAST PTOSIS, correction of (unilateral), to match the position of the contralateral breast (H) (Anaes.) (Assist.) *(See para T8.101 of explanatory notes to this Category)* **Fee:** $766.05 **Benefit:** 75% = $574.55
45557	BREAST PTOSIS, correction of by mastopexy by any means (unilateral), following pregnancy and lactation, when performed not less than 1 year, and not more than 7 years after the end of the most recent pregnancy, and ***where it can be demonstrated*** that the nipple is inferior to the infra-mammary groove, not being a service associated with a service to which item 45522 applies (Anaes.) (Assist.) *(See para T8.101 of explanatory notes to this Category)* **Fee:** $766.05 **Benefit:** 75% = $574.55
45558	BREAST PTOSIS, correction of by mastopexy by any means (bilateral), following pregnancy and lactation, when performed not less than 1 year, and not more than 7 years after the end of the most recent pregnancy, and ***where it can be demonstrated*** that the nipple is inferior to the infra-mammary groove, not being a service associated with a service to which item 45522 applies (Anaes.) (Assist.) *(See para T8.101 of explanatory notes to this Category)* **Fee:** $1,148.95 **Benefit:** 75% = $861.75
45559	TUBEROUS, TUBULAR OR CONSTRICTED BREAST, **where it can be demonstrated,** correction of by simultaneous mastopexy and augmentation of (unilateral) (Anaes.) (Assist.) *(See para T8.101 of explanatory notes to this Category)* **Fee:** $1,136.80 **Benefit:** 75% = $852.60 85% = $1,057.30
45560	HAIR TRANSPLANTATION for the treatment of alopecia of congenital or traumatic origin or due to disease, excluding male pattern baldness, not being a service to which another item in this Group applies (Anaes.) **Fee:** $473.65 **Benefit:** 75% = $355.25 85% = $402.65 **Extended Medicare Safety Net Cap:** $165.80
45561	MICROVASCULAR ANASTOMOSIS of artery or vein using microsurgical techniques, for supercharging of pedicled flaps (Anaes.) (Assist.) **Fee:** $1,774.70 **Benefit:** 75% = $1,331.05
45562	FREE TRANSFER OF TISSUE involving raising of tissue on vascular or neurovascular pedicle, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.) **Fee:** $1,099.40 **Benefit:** 75% = $824.55 85% = $1,019.90
45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.) **Fee:** $1,099.40 **Benefit:** 75% = $824.55 85% = $1,019.90

45564	FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 30165, 30168, 30171, 30174, 30177, 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, principal specialist surgeon (Anaes.) (Assist.) **Fee:** $2,546.30 **Benefit:** 75% = $1,909.75
45565	FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 30165, 30168, 30171, 30174, 30177, 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, conjoint specialist surgeon (Assist.) **Fee:** $1,909.80 **Benefit:** 75% = $1,432.35
45566	TISSUE EXPANSION not being a service to which item 45539 or 45542 applies - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.) **Fee:** $1,071.20 **Benefit:** 75% = $803.40
45568	TISSUE EXPANDER, removal of, with complete excision of fibrous capsule (Anaes.) (Assist.) **Fee:** $443.70 **Benefit:** 75% = $332.80
45569	CLOSURE OF ABDOMEN WITH RECONSTRUCTION OF UMBILICUS, with or without lipectomy, being a service associated with items 45562, 45564, 45565 or 45530 (Anaes.) (Assist.) **Fee:** $677.60 **Benefit:** 75% = $508.20
45570	CLOSURE OF ABDOMEN, repair of musculoaponeurotic layer, being a service associated with item 45569 (Anaes.) (Assist.) **Fee:** $914.95 **Benefit:** 75% = $686.25 85% = $835.45
45572	INTRA OPERATIVE TISSUE EXPANSION performed during an operation when combined with a service to which another item in Group T8 applies including expansion injections and excluding treatment of male pattern baldness (Anaes.) **Fee:** $291.70 **Benefit:** 75% = $218.80 85% = $247.95
45575	FACIAL NERVE PARALYSIS, free fascia graft for (Anaes.) (Assist.) **Fee:** $720.20 **Benefit:** 75% = $540.15 85% = $640.70
45578	FACIAL NERVE PARALYSIS, muscle transfer for (Anaes.) (Assist.) **Fee:** $834.05 **Benefit:** 75% = $625.55
45581	FACIAL NERVE PALSY, excision of tissue for (Anaes.) **Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30
45584	LIPOSUCTION (suction assisted lipolysis) to 1 regional area (thigh, buttock, or similar), for treatment of post-traumatic pseudolipoma (Anaes.) *(See para T8.103 of explanatory notes to this Category)* **Fee:** $631.75 **Benefit:** 75% = $473.85 85% = $552.25 **Extended Medicare Safety Net Cap:** $505.40
45585	Liposuction (suction assisted lipolysis) to one regional area, other than a service associated with a service to which item 31525 applies, if it can be demonstrated that the treatment is for Barraquer-Simon's syndrome (pathological lipodystrophy of hips, buttocks, thighs, knees or lower legs), lymphoedema or macrodystrophia lipomatosa (Anaes.) *(See para T8.103 of explanatory notes to this Category)* **Fee:** $631.75 **Benefit:** 75% = $473.85 85% = $552.25 **Extended Medicare Safety Net Cap:** $505.40
45586	LIPOSUCTION (suction assisted lipolysis) for reduction of a buffalo hump, ***where it can be demonstrated that the buffalo hump is secondary to an endocrine disorder or pharmacological treatment of a medical condition*** (Anaes.) *(See para T8.103 of explanatory notes to this Category)* **Fee:** $631.75 **Benefit:** 75% = $473.85
45587	MELOPLASTY for correction of facial asymmetry due to soft tissue abnormality where the meloplasty is limited to 1 side of the face (Anaes.) (Assist.) *(See para T8.104 of explanatory notes to this Category)* **Fee:** $890.85 **Benefit:** 75% = $668.15 85% = $811.35 **Extended Medicare Safety Net Cap:** $712.70

45588	MELOPLASTY, (excluding browlifts and chinlift platysmaplasties), bilateral ***where it can be demonstrated*** that surgery is indicated because of congenital conditions, disease or trauma (other than trauma resulting from previous elective cosmetic surgery) (Anaes.) (Assist.) *(See para T8.104 of explanatory notes to this Category)* **Fee:** $1,336.40 **Benefit:** 75% = $1,002.30
45590	ORBITAL CAVITY, reconstruction of a wall or floor, with or without foreign implant (Anaes.) (Assist.) **Fee:** $483.25 **Benefit:** 75% = $362.45
45593	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.) **Fee:** $567.65 **Benefit:** 75% = $425.75
45596	MAXILLA, total resection of (Anaes.) (Assist.) **Fee:** $900.45 **Benefit:** 75% = $675.35
45597	MAXILLA, total resection of both maxillae (Anaes.) (Assist.) **Fee:** $1,205.40 **Benefit:** 75% = $904.05
45599	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.) **Fee:** $936.55 **Benefit:** 75% = $702.45 85% = $857.05
45602	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.) **Fee:** $699.45 **Benefit:** 75% = $524.60
45605	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) **Fee:** $587.60 **Benefit:** 75% = $440.70
45608	MANDIBLE, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Anaes.) (Assist.) **Fee:** $827.30 **Benefit:** 75% = $620.50
45611	MANDIBLE, condylectomy (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35
45614	EYELID, WHOLE THICKNESS RECONSTRUCTION OF other than by direct suture only (Anaes.) (Assist.) **Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $508.10 **Extended Medicare Safety Net Cap:** $470.10
45617	UPPER EYELID, REDUCTION OF, for skin redundancy obscuring vision (as evidenced by upper eyelid skin resting on lashes on straight ahead gaze), herniation of orbital fat in exophthalmos, facial nerve palsy or posttraumatic scarring, or the restoration of symmetry of contralateral upper eyelid in respect of 1 of these conditions (Anaes.) *(See para T8.105 of explanatory notes to this Category)* **Fee:** $235.05 **Benefit:** 75% = $176.30 85% = $199.80 **Extended Medicare Safety Net Cap:** $188.05
45620	LOWER EYELID, REDUCTION OF, for herniation of orbital fat in exophthalmos, facial nerve palsy or posttraumatic scarring, or, in respect of 1 of these conditions, the restoration of symmetry of the contralateral lower eyelid (Anaes.) *(See para T8.105 of explanatory notes to this Category)* **Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15 **Extended Medicare Safety Net Cap:** $260.85
45623	PTOSIS of eyelid (unilateral), correction of (Anaes.) (Assist.) **Fee:** $723.05 **Benefit:** 75% = $542.30 85% = $643.55 **Extended Medicare Safety Net Cap:** $578.45
45624	PTOSIS of eyelid, correction of, where previous ptosis surgery has been performed on that side (Anaes.) (Assist.) **Fee:** $937.40 **Benefit:** 75% = $703.05 85% = $857.90 **Extended Medicare Safety Net Cap:** $749.95
45625	PTOSIS of eyelid, correction of eyelid height by revision of levator sutures within one week of primary repair by levator resection or advancement, performed in the operating theatre of a hospital (Anaes.) **Fee:** $187.55 **Benefit:** 75% = $140.70
45626	ECTROPION OR ENTROPION, correction of (unilateral) (Anaes.) **Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15

45629	SYMBLEPHARON, grafting for (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70
45632	RHINOPLASTY, correction of lateral or alar cartilages for correction of nasal obstruction (Anaes.) **Fee:** $511.95 **Benefit:** 75% = $384.00 85% = $435.20 **Extended Medicare Safety Net Cap:** $409.60
45635	RHINOPLASTY, correction of vault only, for correction of nasal obstruction or post-traumatic deformity (other than deformity resulting from previous elective cosmetic surgery), or both (Anaes.) **Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $508.10 **Extended Medicare Safety Net Cap:** $470.10
45638	RHINOPLASTY, TOTAL, including correction of all bony and cartilaginous elements of the external nose, for correction of nasal obstruction or post-traumatic deformity ***(but not as a result of previous elective cosmetic surgery),*** or both (H) (Anaes.) *(See para T8.106 of explanatory notes to this Category)* **Fee:** $1,014.05 **Benefit:** 75% = $760.55
45639	RHINOPLASTY, TOTAL, including correction of all bony and cartilaginous elements of the external nose, ***where it can be demonstrated*** that there is a need for correction of significant developmental deformity (H) (Anaes.) *(See para T8.106 of explanatory notes to this Category)* **Fee:** $1,014.05 **Benefit:** 75% = $760.55
45641	RHINOPLASTY involving nasal or septal cartilage graft, or nasal bone graft, or nasal bone and nasal cartilage graft for correction of nasal obstruction or post-traumatic deformity (other than deformity resulting from previous elective cosmetic surgery), or both. (H) (Anaes.) **Fee:** $1,082.90 **Benefit:** 75% = $812.20
45644	RHINOPLASTY, TOTAL, including correction of all bony and cartilaginous elements of the external nose involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft For correction of nasal obstruction or post-traumatic deformity (other than deformity resulting from previous elective cosmetic surgery), or both. (H) (Anaes.) (Assist.) **Fee:** $1,279.45 **Benefit:** 75% = $959.60
45645	CHOANAL ATRESIA, repair of by puncture and dilatation (Anaes.) **Fee:** $223.60 **Benefit:** 75% = $167.70
45646	CHOANAL ATRESIA - correction by open operation with bone removal (Anaes.) (Assist.) **Fee:** $900.45 **Benefit:** 75% = $675.35 85% = $820.95
45647	FACE, contour restoration of 1 region, using autogenous bone or cartilage graft (not being a service to which item 45644 applies) (Anaes.) (Assist.) *(See para T8.107 of explanatory notes to this Category)* **Fee:** $1,279.45 **Benefit:** 75% = $959.60
45650	RHINOPLASTY, secondary revision of, for correction of nasal obstruction, post-traumatic deformity (other than deformity resulting from previous elective cosmetic surgery) or significant developmental deformity (Anaes.) **Fee:** $147.80 **Benefit:** 75% = $110.85 85% = $125.65
45652	RHINOPHYMA, carbon dioxide laser or erbium laser excision-ablation of (Anaes.) **Fee:** $356.35 **Benefit:** 75% = $267.30 85% = $302.90 **Extended Medicare Safety Net Cap:** $285.10
45653	RHINOPHYMA, shaving of (Anaes.) **Fee:** $356.35 **Benefit:** 75% = $267.30 85% = $302.90
45656	COMPOSITE GRAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist.) **Fee:** $502.25 **Benefit:** 75% = $376.70 85% = $426.95
45659	LOP EAR, BAT EAR OR SIMILAR DEFORMITY, correction of (Anaes.) **Fee:** $521.25 **Benefit:** 75% = $390.95 85% = $443.10 **Extended Medicare Safety Net Cap:** $417.00
45660	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, using multiple costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.) **Fee:** $2,878.75 **Benefit:** 75% = $2,159.10

45661	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, elevation of costal cartilage framework using cartilage previously stored in abdominal wall, including the use of local skin and fascia flaps and full thickness skin graft to cover cartilage (second stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.) **Fee:** $1,279.45 **Benefit:** 75% = $959.60
45662	CONGENITAL ATRESIA, reconstruction of external auditory canal (Anaes.) (Assist.) **Fee:** $701.30 **Benefit:** 75% = $526.00
45665	LIP, EYELID OR EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures (Anaes.) **Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15
45668	VERMILIONECTOMY, by surgical excision (Anaes.) **Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15
45669	VERMILIONECTOMY, using carbon dioxide laser or erbium laser excision-ablation (Anaes.) *(See para T8.108 of explanatory notes to this Category)* **Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15
45671	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) **Fee:** $834.05 **Benefit:** 75% = $625.55 85% = $754.55
45674	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) **Fee:** $242.55 **Benefit:** 75% = $181.95 85% = $206.20
45675	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) **Fee:** $483.25 **Benefit:** 75% = $362.45
45676	MACROSTOMIA, operation for (Anaes.) (Assist.) **Fee:** $575.30 **Benefit:** 75% = $431.50
45677	CLEFT LIP, unilateral primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $541.35 **Benefit:** 75% = $406.05
45680	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $676.80 **Benefit:** 75% = $507.60
45683	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $751.85 **Benefit:** 75% = $563.90
45686	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $887.50 **Benefit:** 75% = $665.65
45689	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes.) (Assist.) **Fee:** $261.75 **Benefit:** 75% = $196.35
45692	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) **Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65
45695	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) **Fee:** $488.75 **Benefit:** 75% = $366.60
45698	CLEFT LIP, primary columella lengthening procedure, bilateral (Anaes.) **Fee:** $458.75 **Benefit:** 75% = $344.10
45701	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) **Fee:** $827.30 **Benefit:** 75% = $620.50
45704	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) **Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65
45707	CLEFT PALATE, primary repair (Anaes.) (Assist.) **Fee:** $781.95 **Benefit:** 75% = $586.50
45710	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) **Fee:** $488.75 **Benefit:** 75% = $366.60

45713	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) **Fee:** $556.60 **Benefit:** 75% = $417.45
45714	ORO-NASAL FISTULA, plastic closure of, including services to which item 45200, 45203 or 45239 applies (Anaes.) (Assist.) **Fee:** $781.95 **Benefit:** 75% = $586.50
45716	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) **Fee:** $781.95 **Benefit:** 75% = $586.50
45720	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and excluding services to which item 47933or 47936 apply (Anaes.) (Assist.) *(See para T8.109 of explanatory notes to this Category)* **Fee:** $966.80 **Benefit:** 75% = $725.10 85% = $887.30
45723	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.109 of explanatory notes to this Category)* **Fee:** $1,090.35 **Benefit:** 75% = $817.80
45726	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.109 of explanatory notes to this Category)* **Fee:** $1,232.05 **Benefit:** 75% = $924.05
45729	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.109 of explanatory notes to this Category)* **Fee:** $1,383.65 **Benefit:** 75% = $1,037.75
45731	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.109 of explanatory notes to this Category)* **Fee:** $1,402.70 **Benefit:** 75% = $1,052.05
45732	MANDIBLE OR MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.109 of explanatory notes to this Category)* **Fee:** $1,579.20 **Benefit:** 75% = $1,184.40
45735	MANDIBLE AND MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.109 of explanatory notes to this Category)* **Fee:** $1,611.05 **Benefit:** 75% = $1,208.30
45738	MANDIBLE AND MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.109 of explanatory notes to this Category)* **Fee:** $1,812.40 **Benefit:** 75% = $1,359.30
45741	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.109 of explanatory notes to this Category)* **Fee:** $1,772.30 **Benefit:** 75% = $1,329.25
45744	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.109 of explanatory notes to this Category)* **Fee:** $1,992.70 **Benefit:** 75% = $1,494.55

45747	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty (when performed) and transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.109 of explanatory notes to this Category)* **Fee:** $1,933.55 **Benefit:** 75% = $1,450.20 85% = $1,854.05
45752	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.109 of explanatory notes to this Category)* **Fee:** $2,165.75 **Benefit:** 75% = $1,624.35
45753	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III(Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) **Fee:** $2,178.60 **Benefit:** 75% = $1,633.95 85% = $2,099.10
45754	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) **Fee:** $2,611.60 **Benefit:** 75% = $1,958.70
45755	TEMPOROMANDIBULAR PARTIAL OR TOTAL MENISCECTOMY (Anaes.) (Assist.) **Fee:** $367.75 **Benefit:** 75% = $275.85 85% = $312.60
45758	TEMPORO-MANDIBULAR JOINT, arthroplasty (Anaes.) (Assist.) **Fee:** $658.05 **Benefit:** 75% = $493.55
45761	GENIOPLASTY, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para T8.110 of explanatory notes to this Category)* **Fee:** $748.65 **Benefit:** 75% = $561.50
45767	HYPERTELORISM, correction of, intracranial (Anaes.) (Assist.) **Fee:** $2,511.65 **Benefit:** 75% = $1,883.75 85% = $2,432.15
45770	HYPERTELORISM, correction of, subcranial (Anaes.) (Assist.) **Fee:** $1,923.90 **Benefit:** 75% = $1,442.95
45773	TREACHER COLLINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone grafts (Anaes.) (Assist.) **Fee:** $1,753.40 **Benefit:** 75% = $1,315.05 85% = $1,673.90
45776	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, intracranial (Anaes.) (Assist.) **Fee:** $1,753.40 **Benefit:** 75% = $1,315.05
45779	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.) **Fee:** $1,289.15 **Benefit:** 75% = $966.90
45782	FRONTOORBITAL ADVANCEMENT, UNILATERAL (Anaes.) (Assist.) **Fee:** $985.70 **Benefit:** 75% = $739.30 85% = $906.20
45785	CRANIAL VAULT RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar condition (bilateral frontoorbital advancement) (Anaes.) (Assist.) **Fee:** $1,668.10 **Benefit:** 75% = $1,251.10
45788	GLENOID FOSSA, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, (Obwegeser technique) (Anaes.) (Assist.) **Fee:** $1,649.10 **Benefit:** 75% = $1,236.85
45791	ABSENT CONDYLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF, not including harvesting of graft material (Anaes.) (Assist.) **Fee:** $890.85 **Benefit:** 75% = $668.15
45794	OSSEO-INTEGRATION PROCEDURE - extra-oral, implantation of titanium fixture, not for implantable bone conduction hearing system device (Anaes.) **Fee:** $503.85 **Benefit:** 75% = $377.90 85% = $428.30

45797	OSSEO-INTEGRATION PROCEDURE, fixation of transcutaneous abutment, not for implantable bone conduction hearing system device (Anaes.) **Fee:** $186.50 **Benefit:** 75% = $139.90 85% = $158.55
	ORAL AND MAXILLOFACIAL SURGERY
45799	ASPIRATION BIOPSY of 1 or MORE JAW CYSTS as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (Anaes.) **Fee:** $29.45 **Benefit:** 75% = $22.10 85% = $25.05
45801	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation),in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 45803 applies (Anaes.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $126.90 **Benefit:** 75% = $95.20 85% = $107.90
45803	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15
45805	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $172.50 **Benefit:** 75% = $129.40 85% = $146.65
45807	TUMOUR, CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, removal of, not being a service to which another item in this Subgroup applies, involving muscle, bone, or other deep tissue (Anaes.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $246.50 **Benefit:** 75% = $184.90 85% = $209.55
45809	TUMOUR OR DEEP CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), in the oral and maxillofacial region, removal of, requiring wide excision, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $371.50 **Benefit:** 75% = $278.65 85% = $315.80
45811	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $502.25 **Benefit:** 75% = $376.70 85% = $426.95
45813	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $508.10
45815	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.) **Fee:** $356.35 **Benefit:** 75% = $267.30 85% = $302.90
45817	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.) **Fee:** $464.50 **Benefit:** 75% = $348.40 85% = $394.85
45819	OPERATION ON ANY COMBINATION OF ADJOINING BONES IN THE ORAL AND MAXILLOFACIAL REGION, being bones referred to in item 45817 (Anaes.) (Assist.) **Fee:** $587.55 **Benefit:** 75% = $440.70 85% = $508.05
45821	BONE GROWTH STIMULATOR IN THE ORAL AND MAXILLOFACIAL REGION, insertion of (Anaes.) (Assist.) **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70

45823	ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $108.90 **Benefit:** 75% = $81.70 85% = $92.60
45825	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) **Fee:** $338.35 **Benefit:** 75% = $253.80 85% = $287.60
45827	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) **Fee:** $323.40 **Benefit:** 75% = $242.55 85% = $274.90
45829	MAXILLARY TUBEROSITY, reduction of (Anaes.) **Fee:** $246.70 **Benefit:** 75% = $185.05 85% = $209.70
45831	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.) **Fee:** $323.40 **Benefit:** 75% = $242.55 85% = $274.90
45833	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.) **Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15
45835	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.) **Fee:** $503.85 **Benefit:** 75% = $377.90 85% = $428.30
45837	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) **Fee:** $586.50 **Benefit:** 75% = $439.90 85% = $507.00
45839	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.) **Fee:** $586.50 **Benefit:** 75% = $439.90 85% = $507.00
45841	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) **Fee:** $473.65 **Benefit:** 75% = $355.25 85% = $402.65
45843	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.) **Fee:** $290.50 **Benefit:** 75% = $217.90 85% = $246.95
45845	OSSEO-INTEGRATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $503.85 **Benefit:** 75% = $377.90 85% = $428.30
45847	OSSEO-INTEGRATION PROCEDURE - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $186.50 **Benefit:** 75% = $139.90 85% = $158.55
45849	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.) **Fee:** $580.90 **Benefit:** 75% = $435.70 85% = $501.40
45851	TEMPOROMANDIBULAR JOINT, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) **Fee:** $142.95 **Benefit:** 75% = $107.25 85% = $121.55
45853	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.) **Fee:** $890.85 **Benefit:** 75% = $668.15 85% = $811.35
45855	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.) **Fee:** $408.70 **Benefit:** 75% = $306.55 85% = $347.40
45857	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedure of that joint, not being a service associated with any other arthroscopic procedure of the temporomandibular joint (Anaes.) (Assist.) **Fee:** $653.80 **Benefit:** 75% = $490.35 85% = $574.30

45859	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $329.60 **Benefit:** 75% = $247.20 85% = $280.20
45861	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $872.30 **Benefit:** 75% = $654.25 85% = $792.80
45863	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $967.00 **Benefit:** 75% = $725.25 85% = $887.50
45865	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) **Fee:** $290.50 **Benefit:** 75% = $217.90 85% = $246.95
45867	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $312.30 **Benefit:** 75% = $234.25 85% = $265.50
45869	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including partial or total meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,188.20 **Benefit:** 75% = $891.15 85% = $1,108.70
45871	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,338.45 **Benefit:** 75% = $1,003.85 85% = $1,258.95
45873	TEMPOROMANDIBULAR JOINT, surgery of, involving procedures to which items 45863, 45867, 45869 and 45871 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,504.05 **Benefit:** 75% = $1,128.05 85% = $1,424.55
45875	TEMPOROMANDIBULAR JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $470.70 **Benefit:** 75% = $353.05 85% = $400.10
45877	TEMPOROMANDIBULAR JOINT, arthrodesis of, with synovectomy if performed, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $470.70 **Benefit:** 75% = $353.05 85% = $400.10
45879	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) **Fee:** $312.30 **Benefit:** 75% = $234.25 85% = $265.50
45882	The treatment of a premalignant lesion of the oral mucosa by a treatment using cryotherapy, diathermy or carbon dioxide laser. **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55
45885	Facial, mandibular or lingual artery or vein or artery and vein, ligation of, not being a service to which item 41707 applies (Anaes.) (Assist.) **Fee:** $443.70 **Benefit:** 75% = $332.80 85% = $377.15
45888	FOREIGN BODY, in the oral and maxillofacial region, deep, removal of using interventional imaging techniques (Anaes.) (Assist.) **Fee:** $413.55 **Benefit:** 75% = $310.20 85% = $351.55
45891	SINGLE-STAGE LOCAL FLAP where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.) **Fee:** $602.45 **Benefit:** 75% = $451.85 85% = $522.95
45894	FREE GRAFTING, in the oral and maxillofacial region, (mucosa or split skin) of a granulating area (Anaes.) **Fee:** $204.70 **Benefit:** 75% = $153.55 85% = $174.00
45897	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.) **Fee:** $1,069.10 **Benefit:** 75% = $801.85 85% = $989.60
45900	MANDIBLE, fixation by intermaxillary wiring, excluding wiring for obesity **Fee:** $241.15 **Benefit:** 75% = $180.90 85% = $205.00

45939	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.) **Fee:** $447.10 **Benefit:** 75% = $335.35 85% = $380.05
45945	MANDIBLE, treatment of a dislocation of, requiring open reduction (Anaes.) **Fee:** $118.70 **Benefit:** 75% = $89.05 85% = $100.90
45975	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting *(See para T8.112 of explanatory notes to this Category)* **Fee:** $129.20 **Benefit:** 75% = $96.90 85% = $109.85
45978	MANDIBLE, treatment of fracture of, not requiring splinting *(See para T8.112 of explanatory notes to this Category)* **Fee:** $157.85 **Benefit:** 75% = $118.40 85% = $134.20
45981	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction *(See para T8.112 of explanatory notes to this Category)* **Fee:** $85.65 **Benefit:** 75% = $64.25 85% = $72.85
45984	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction not involving plate(s) (Anaes.) (Assist.) *(See para T8.112 of explanatory notes to this Category)* **Fee:** $616.65 **Benefit:** 75% = $462.50 85% = $537.15
45987	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) *(See para T8.112 of explanatory notes to this Category)* **Fee:** $616.65 **Benefit:** 75% = $462.50 85% = $537.15
45990	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) *(See para T8.112 of explanatory notes to this Category)* **Fee:** $842.25 **Benefit:** 75% = $631.70 85% = $762.75
45993	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) *(See para T8.112 of explanatory notes to this Category)* **Fee:** $842.25 **Benefit:** 75% = $631.70 85% = $762.75
45996	MANDIBLE, treatment of a closed fracture of, involving a joint surface (Anaes.) *(See para T8.112 of explanatory notes to this Category)* **Fee:** $238.80 **Benefit:** 75% = $179.10 85% = $203.00
	SUBGROUP 14 - HAND SURGERY
46300	*Note: Items 46300 to 46534 are restricted to surgery on the hand/s.* INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $338.40 **Benefit:** 75% = $253.80
46303	CARPOMETACARPAL JOINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $376.10 **Benefit:** 75% = $282.10
46306	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, interposition arthroplasty of and including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.) **Fee:** $526.50 **Benefit:** 75% = $394.90
46307	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT - volar plate arthroplasty for traumatic deformity including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.) **Fee:** $526.50 **Benefit:** 75% = $394.90
46309	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 1 joint (Anaes.) (Assist.) **Fee:** $526.50 **Benefit:** 75% = $394.90

46312	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 2 joints (Anaes.) (Assist.) **Fee:** $676.95 **Benefit:** 75% = $507.75
46315	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 3 joints (Anaes.) (Assist.) **Fee:** $902.55 **Benefit:** 75% = $676.95
46318	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 4 joints (Anaes.) (Assist.) **Fee:** $1,128.25 **Benefit:** 75% = $846.20
46321	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 5 or more joints (Anaes.) (Assist.) **Fee:** $1,353.90 **Benefit:** 75% = $1,015.45 85% = $1,274.40
46324	CARPAL BONE REPLACEMENT ARTHROPLASTY including associated tendon transfer or realignment when performed (Anaes.) (Assist.) **Fee:** $807.35 **Benefit:** 75% = $605.55
46325	CARPAL BONE REPLACEMENT OR RESECTION ARTHROPLASTY using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed (Anaes.) (Assist.) **Fee:** $842.50 **Benefit:** 75% = $631.90
46327	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of (Anaes.) **Fee:** $203.15 **Benefit:** 75% = $152.40 85% = $172.70
46330	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous or capsular repair with or without arthrotomy (Anaes.) (Assist.) **Fee:** $346.10 **Benefit:** 75% = $259.60
46333	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of, using free tissue graft or implant (Anaes.) (Assist.) **Fee:** $564.05 **Benefit:** 75% = $423.05
46336	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, capsulectomy or debridement of, not being a service associated with any procedure related to that joint (Anaes.) (Assist.) **Fee:** $263.30 **Benefit:** 75% = $197.50 85% = $223.85
46339	EXTENSOR TENDONS or FLEXOR TENDONS of hand or wrist, synovectomy of (Anaes.) (Assist.) **Fee:** $466.20 **Benefit:** 75% = $349.65 85% = $396.30
46342	DISTAL RADIOULNAR JOINT or CARPOMETACARPAL JOINT OR JOINTS, synovectomy of (Anaes.) (Assist.) **Fee:** $466.20 **Benefit:** 75% = $349.65
46345	DISTAL RADIOULNAR JOINT, reconstruction or stabilisation of, including fusion, or ligamentous arthroplasty and excision of distal ulna, when performed (Anaes.) (Assist.) **Fee:** $564.05 **Benefit:** 75% = $423.05
46348	DIGIT, synovectomy of flexor tendon or tendons - 1 digit (Anaes.) **Fee:** $244.45 **Benefit:** 75% = $183.35 85% = $207.80
46351	DIGIT, synovectomy of flexor tendon or tendons - 2 digits (Anaes.) (Assist.) **Fee:** $364.80 **Benefit:** 75% = $273.60
46354	DIGIT, synovectomy of flexor tendon or tendons - 3 digits (Anaes.) (Assist.) **Fee:** $488.85 **Benefit:** 75% = $366.65
46357	DIGIT, synovectomy of flexor tendon or tendons - 4 digits (Anaes.) (Assist.) **Fee:** $609.20 **Benefit:** 75% = $456.90 85% = $529.70
46360	DIGIT, synovectomy of flexor tendon or tendons - 5 digits (Anaes.) (Assist.) **Fee:** $733.35 **Benefit:** 75% = $550.05
46363	TENDON SHEATH OF HAND OR WRIST, open operation on, for STENOSING TENOVAGINITIS (Anaes.) **Fee:** $210.60 **Benefit:** 75% = $157.95 85% = $179.05

46366	DUPUYTREN'S CONTRACTURE, subcutaneous fasciotomy for - each hand (Anaes.) **Fee:** $127.90 **Benefit:** 75% = $95.95 85% = $108.75
46369	DUPUYTREN'S CONTRACTURE, palmar fasciectomy for - 1 hand (Anaes.) **Fee:** $210.60 **Benefit:** 75% = $157.95 85% = $179.05
46372	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand (Anaes.) (Assist.) **Fee:** $427.95 **Benefit:** 75% = $321.00 85% = $363.80
46375	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - 1 hand (Anaes.) (Assist.) **Fee:** $507.70 **Benefit:** 75% = $380.80 85% = $431.55
46378	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - 1 hand (Anaes.) (Assist.) **Fee:** $676.95 **Benefit:** 75% = $507.75
46381	INTER-PHALANGEAL JOINT, joint capsule release when performed in conjunction with operation for Dupuytren's Contracture - each procedure (Anaes.) (Assist.) **Fee:** $300.80 **Benefit:** 75% = $225.60
46384	Z PLASTY (or similar local flap procedure) when performed in conjunction with operation for Dupuytren's Contracture - 1 such procedure (Anaes.) (Assist.) **Fee:** $300.80 **Benefit:** 75% = $225.60
46387	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - operation for recurrence in that ray (Anaes.) (Assist.) **Fee:** $620.60 **Benefit:** 75% = $465.45 85% = $541.10
46390	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - operation for recurrence in those rays (Anaes.) (Assist.) **Fee:** $827.50 **Benefit:** 75% = $620.65
46393	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - operation for recurrence in those rays (Anaes.) (Assist.) **Fee:** $959.00 **Benefit:** 75% = $719.25
46396	PHALANX OR METACARPAL OF THE HAND, osteotomy or osteectomy of, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $329.60 **Benefit:** 75% = $247.20 85% = $280.20
46399	PHALANX OR METACARPAL OF THE HAND, osteotomy of, with internal fixation (Anaes.) (Assist.) **Fee:** $517.80 **Benefit:** 75% = $388.35
46402	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), including obtaining of graft material (Anaes.) (Assist.) **Fee:** $517.80 **Benefit:** 75% = $388.35
46405	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), involving internal fixation and including obtaining of graft material (Anaes.) (Assist.) **Fee:** $631.90 **Benefit:** 75% = $473.95
46408	TENDON, reconstruction of, by tendon graft (Anaes.) (Assist.) **Fee:** $692.00 **Benefit:** 75% = $519.00
46411	FLEXOR TENDON PULLEY, reconstruction of, by graft (Anaes.) (Assist.) **Fee:** $406.15 **Benefit:** 75% = $304.65
46414	ARTIFICIAL TENDON PROSTHESIS, INSERTION OF, in preparation for tendon grafting (Anaes.) (Assist.) **Fee:** $526.40 **Benefit:** 75% = $394.80 85% = $447.45
46417	TENDON transfer for restoration of hand function, each transfer (Anaes.) (Assist.) **Fee:** $488.85 **Benefit:** 75% = $366.65
46420	EXTENSOR TENDON OF HAND OR WRIST, primary repair of, each tendon (Anaes.) **Fee:** $204.60 **Benefit:** 75% = $153.45 85% = $173.95

46423	EXTENSOR TENDON OF HAND OR WRIST, secondary repair of, each tendon (Anaes.) (Assist.) **Fee:** $327.15 **Benefit:** 75% = $245.40 85% = $278.10
46426	FLEXOR TENDON OF HAND OR WRIST, primary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $338.40 **Benefit:** 75% = $253.80
46429	FLEXOR TENDON OF HAND OR WRIST, secondary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $413.65 **Benefit:** 75% = $310.25 85% = $351.65
46432	FLEXOR TENDON OF HAND, primary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $451.35 **Benefit:** 75% = $338.55
46435	FLEXOR TENDON OF HAND, secondary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $526.50 **Benefit:** 75% = $394.90
46438	MALLET FINGER, closed pin fixation of (Anaes.) **Fee:** $135.45 **Benefit:** 75% = $101.60 85% = $115.15
46441	MALLET FINGER, open repair of, including pin fixation when performed (Anaes.) (Assist.) **Fee:** $327.15 **Benefit:** 75% = $245.40 85% = $278.10
46442	MALLET FINGER with intra articular fracture involving more than one third of base of terminal phalanx - open reduction (Anaes.) (Assist.) **Fee:** $280.85 **Benefit:** 75% = $210.65
46444	BOUTONNIERE DEFORMITY without joint contracture, reconstruction of (Anaes.) (Assist.) **Fee:** $488.85 **Benefit:** 75% = $366.65
46447	BOUTONNIERE DEFORMITY with joint contracture, reconstruction of (Anaes.) (Assist.) **Fee:** $609.20 **Benefit:** 75% = $456.90
46450	EXTENSOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) **Fee:** $225.70 **Benefit:** 75% = $169.30
46453	FLEXOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) (Assist.) **Fee:** $376.10 **Benefit:** 75% = $282.10
46456	FINGER, percutaneous tenotomy of (Anaes.) **Fee:** $97.80 **Benefit:** 75% = $73.35 85% = $83.15
46459	OPERATION for OSTEOMYELITIS on distal phalanx (Anaes.) **Fee:** $188.05 **Benefit:** 75% = $141.05 85% = $159.85
46462	OPERATION for OSTEOMYELITIS on middle or proximal phalanx, metacarpal or carpus (Anaes.) (Assist.) **Fee:** $300.80 **Benefit:** 75% = $225.60 85% = $255.70
46464	AMPUTATION of a supernumerary complete digit (Anaes.) **Fee:** $225.70 **Benefit:** 75% = $169.30 85% = $191.85
46465	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) **Fee:** $225.70 **Benefit:** 75% = $169.30 85% = $191.85
46468	AMPUTATION of 2 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $394.90 **Benefit:** 75% = $296.20
46471	AMPUTATION of 3 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $564.05 **Benefit:** 75% = $423.05 85% = $484.55
46474	AMPUTATION of 4 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $733.35 **Benefit:** 75% = $550.05

46477	AMPUTATION of 5 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $902.55	**Benefit:** 75% = $676.95	
46480	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover, including metacarpal (Anaes.) (Assist.) **Fee:** $376.10	**Benefit:** 75% = $282.10	85% = $319.70
46483	REVISION of AMPUTATION STUMP to provide adequate soft tissue cover (Anaes.) (Assist.) **Fee:** $300.80	**Benefit:** 75% = $225.60	85% = $255.70
46486	NAIL BED, accurate reconstruction of nail bed laceration using magnification, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $225.70	**Benefit:** 75% = $169.30	85% = $191.85
46489	NAIL BED, secondary exploration and accurate repair of nail bed deformity using magnification, undertaken in the operating theatre of a hospital (Anaes.) (Assist.) **Fee:** $263.30	**Benefit:** 75% = $197.50	85% = $223.85
46492	CONTRACTURE OF DIGITS OF HAND, flexor or extensor, correction of, involving tissues deeper than skin and subcutaneous tissue (Anaes.) (Assist.) **Fee:** $361.05	**Benefit:** 75% = $270.80	
46494	GANGLION OF HAND, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $219.95	**Benefit:** 75% = $165.00	85% = $187.00
46495	GANGLION OR MUCOUS CYST OF DISTAL DIGIT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) **Fee:** $203.15	**Benefit:** 75% = $152.40	85% = $172.70
46498	GANGLION OF FLEXOR TENDON SHEATH, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) **Fee:** $219.95	**Benefit:** 75% = $165.00	85% = $187.00
46500	GANGLION OF DORSAL WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.) **Fee:** $263.30	**Benefit:** 75% = $197.50	85% = $223.85
46501	GANGLION OF VOLAR WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.) **Fee:** $329.20	**Benefit:** 75% = $246.90	85% = $279.85
46502	RECURRENT GANGLION OF DORSAL WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.) **Fee:** $302.95	**Benefit:** 75% = $227.25	85% = $257.55
46503	RECURRENT GANGLION OF VOLAR WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.) **Fee:** $378.40	**Benefit:** 75% = $283.80	85% = $321.65
46504	NEUROVASCULAR ISLAND FLAP, for pulp innervation (Anaes.) (Assist.) **Fee:** $1,105.55	**Benefit:** 75% = $829.20	85% = $1,026.05
46507	DIGIT OR RAY, transposition or transfer of, on vascular pedicle, complete procedure (Anaes.) (Assist.) **Fee:** $1,286.20	**Benefit:** 75% = $964.65	
46510	MACRODACTYLY, surgical reduction of enlarged elements - each digit (Anaes.) (Assist.) **Fee:** $351.00	**Benefit:** 75% = $263.25	
46513	DIGITAL NAIL OF FINGER OR THUMB, removal of, not being a service to which item 46516 applies (Anaes.) **Fee:** $56.50	**Benefit:** 75% = $42.40	85% = $48.05
46516	DIGITAL NAIL OF FINGER OR THUMB, removal of, in the operating theatre of a hospital (Anaes.) **Fee:** $112.85	**Benefit:** 75% = $84.65	85% = $95.95

46519	MIDDLE PALMAR, THENAR OR HYPOTHENAR SPACES OF HAND, drainage of (excluding aftercare) (Anaes.) **Fee:** $141.25 **Benefit:** 75% = $105.95 85% = $120.10
46522	FLEXOR TENDON SHEATH OF FINGER OR THUMB, open operation and drainage for infection (Anaes.) (Assist.) **Fee:** $421.20 **Benefit:** 75% = $315.90
46525	PULP SPACE INFECTION, PARONYCHIA OF HAND, incision for, when performed in an operating theatre of a hospital, not being a service to which another item in this Group applies (excluding after-care) (Anaes.) **Fee:** $56.50 **Benefit:** 75% = $42.40 85% = $48.05
46528	INGROWING NAIL OF FINGER OR THUMB, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
46531	INGROWING NAIL OF FINGER OR THUMB, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.) **Fee:** $85.15 **Benefit:** 75% = $63.90 85% = $72.40
46534	NAIL PLATE INJURY OR DEFORMITY, radical excision of nail germinal matrix (Anaes.) **Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20
	SUBGROUP 15 - ORTHOPAEDIC
	TREATMENT OF DISLOCATIONS
47000	MANDIBLE, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $70.65 **Benefit:** 75% = $53.00 85% = $60.10
47003	CLAVICLE, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $84.80 **Benefit:** 75% = $63.60 85% = $72.10
47006	CLAVICLE, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $170.25 **Benefit:** 75% = $127.70 85% = $144.75
47009	SHOULDER, treatment of dislocation of, requiring general anaesthesia, not being a service to which item 47012 applies (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
47012	SHOULDER, treatment of dislocation of, requiring general anaesthesia, open reduction (Anaes.) (Assist.) **Fee:** $338.85 **Benefit:** 75% = $254.15
47015	SHOULDER, treatment of dislocation of, not requiring general anaesthesia **Fee:** $84.80 **Benefit:** 75% = $63.60 85% = $72.10
47018	ELBOW, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $197.60 **Benefit:** 75% = $148.20 85% = $168.00
47021	ELBOW, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $263.60 **Benefit:** 75% = $197.70
47024	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not being a service associated with fracture or dislocation in the same region (Anaes.) **Fee:** $197.60 **Benefit:** 75% = $148.20 85% = $168.00
47027	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by open reduction, not being a service associated with fracture or dislocation in the same region (Anaes.) (Assist.) **Fee:** $263.60 **Benefit:** 75% = $197.70
47030	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $197.60 **Benefit:** 75% = $148.20 85% = $168.00
47033	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $263.60 **Benefit:** 75% = $197.70 85% = $224.10
47036	INTERPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $84.80 **Benefit:** 75% = $63.60 85% = $72.10

47039	INTERPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95
47042	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95
47045	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $150.75 **Benefit:** 75% = $113.10 85% = $128.15
47048	HIP, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $324.80 **Benefit:** 75% = $243.60 85% = $276.10
47051	HIP, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $432.95 **Benefit:** 75% = $324.75
47054	KNEE, treatment of dislocation of, by closed reduction (Anaes.) (Assist.) **Fee:** $324.80 **Benefit:** 75% = $243.60 85% = $276.10
47057	PATELLA, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $127.00 **Benefit:** 75% = $95.25 85% = $107.95
47060	PATELLA, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
47063	ANKLE or TARSUS, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $254.20 **Benefit:** 75% = $190.65 85% = $216.10
47066	ANKLE or TARSUS, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $338.85 **Benefit:** 75% = $254.15
47069	TOE, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $70.65 **Benefit:** 75% = $53.00 85% = $60.10
47072	TOE, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $94.00 **Benefit:** 75% = $70.50 85% = $79.90
	TREATMENT OF FRACTURES
47300	DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by closed reduction, including percutaneous fixation where used (Anaes.) **Fee:** $84.80 **Benefit:** 75% = $63.60 85% = $72.10
47303	DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by closed reduction (Anaes.) **Fee:** $98.90 **Benefit:** 75% = $74.20 85% = $84.10
47306	DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by open reduction (Anaes.) **Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95
47309	DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by open reduction (Anaes.) **Fee:** $141.25 **Benefit:** 75% = $105.95 85% = $120.10
47312	MIDDLE PHALANX of FINGER, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $127.00 **Benefit:** 75% = $95.25 85% = $107.95
47315	MIDDLE PHALANX of FINGER, treatment of intra-articular fracture of, by closed reduction (Anaes.) **Fee:** $145.95 **Benefit:** 75% = $109.50 85% = $124.10
47318	MIDDLE PHALANX OF FINGER, treatment of fracture of, by open reduction (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
47321	MIDDLE PHALANX OF FINGER, treatment of intra-articular fracture of, by open reduction (Anaes.) **Fee:** $211.75 **Benefit:** 75% = $158.85
47324	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10

47327	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by closed reduction (Anaes.) **Fee:** $197.60 **Benefit:** 75% = $148.20 85% = $168.00
47330	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by open reduction (Anaes.) **Fee:** $226.00 **Benefit:** 75% = $169.50 85% = $192.10
47333	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by open operation (Anaes.) (Assist.) **Fee:** $282.35 **Benefit:** 75% = $211.80
47336	METACARPAL, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
47339	METACARPAL, treatment of intra-articular fracture of, by closed reduction (Anaes.) **Fee:** $197.60 **Benefit:** 75% = $148.20 85% = $168.00
47342	METACARPAL, treatment of fracture of, by open reduction (Anaes.) **Fee:** $226.00 **Benefit:** 75% = $169.50 85% = $192.10
47345	METACARPAL, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $282.35 **Benefit:** 75% = $211.80
47348	CARPUS (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies (Anaes.) **Fee:** $94.00 **Benefit:** 75% = $70.50 85% = $79.90
47351	CARPUS (excluding scaphoid), treatment of fracture of, by open reduction (Anaes.) **Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20
47354	CARPAL SCAPHOID, treatment of fracture of, not being a service to which item 47357 applies (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
47357	CARPAL SCAPHOID, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $376.55 **Benefit:** 75% = $282.45 85% = $320.10
47360	RADIUS OR ULNA, distal end of, treatment of fracture of, by cast immobilisation, not being a service to which item 47363 or 47366 applies (Anaes.) **Fee:** $131.85 **Benefit:** 75% = $98.90 85% = $112.10
47363	RADIUS OR ULNA, distal end of, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $197.60 **Benefit:** 75% = $148.20 85% = $168.00
47366	RADIUS OR ULNA, distal end of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $263.60 **Benefit:** 75% = $197.70 85% = $224.10
47369	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by cast immobilisation, not being a service to which item 47372 or 47375 applies (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
47372	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.) **Fee:** $282.35 **Benefit:** 75% = $211.80 85% = $240.00
47375	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $376.55 **Benefit:** 75% = $282.45
47378	RADIUS OR ULNA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47381, 47384, 47385 or 47386 applies (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
47381	RADIUS OR ULNA, shaft of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $254.20 **Benefit:** 75% = $190.65 85% = $216.10
47384	RADIUS OR ULNA, shaft of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $338.85 **Benefit:** 75% = $254.15

47385	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital (Anaes.) (Assist.) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
47386	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by open reduction or internal fixation (Anaes.) (Assist.) **Fee:** $470.70 **Benefit:** 75% = $353.05
47387	RADIUS AND ULNA, shafts of, treatment of fracture of, by cast immobilisation, not being a service to which item 47390 or 47393 applies (Anaes.) (Assist.) **Fee:** $272.95 **Benefit:** 75% = $204.75 85% = $232.05
47390	RADIUS AND ULNA, shafts of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $409.55 **Benefit:** 75% = $307.20
47393	RADIUS AND ULNA, shafts of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $546.00 **Benefit:** 75% = $409.50
47396	OLECRANON, treatment of fracture of, not being a service to which item 47399 applies (Anaes.) **Fee:** $188.20 **Benefit:** 75% = $141.15 85% = $160.00
47399	OLECRANON, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $376.55 **Benefit:** 75% = $282.45
47402	OLECRANON, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (Anaes.) (Assist.) **Fee:** $282.35 **Benefit:** 75% = $211.80 85% = $240.00
47405	RADIUS, treatment of fracture of head or neck of, closed reduction of (Anaes.) **Fee:** $188.20 **Benefit:** 75% = $141.15 85% = $160.00
47408	RADIUS, treatment of fracture of head or neck of, open reduction of, including internal fixation and excision where performed (Anaes.) (Assist.) **Fee:** $376.55 **Benefit:** 75% = $282.45
47411	HUMERUS, treatment of fracture of tuberosity of, not being a service to which item 47417 applies (Anaes.) **Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95
47414	HUMERUS, treatment of fracture of tuberosity of, by open reduction (Anaes.) **Fee:** $226.00 **Benefit:** 75% = $169.50 85% = $192.10
47417	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) **Fee:** $263.60 **Benefit:** 75% = $197.70 85% = $224.10
47420	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) **Fee:** $517.80 **Benefit:** 75% = $388.35
47423	HUMERUS, proximal, treatment of fracture of, not being a service to which item 47426, 47429 or 47432 applies (Anaes.) **Fee:** $216.50 **Benefit:** 75% = $162.40 85% = $184.05
47426	HUMERUS, proximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $324.80 **Benefit:** 75% = $243.60 85% = $276.10
47429	HUMERUS, proximal, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $432.95 **Benefit:** 75% = $324.75
47432	HUMERUS, proximal, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $541.30 **Benefit:** 75% = $406.00
47435	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) **Fee:** $414.25 **Benefit:** 75% = $310.70 85% = $352.15
47438	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) **Fee:** $659.15 **Benefit:** 75% = $494.40

47441	HUMERUS, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) **Fee:** $823.75 **Benefit:** 75% = $617.85
47444	HUMERUS, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies (Anaes.) **Fee:** $226.00 **Benefit:** 75% = $169.50 85% = $192.10
47447	HUMERUS, shaft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $338.85 **Benefit:** 75% = $254.15
47450	HUMERUS, shaft of, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.) **Fee:** $451.95 **Benefit:** 75% = $339.00
47451	HUMERUS, shaft of, treatment of fracture of, by intramedullary fixation (Anaes.) (Assist.) **Fee:** $544.80 **Benefit:** 75% = $408.60
47453	HUMERUS, distal, (supracondylar or condylar), treatment of fracture of, not being a service to which item 47456 or 47459 applies (Anaes.) (Assist.) **Fee:** $263.60 **Benefit:** 75% = $197.70 85% = $224.10
47456	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $395.50 **Benefit:** 75% = $296.65 85% = $336.20
47459	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken in the operating theatre of a hospital (Anaes.) (Assist.) **Fee:** $527.25 **Benefit:** 75% = $395.45
47462	CLAVICLE, treatment of fracture of, not being a service to which item 47465 applies (Anaes.) **Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95
47465	CLAVICLE, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $226.00 **Benefit:** 75% = $169.50 85% = $192.10
47466	STERNUM, treatment of fracture of, not being a service to which item 47467 applies (Anaes.) **Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95
47467	STERNUM, treatment of fracture of, by open reduction (Anaes.) **Fee:** $226.00 **Benefit:** 75% = $169.50
47468	SCAPULA, neck or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $432.95 **Benefit:** 75% = $324.75 85% = $368.05
47471	RIBS (1 or more), treatment of fracture of - each attendance **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55
47474	PELVIC RING, treatment of fracture of, not involving disruption of pelvic ring or acetabulum **Fee:** $188.20 **Benefit:** 75% = $141.15 85% = $160.00
47477	PELVIC RING, treatment of fracture of, with disruption of pelvic ring or acetabulum **Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20
47480	PELVIC RING, treatment of fracture of, requiring traction (Anaes.) (Assist.) **Fee:** $470.70 **Benefit:** 75% = $353.05
47483	PELVIC RING, treatment of fracture of, requiring control by external fixation (Anaes.) (Assist.) **Fee:** $564.85 **Benefit:** 75% = $423.65
47486	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of anterior segment, including diastasis of pubic symphysis (Anaes.) (Assist.) **Fee:** $941.45 **Benefit:** 75% = $706.10
47489	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of posterior segment (including sacro-iliac joint), with or without fixation of anterior segment (Anaes.) (Assist.) **Fee:** $1,412.20 **Benefit:** 75% = $1,059.15

47492	ACETABULUM, treatment of fracture of, and associated dislocation of hip (Anaes.) **Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20
47495	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring traction (Anaes.) (Assist.) **Fee:** $470.70 **Benefit:** 75% = $353.05 85% = $400.10
47498	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, with or without traction (Anaes.) (Assist.) **Fee:** $706.05 **Benefit:** 75% = $529.55
47501	ACETABULUM, treatment of single column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $941.45 **Benefit:** 75% = $706.10
47504	ACETABULUM, treatment of T-shape fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $1,412.20 **Benefit:** 75% = $1,059.15 85% = $1,332.70
47507	ACETABULUM, treatment of transverse fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $1,412.20 **Benefit:** 75% = $1,059.15
47510	ACETABULUM, treatment of double column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $1,412.20 **Benefit:** 75% = $1,059.15
47513	SACRO-ILIAC JOINT DISRUPTION, treatment of, requiring internal fixation, being a service associated with a service to which items 47501 to 47510 apply (Anaes.) (Assist.) **Fee:** $376.55 **Benefit:** 75% = $282.45
47516	FEMUR, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.) **Fee:** $432.95 **Benefit:** 75% = $324.75 85% = $368.05
47519	FEMUR, treatment of trochanteric or subcapital fracture of, by internal fixation (Anaes.) (Assist.) **Fee:** $866.20 **Benefit:** 75% = $649.65
47522	FEMUR, treatment of subcapital fracture of, by hemi-arthroplasty (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95
47525	FEMUR, treatment of fracture of, for slipped capital femoral epiphysis (Anaes.) (Assist.) **Fee:** $866.20 **Benefit:** 75% = $649.65
47528	FEMUR, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95
47531	FEMUR, treatment of fracture of shaft, by intramedullary fixation and cross fixation (Anaes.) (Assist.) **Fee:** $960.25 **Benefit:** 75% = $720.20
47534	FEMUR, condylar region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring internal fixation, with or without internal fixation of 1 or more osteochondral fragments (Anaes.) (Assist.) **Fee:** $1,082.70 **Benefit:** 75% = $812.05
47537	FEMUR, condylar region of, treatment of fracture of, requiring internal fixation of 1 or more osteochondral fragments, not being a service associated with a service to which item 47534 applies (Anaes.) (Assist.) **Fee:** $432.95 **Benefit:** 75% = $324.75 85% = $368.05
47540	HIP SPICA OR SHOULDER SPICA, application of, as an independent procedure (Anaes.) **Fee:** $216.50 **Benefit:** 75% = $162.40 85% = $184.05
47543	TIBIA, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies (Anaes.) **Fee:** $226.00 **Benefit:** 75% = $169.50 85% = $192.10

47546	TIBIA, plateau of, treatment of medial or lateral fracture of, by closed reduction (Anaes.) **Fee:** $338.85 **Benefit:** 75% = $254.15 85% = $288.05
47549	TIBIA, plateau of, treatment of medial or lateral fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $451.95 **Benefit:** 75% = $339.00
47552	TIBIA, plateau of, treatment of both medial and lateral fractures of, not being a service to which item 47555 or 47558 applies (Anaes.) (Assist.) **Fee:** $376.55 **Benefit:** 75% = $282.45 85% = $320.10
47555	TIBIA, plateau of, treatment of both medial and lateral fractures of, by closed reduction (Anaes.) **Fee:** $564.85 **Benefit:** 75% = $423.65
47558	TIBIA, plateau of, treatment of both medial and lateral fractures of, by open reduction (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95
47561	TIBIA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47564, 47567, 47570 or 47573 applies (Anaes.) **Fee:** $272.95 **Benefit:** 75% = $204.75 85% = $232.05
47564	TIBIA, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) **Fee:** $409.55 **Benefit:** 75% = $307.20 85% = $348.15
47565	TIBIA, shaft of, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.) **Fee:** $712.40 **Benefit:** 75% = $534.30
47566	TIBIA, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (Anaes.) (Assist.) **Fee:** $908.05 **Benefit:** 75% = $681.05
47567	TIBIA, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) (Assist.) **Fee:** $475.35 **Benefit:** 75% = $356.55 85% = $404.05
47570	TIBIA, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Anaes.) (Assist.) **Fee:** $546.00 **Benefit:** 75% = $409.50 85% = $466.50
47573	TIBIA, shaft of, treatment of intra-articular fracture of, by open reduction, with or without treatment of fibula fracture (Anaes.) (Assist.) **Fee:** $682.55 **Benefit:** 75% = $511.95
47576	FIBULA, treatment of fracture of (Anaes.) **Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95
47579	PATELLA, treatment of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.) **Fee:** $160.05 **Benefit:** 75% = $120.05 85% = $136.05
47582	PATELLA, treatment of fracture of, by excision of patella or pole with reattachment of tendon (Anaes.) (Assist.) **Fee:** $329.60 **Benefit:** 75% = $247.20
47585	PATELLA, treatment of fracture of, by internal fixation (Anaes.) (Assist.) **Fee:** $423.75 **Benefit:** 75% = $317.85
47588	KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes.) (Assist.) **Fee:** $1,317.80 **Benefit:** 75% = $988.35
47591	KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar and tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes.) (Assist.) **Fee:** $1,600.65 **Benefit:** 75% = $1,200.50
47594	ANKLE JOINT, treatment of fracture of, not being a service to which item 47597 applies (Anaes.) **Fee:** $216.50 **Benefit:** 75% = $162.40 85% = $184.05
47597	ANKLE JOINT, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $324.80 **Benefit:** 75% = $243.60 85% = $276.10

47600	ANKLE JOINT, treatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis (Anaes.) (Assist.) **Fee:** $432.95 **Benefit:** 75% = $324.75
47603	ANKLE JOINT, treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or diastasis (Anaes.) (Assist.) **Fee:** $564.85 **Benefit:** 75% = $423.65
47606	CALCANEUM OR TALUS, treatment of fracture of, not being a service to which item 47609, 47612, 47615 or 47618 applies, with or without dislocation (Anaes.) **Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20
47609	CALCANEUM OR TALUS, treatment of fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $353.05 **Benefit:** 75% = $264.80 85% = $300.10
47612	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $409.55 **Benefit:** 75% = $307.20 85% = $348.15
47615	CALCANEUM OR TALUS, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $470.70 **Benefit:** 75% = $353.05 85% = $400.10
47618	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $588.45 **Benefit:** 75% = $441.35
47621	TARSO-METATARSAL, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $409.55 **Benefit:** 75% = $307.20 85% = $348.15
47624	TARSO-METATARSAL, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $564.85 **Benefit:** 75% = $423.65
47627	TARSUS (excluding calcaneum or talus), treatment of fracture of (Anaes.) **Fee:** $160.05 **Benefit:** 75% = $120.05 85% = $136.05
47630	TARSUS (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $338.85 **Benefit:** 75% = $254.15 85% = $288.05
47633	METATARSAL, 1 of, treatment of fracture of (Anaes.) **Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95
47636	METATARSAL, 1 of, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
47639	METATARSAL, 1 of, treatment of fracture of, by open reduction (Anaes.) **Fee:** $226.00 **Benefit:** 75% = $169.50 85% = $192.10
47642	METATARSALS, 2 of, treatment of fracture of (Anaes.) **Fee:** $150.75 **Benefit:** 75% = $113.10 85% = $128.15
47645	METATARSALS, 2 of, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $226.00 **Benefit:** 75% = $169.50 85% = $192.10
47648	METATARSALS, 2 of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $301.05 **Benefit:** 75% = $225.80
47651	METATARSALS, 3 or more of, treatment of fracture of (Anaes.) **Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20
47654	METATARSALS, 3 or more of, treatment of fracture of, by closed reduction (Anaes.) (Assist.) **Fee:** $353.05 **Benefit:** 75% = $264.80 85% = $300.10
47657	METATARSALS, 3 or more of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $470.70 **Benefit:** 75% = $353.05
47663	PHALANX OF GREAT TOE, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $141.25 **Benefit:** 75% = $105.95 85% = $120.10

47666	PHALANX OF GREAT TOE, treatment of fracture of, by open reduction (Anaes.) **Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20
47672	PHALANX OF TOE (other than great toe), 1 of, treatment of fracture of, by open reduction (Anaes.) **Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95
47678	PHALANX OF TOE (other than great toe), more than 1 of, treatment of fracture of, by open reduction (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
47681	SPINE (excluding sacrum), treatment of fracture of transverse process, vertebral body, or posterior elements - each attendance **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55
47684	SPINE, treatment of fracture, dislocation or fracture-dislocation, without spinal cord involvement, with immobilisation by calipers or halo (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95 85% = $673.75
47687	SPINE, treatment of fracture, dislocation or fracture-dislocation, with spinal cord involvement, with immobilisation by calipers or halo, and including up to 14 days post-operative care (Assist.) **Fee:** $1,317.80 **Benefit:** 75% = $988.35
47690	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, with immobilisation by calipers or halo, requiring reduction by closed manipulation (Anaes.) (Assist.) **Fee:** $1,035.55 **Benefit:** 75% = $776.70
47693	SPINE, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, with immobilisation by calipers or halo, requiring reduction by closed manipulation, including up to 14 days post-operative care (Assist.) **Fee:** $1,317.80 **Benefit:** 75% = $988.35
47696	SPINE, reduction of fracture or dislocation of, without cord involvement, undertaken in the operating theatre of a hospital (Anaes.) (Assist.) **Fee:** $376.55 **Benefit:** 75% = $282.45 85% = $320.10
47699	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, requiring open reduction with or without internal fixation (Anaes.) (Assist.) **Fee:** $1,506.45 **Benefit:** 75% = $1,129.85
47702	SPINE, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, requiring open reduction with or without internal fixation, including up to 14 days post-operative care (Anaes.) (Assist.) **Fee:** $1,882.95 **Benefit:** 75% = $1,412.25
47703	SKULL, treatment of fracture of, each attendance **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55
47705	SKULL CALIPERS, insertion of, as an independent procedure (Anaes.) (Assist.) **Fee:** $282.35 **Benefit:** 75% = $211.80
47708	PLASTER JACKET, application of, as an independent procedure (Anaes.) **Fee:** $216.50 **Benefit:** 75% = $162.40 85% = $184.05
47711	HALO, application of, as an independent procedure (Anaes.) (Assist.) **Fee:** $320.15 **Benefit:** 75% = $240.15
47714	HALO, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.) **Fee:** $240.05 **Benefit:** 75% = $180.05
47717	HALO-THORACIC TRACTION - application of both halo and thoracic jacket (Anaes.) (Assist.) **Fee:** $423.75 **Benefit:** 75% = $317.85
47720	HALO-FEMORAL TRACTION, as an independent procedure (Anaes.) (Assist.) **Fee:** $423.75 **Benefit:** 75% = $317.85 85% = $360.20
47723	HALO-FEMORAL TRACTION, in conjunction with a major spine operation (Anaes.) (Assist.) **Fee:** $423.75 **Benefit:** 75% = $317.85 85% = $360.20
47726	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - small quantity (Anaes.) **Fee:** $141.25 **Benefit:** 75% = $105.95

47729	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - large quantity (Anaes.) **Fee:** $235.50 **Benefit:** 75% = $176.65
47732	VASCULARISED PEDICLE BONE GRAFT, harvesting of, in conjunction with another service (Anaes.) (Assist.) **Fee:** $376.55 **Benefit:** 75% = $282.45
47735	NASAL BONES, treatment of fracture of, not being a service to which item 47738 or 47741 applies - each attendance **Fee:** $43.05 **Benefit:** 75% = $32.30 85% = $36.60
47738	NASAL BONES, treatment of fracture of, by reduction (Anaes.) **Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20
47741	NASAL BONES, treatment of fracture of, by open reduction involving osteotomies (Anaes.) (Assist.) **Fee:** $480.35 **Benefit:** 75% = $360.30
47753	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) **Fee:** $406.65 **Benefit:** 75% = $305.00
47756	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) **Fee:** $406.65 **Benefit:** 75% = $305.00
47762	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.) **Fee:** $238.80 **Benefit:** 75% = $179.10 85% = $203.00
47765	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.) **Fee:** $392.10 **Benefit:** 75% = $294.10
47768	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.) **Fee:** $480.35 **Benefit:** 75% = $360.30
47771	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.) **Fee:** $551.85 **Benefit:** 75% = $413.90
47774	MAXILLA, treatment of fracture of, requiring open operation (Anaes.) (Assist.) **Fee:** $435.65 **Benefit:** 75% = $326.75
47777	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) **Fee:** $435.65 **Benefit:** 75% = $326.75
47780	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) **Fee:** $566.35 **Benefit:** 75% = $424.80
47783	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) **Fee:** $566.35 **Benefit:** 75% = $424.80 85% = $486.85
47786	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) **Fee:** $718.75 **Benefit:** 75% = $539.10
47789	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) **Fee:** $718.75 **Benefit:** 75% = $539.10
	GENERAL
47900	BONE CYST, injection into or aspiration of (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
47903	EPICONDYLITIS, open operation for (Anaes.) **Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20
47904	DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies (Anaes.) **Fee:** $56.50 **Benefit:** 75% = $42.40 85% = $48.05

47906	DIGITAL NAIL OF TOE, removal of, in the operating theatre of a hospital (Anaes.) **Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95
47912	PULP SPACE INFECTION, PARONYCHIA of FOOT, incision for, not being a service to which another item in this Group applies (excluding aftercare) (Anaes.) **Fee:** $56.50 **Benefit:** 75% = $42.40 85% = $48.05
47915	INGROWING NAIL OF TOE, wedge resection for, with removal of segment of nail, ungual fold and portion of the nail bed (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
47916	INGROWING NAIL OF TOE, partial resection of nail, with destruction of nail matrix by phenolisation, electrocautery, laser, sodium hydroxide or acid but not including excision of nail bed (Anaes.) **Fee:** $85.15 **Benefit:** 75% = $63.90 85% = $72.40
47918	INGROWING TOENAIL, radical excision of nailbed (Anaes.) **Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20
47920	BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.) **Fee:** $380.80 **Benefit:** 75% = $285.60
47921	ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes.) **Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95
47924	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of requiring incision and suture, not being a service to which item 47927 or 47930 applies - per bone (Anaes.) **Fee:** $37.65 **Benefit:** 75% = $28.25 85% = $32.05
47927	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital - per bone (Anaes.) **Fee:** $141.25 **Benefit:** 75% = $105.95
47930	PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all of which were inserted for internal fixation purposes, removal of, not being a service associated with a service to which item 47924 or 47927 applies - per bone (Anaes.) (Assist.) **Fee:** $263.60 **Benefit:** 75% = $197.70
47933	SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision of, or simple removal of bunion and any associated bursa, not being a service associated with a service for removal of bursa (Anaes.) *(See para T8.114 of explanatory notes to this Category)* **Fee:** $207.00 **Benefit:** 75% = $155.25 85% = $175.95
47936	LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (Anaes.) (Assist.) *(See para T8.114 of explanatory notes to this Category)* **Fee:** $254.20 **Benefit:** 75% = $190.65
47948	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital (Anaes.) **Fee:** $160.05 **Benefit:** 75% = $120.05
47951	EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.) **Fee:** $188.20 **Benefit:** 75% = $141.15 85% = $160.00
47954	TENDON, repair of, as an independent procedure (Anaes.) (Assist.) **Fee:** $376.55 **Benefit:** 75% = $282.45 85% = $320.10
47957	TENDON, large, lengthening of, as an independent procedure (Anaes.) (Assist.) **Fee:** $282.35 **Benefit:** 75% = $211.80
47960	TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies (Anaes.) **Fee:** $131.85 **Benefit:** 75% = $98.90 85% = $112.10
47963	TENOTOMY, OPEN, with or without tenoplasty, not being a service to which another item in this Group applies (Anaes.) **Fee:** $216.50 **Benefit:** 75% = $162.40 85% = $184.05
47966	TENDON OR LIGAMENT, TRANSFER, as an independent procedure (Anaes.) (Assist.) **Fee:** $432.95 **Benefit:** 75% = $324.75

47969	TENOSYNOVECTOMY, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $263.60 **Benefit:** 75% = $197.70
47972	TENDON SHEATH, open operation for teno-vaginitis, not being a service to which another item in this Group applies (Anaes.) **Fee:** $210.60 **Benefit:** 75% = $157.95
47975	FOREARM OR CALF, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) (Assist.) **Fee:** $369.15 **Benefit:** 75% = $276.90
47978	FOREARM OR CALF, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) **Fee:** $224.20 **Benefit:** 75% = $168.15
47981	FOREARM, CALF OR INTEROSSEOUS MUSCLE SPACE OF HAND, decompression fasciotomy of, not being a service to which another item applies (Anaes.) **Fee:** $150.55 **Benefit:** 75% = $112.95 85% = $128.00
47982	FORAGE (Drill decompression), of NECK OR HEAD of FEMUR, or BOTH (Anaes.) (Assist.) **Fee:** $364.90 **Benefit:** 75% = $273.70
	BONE GRAFTS
48200	FEMUR, bone graft to (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95
48203	FEMUR, bone graft to, with internal fixation (Anaes.) (Assist.) **Fee:** $913.25 **Benefit:** 75% = $684.95
48206	TIBIA, bone graft to (Anaes.) (Assist.) **Fee:** $565.45 **Benefit:** 75% = $424.10
48209	TIBIA, bone graft to, with internal fixation (Anaes.) (Assist.) **Fee:** $724.95 **Benefit:** 75% = $543.75
48212	HUMERUS, bone graft to (Anaes.) (Assist.) **Fee:** $565.45 **Benefit:** 75% = $424.10
48215	HUMERUS, bone graft to, with internal fixation (Anaes.) (Assist.) **Fee:** $724.95 **Benefit:** 75% = $543.75
48218	RADIUS AND ULNA, bone graft to (Anaes.) (Assist.) **Fee:** $565.45 **Benefit:** 75% = $424.10
48221	RADIUS AND ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95
48224	RADIUS OR ULNA, bone graft to (Anaes.) (Assist.) **Fee:** $376.55 **Benefit:** 75% = $282.45
48227	RADIUS OR ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.) **Fee:** $489.55 **Benefit:** 75% = $367.20
48230	SCAPHOID, bone graft to, for non-union (Anaes.) (Assist.) **Fee:** $423.75 **Benefit:** 75% = $317.85
48233	SCAPHOID, bone graft to, for non-union, with internal fixation (Anaes.) (Assist.) **Fee:** $611.90 **Benefit:** 75% = $458.95
48236	SCAPHOID, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (Anaes.) (Assist.) **Fee:** $800.20 **Benefit:** 75% = $600.15
48239	BONE GRAFT, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $442.45 **Benefit:** 75% = $331.85
48242	BONE GRAFT, with internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $611.90 **Benefit:** 75% = $458.95

	OSTEOTOMY AND OSTEECTOMY
48400	PHALANX, METATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or osteectomy of, excluding services to which item 49848 or 49851 applies, any of items 49848, 49851, 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $329.60 **Benefit:** 75% = $247.20
48403	PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $517.80 **Benefit:** 75% = $388.35
48406	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $329.60 **Benefit:** 75% = $247.20
48409	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than Acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $517.80 **Benefit:** 75% = $388.35
48412	HUMERUS, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $630.65 **Benefit:** 75% = $473.00
48415	HUMERUS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $800.20 **Benefit:** 75% = $600.15
48418	TIBIA, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $630.65 **Benefit:** 75% = $473.00
48421	TIBIA, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $800.20 **Benefit:** 75% = $600.15
48424	FEMUR OR PELVIS, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95
48427	FEMUR OR PELVIS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $913.25 **Benefit:** 75% = $684.95
	EPIPHYSEODESIS
48500	FEMUR, epiphysiodesis of (Anaes.) (Assist.) **Fee:** $329.60 **Benefit:** 75% = $247.20
48503	TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.) **Fee:** $329.60 **Benefit:** 75% = $247.20
48506	FEMUR, TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.) **Fee:** $489.55 **Benefit:** 75% = $367.20
48509	EPIPHYSIODESIS, staple arrest of hemiepiphysis (Anaes.) **Fee:** $235.50 **Benefit:** 75% = $176.65
48512	EPIPHYSIOLYSIS, operation to prevent closure of plate (Anaes.) (Assist.) **Fee:** $894.40 **Benefit:** 75% = $670.80
	SPINE
48600	SPINE, MANIPULATION OF, performed in the operating theatre of a hospital (Anaes.) **Fee:** $94.00 **Benefit:** 75% = $70.50
48603	SPINE, manipulation of, under epidural anaesthesia, with or without steroid injection, where the manipulation and the administration of the epidural anaesthetic are performed by the same medical practitioner in the operating theatre of a hospital, not being a service associated with a service to which item 48600 or 50115 applies (Anaes.) **Fee:** $141.25 **Benefit:** 75% = $105.95 85% = $120.10

48606	SCOLIOSIS or KYPHOSIS, spinal fusion for (without instrumentation) (Anaes.) (Assist.) **Fee:** $1,317.80 **Benefit:** 75% = $988.35
48612	SCOLIOSIS, spinal fusion for, using segmental instrumentation (C D, Zielke, Luque, or similar) (Anaes.) (Assist.) **Fee:** $2,447.85 **Benefit:** 75% = $1,835.90
48613	SCOLIOSIS OR KYPHOSIS, spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes.) (Assist.) **Fee:** $3,481.80 **Benefit:** 75% = $2,611.35
48615	SCOLIOSIS, re-exploration for, involving adjustment or removal of instrumentation or simple bone grafting procedure (Anaes.) (Assist.) **Fee:** $442.45 **Benefit:** 75% = $331.85
48618	SCOLIOSIS, revision of failed scoliosis surgery, involving more than 1 of multiple osteotomy, fusion or instrumentation (Anaes.) (Assist.) **Fee:** $2,447.85 **Benefit:** 75% = $1,835.90
48621	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke, or similar) - not more than 4 levels (Anaes.) (Assist.) **Fee:** $1,600.65 **Benefit:** 75% = $1,200.50
48624	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes.) (Assist.) **Fee:** $1,977.20 **Benefit:** 75% = $1,482.90
48627	SCOLIOSIS, spinal fusion for, combined with segmental instrumentation (C D, Zielke or similar) down to and including pelvis (Anaes.) (Assist.) **Fee:** $2,541.85 **Benefit:** 75% = $1,906.40
48630	SCOLIOSIS, requiring anterior decompression of spinal cord with resection of vertebrae including bone graft and instrumentation in the presence of spinal cord involvement (Anaes.) (Assist.) **Fee:** $2,824.35 **Benefit:** 75% = $2,118.30
48632	SCOLIOSIS, congenital, vertebral resection and fusion for (Anaes.) (Assist.) **Fee:** $1,561.30 **Benefit:** 75% = $1,171.00
48636	PERCUTANEOUS LUMBAR PARTIAL OR TOTAL DISCECTOMY, 1 or more levels, not being a service associated with intradiscal electrothermal annuloplasty (Anaes.) (Assist.) *(See para T8.115 of explanatory notes to this Category)* **Fee:** $809.55 **Benefit:** 75% = $607.20 85% = $730.05
48639	VERTEBRAL BODY, total or subtotal excision of, including bone grafting or other form of fixation (Anaes.) (Assist.) **Fee:** $1,365.00 **Benefit:** 75% = $1,023.75
48640	VERTEBRAL BODY, disease of, excision and spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes.) (Assist.) **Fee:** $3,481.80 **Benefit:** 75% = $2,611.35
48642	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - 1 or 2 levels (Anaes.) (Assist.) **Fee:** $800.20 **Benefit:** 75% = $600.15
48645	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - more than 2 levels (Anaes.) (Assist.) **Fee:** $1,082.70 **Benefit:** 75% = $812.05
48648	SPINE, bone graft to, (postero-lateral fusion) - 1 or 2 levels (Anaes.) (Assist.) **Fee:** $1,082.70 **Benefit:** 75% = $812.05
48651	SPINE, bone graft to, (postero-lateral fusion) - more than 2 levels (Anaes.) (Assist.) **Fee:** $1,506.45 **Benefit:** 75% = $1,129.85
48654	SPINAL FUSION (posterior interbody), with partial or total laminectomy, 1 level (Anaes.) (Assist.) **Fee:** $1,082.70 **Benefit:** 75% = $812.05
48657	SPINAL FUSION (posterior interbody), with partial or total laminectomy, more than 1 level (Anaes.) (Assist.) **Fee:** $1,506.45 **Benefit:** 75% = $1,129.85

48660	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (Anaes.) (Assist.) *(See para T8.2 and T8.116 of explanatory notes to this Category)* **Fee:** $1,082.70 **Benefit:** 75% = $812.05
48663	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level - principal surgeon (Anaes.) *(See para T8.2 and T8.116 of explanatory notes to this Category)* **Fee:** $809.55 **Benefit:** 75% = $607.20
48666	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level - assisting surgeon *(See para T8.2 and T8.116 of explanatory notes to this Category)* **Fee:** $489.55 **Benefit:** 75% = $367.20
48669	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (Anaes.) (Assist.) *(See para T8.2 and T8.116 of explanatory notes to this Category)* **Fee:** $1,459.20 **Benefit:** 75% = $1,094.40
48672	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level - principal surgeon (Anaes.) (Assist.) *(See para T8.2 and T8.116 of explanatory notes to this Category)* **Fee:** $1,092.25 **Benefit:** 75% = $819.20
48675	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level - assisting surgeon *(See para T8.2 and T8.116 of explanatory notes to this Category)* **Fee:** $659.15 **Benefit:** 75% = $494.40
48678	SPINE, simple internal fixation of, involving 1 or more of facetal screw, wire loop or similar, being a service associated with a service to which items 48642 to 48675 apply (Anaes.) (Assist.) *(See para T8.117 of explanatory notes to this Category)* **Fee:** $565.45 **Benefit:** 75% = $424.10
48681	SPINE, non-segmental internal fixation of (Harrington or similar), other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies (Anaes.) (Assist.) *(See para T8.117 of explanatory notes to this Category)* **Fee:** $941.45 **Benefit:** 75% = $706.10
48684	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies - 1 or 2 levels (Anaes.) (Assist.) *(See para T8.2 and T8.117 of explanatory notes to this Category)* **Fee:** $941.45 **Benefit:** 75% = $706.10
48687	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - 3 or 4 levels (Anaes.) (Assist.) *(See para T8.117 of explanatory notes to this Category)* **Fee:** $1,317.80 **Benefit:** 75% = $988.35
48690	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - more than 4 levels (Anaes.) (Assist.) *(See para T8.117 of explanatory notes to this Category)* **Fee:** $1,506.45 **Benefit:** 75% = $1,129.85
48691	Lumbar artificial intervertebral total disc replacement, at one level only, including removal of disc, for a patient who: (a) has not had prior spinal fusion surgery at the same lumbar level; and (b) does not have vertebral osteoporosis; and (c) has failed conservative therapy; other than a service associated with item 40300 or 40301 (Anaes.) (Assist.) *(See para T8.2 of explanatory notes to this Category)* **Fee:** $1,793.65 **Benefit:** 75% = $1,345.25

48692	Lumbar artificial intervertebral total disc replacement, at one level only, including removal of disc, for a patient who: (a) has not had prior spinal fusion surgery at the same lumbar level; and (b) does not have vertebral osteoporosis; and (c) has failed conservative therapy; other than a service associated with item 40300 or 40301—principal surgeon (Anaes.) (Assist.) *(See para T8.2 of explanatory notes to this Category)* **Fee:** $1,208.95 **Benefit:** 75% = $906.75
48693	Lumbar artificial intervertebral total disc replacement, at one level only, including removal of disc, for a patient who: (a) has not had prior spinal fusion surgery at the same lumbar level; and (b) does not have vertebral osteoporosis; and (c) has failed conservative therapy; other than a service associated with item 40300 or 40301—assisting surgeon (Anaes.) (Assist.) *(See para T8.2 of explanatory notes to this Category)* **Fee:** $584.70 **Benefit:** 75% = $438.55
48694	Cervical artificial intervertebral total disc replacement, at one level only, including removal of disc, for a patient who: (a) has not had prior spinal surgery at the same cervical level; and (b) is skeletally mature; and (c) has symptomatic degenerative disc disease with radiculopathy; and (d) does not have vertebral osteoporosis; and (e) has failed conservative therapy; other than a service associated with item 40300 or 40301 (Anaes.) (Assist.) **Fee:** $1,082.70 **Benefit:** 75% = $812.05
	SHOULDER
48900	SHOULDER, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Anaes.) (Assist.) **Fee:** $282.35 **Benefit:** 75% = $211.80 85% = $240.00
48903	SHOULDER, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (Anaes.) (Assist.) **Fee:** $564.85 **Benefit:** 75% = $423.65
48906	SHOULDER, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both - not being a service associated with a service to which item 48900 applies (Anaes.) (Assist.) **Fee:** $564.85 **Benefit:** 75% = $423.65
48909	SHOULDER, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, not being a service associated with a service to which item 48903 applies (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95
48912	SHOULDER, arthrotomy of (Anaes.) (Assist.) **Fee:** $329.60 **Benefit:** 75% = $247.20 85% = $280.20
48915	SHOULDER, hemi-arthroplasty of (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95
48918	SHOULDER, total replacement arthroplasty of, including any associated rotator cuff repair (Anaes.) (Assist.) **Fee:** $1,506.45 **Benefit:** 75% = $1,129.85
48921	SHOULDER, total replacement arthroplasty, revision of (Anaes.) (Assist.) **Fee:** $1,553.40 **Benefit:** 75% = $1,165.05
48924	SHOULDER, total replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or both (Anaes.) (Assist.) **Fee:** $1,788.85 **Benefit:** 75% = $1,341.65
48927	SHOULDER prosthesis, removal of (Anaes.) (Assist.) **Fee:** $367.05 **Benefit:** 75% = $275.30
48930	SHOULDER, stabilisation procedure for recurrent anterior or posterior dislocation (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95

48933	SHOULDER, stabilisation procedure for multi-directional instability, including anterior or posterior (or both) repair when performed (Anaes.) (Assist.) **Fee:** $988.55 **Benefit:** 75% = $741.45
48936	SHOULDER, synovectomy of, as an independent procedure (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95
48939	SHOULDER, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $1,082.70 **Benefit:** 75% = $812.05
48942	SHOULDER, arthrodesis of, with synovectomy if performed, with removal of prosthesis, requiring bone grafting or internal fixation (Anaes.) (Assist.) **Fee:** $1,412.20 **Benefit:** 75% = $1,059.15
48945	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $272.95 **Benefit:** 75% = $204.75
48948	SHOULDER, arthroscopic surgery of, involving any 1 or more of: removal of loose bodies; decompression of calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $611.90 **Benefit:** 75% = $458.95
48951	SHOULDER, arthroscopic division of coraco-acromial ligament including acromioplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $894.40 **Benefit:** 75% = $670.80
48954	SHOULDER, arthroscopic total synovectomy of, including release of contracture when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $941.45 **Benefit:** 75% = $706.10
48957	SHOULDER, arthroscopic stabilisation of, for recurrent instability including labral repair or reattachment when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $1,082.70 **Benefit:** 75% = $812.05
48960	SHOULDER, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed - not being a service associated with any other procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $941.45 **Benefit:** 75% = $706.10
	ELBOW
49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (Anaes.) (Assist.) **Fee:** $329.60 **Benefit:** 75% = $247.20
49103	ELBOW, ligamentous stabilisation of (Anaes.) (Assist.) **Fee:** $706.05 **Benefit:** 75% = $529.55
49106	ELBOW, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $941.45 **Benefit:** 75% = $706.10 85% = $861.95
49109	ELBOW, total synovectomy of (Anaes.) (Assist.) **Fee:** $706.05 **Benefit:** 75% = $529.55
49112	ELBOW, silastic or other replacement of radial head (Anaes.) (Assist.) **Fee:** $706.05 **Benefit:** 75% = $529.55
49115	ELBOW, total joint replacement of (Anaes.) (Assist.) **Fee:** $1,129.65 **Benefit:** 75% = $847.25
49116	ELBOW, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,491.15 **Benefit:** 75% = $1,118.40
49117	ELBOW, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,789.35 **Benefit:** 75% = $1,342.05

49118	ELBOW, diagnostic arthroscopy of, including biopsy and lavage, not being a service associated with any other arthroscopic procedure of the elbow (Anaes.) (Assist.) **Fee:** $272.95 **Benefit:** 75% = $204.75
49121	ELBOW, arthroscopic surgery involving any 1 or more of: drilling of defect, removal of loose body; release of contracture or adhesions; chondroplasty; or osteoplasty - not being a service associated with any other arthroscopic procedure of the elbow (Anaes.) (Assist.) **Fee:** $611.90 **Benefit:** 75% = $458.95
	WRIST
49200	WRIST, arthrodesis of, with synovectomy if performed, with or without bone graft and internal fixation of the radiocarpal joint (Anaes.) (Assist.) *(See para T8.118 of explanatory notes to this Category)* **Fee:** $818.95 **Benefit:** 75% = $614.25
49203	WRIST, limited arthrodesis of the intercarpal joint, with synovectomy if performed, with or without bone graft (Anaes.) (Assist.) *(See para T8.118 of explanatory notes to this Category)* **Fee:** $611.90 **Benefit:** 75% = $458.95
49206	WRIST, proximal carpectomy of, including styloidectomy when performed (Anaes.) (Assist.) *(See para T8.118 of explanatory notes to this Category)* **Fee:** $564.85 **Benefit:** 75% = $423.65
49209	WRIST, total replacement arthroplasty of (Anaes.) (Assist.) *(See para T8.118 of explanatory notes to this Category)* **Fee:** $753.25 **Benefit:** 75% = $564.95
49210	WRIST, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $994.30 **Benefit:** 75% = $745.75
49211	WRIST, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,193.15 **Benefit:** 75% = $894.90
49212	WRIST, arthrotomy of (Anaes.) *(See para T8.118 of explanatory notes to this Category)* **Fee:** $235.50 **Benefit:** 75% = $176.65
49215	WRIST, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy (Anaes.) (Assist.) *(See para T8.118 of explanatory notes to this Category)* **Fee:** $649.70 **Benefit:** 75% = $487.30
49218	WRIST, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy) - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) *(See para T8.118 of explanatory notes to this Category)* **Fee:** $272.95 **Benefit:** 75% = $204.75
49221	WRIST, arthroscopic surgery of, involving any 1 or more of: drilling of defect; removal of loose body; release of adhesions; local synovectomy; or debridement of one area - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) *(See para T8.118 of explanatory notes to this Category)* **Fee:** $611.90 **Benefit:** 75% = $458.95
49224	WRIST, arthroscopic debridement of 2 or more distinct areas; or osteoplasty including excision of the distal ulna; or total synovectomy, not being a service associated with any other arthroscopic procedure of the wrist (Anaes.) (Assist.) *(See para T8.118 of explanatory notes to this Category)* **Fee:** $706.05 **Benefit:** 75% = $529.55
49227	WRIST, arthroscopic pinning of osteochondral fragment or stabilisation procedure for ligamentous disruption - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) *(See para T8.118 of explanatory notes to this Category)* **Fee:** $706.05 **Benefit:** 75% = $529.55

	HIP
49300	SACROILIAC JOINT arthrodesis of (Anaes.) (Assist.) **Fee:** $521.25 **Benefit:** 75% = $390.95
49303	HIP, arthrotomy of, including lavage, drainage or biopsy when performed (Anaes.) (Assist.) **Fee:** $546.00 **Benefit:** 75% = $409.50
49306	HIP arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $1,082.70 **Benefit:** 75% = $812.05
49309	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (Austin Moore or similar (non cement)) (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95
49312	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (cemented, porous coated or similar) (Anaes.) (Assist.) **Fee:** $941.45 **Benefit:** 75% = $706.10
49315	HIP, arthroplasty of, unipolar or bipolar (Anaes.) (Assist.) **Fee:** $847.35 **Benefit:** 75% = $635.55
49318	HIP, total replacement arthroplasty of, including minor bone grafting (Anaes.) (Assist.) **Fee:** $1,317.80 **Benefit:** 75% = $988.35
49319	HIP, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.) (Assist.) **Fee:** $2,315.30 **Benefit:** 75% = $1,736.50
49321	HIP, total replacement arthroplasty of, including major bone grafting, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,600.65 **Benefit:** 75% = $1,200.50
49324	HIP, total replacement arthroplasty of, revision procedure including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,882.95 **Benefit:** 75% = $1,412.25
49327	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (Anaes.) (Assist.) **Fee:** $2,165.35 **Benefit:** 75% = $1,624.05
49330	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Anaes.) (Assist.) **Fee:** $2,165.35 **Benefit:** 75% = $1,624.05
49333	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Anaes.) (Assist.) **Fee:** $2,447.85 **Benefit:** 75% = $1,835.90
49336	HIP, treatment of a fracture of the femur where revision total hip replacement is required as part of the treatment of the fracture (not including intra-operative fracture), being a service associated with a service to which items 49324 to 49333 apply (Anaes.) (Assist.) **Fee:** $357.70 **Benefit:** 75% = $268.30
49339	HIP, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cm in length (Anaes.) (Assist.) **Fee:** $2,777.30 **Benefit:** 75% = $2,083.00
49342	HIP, revision total replacement of, requiring anatomic specific allograft of acetabulum (Anaes.) (Assist.) **Fee:** $2,777.30 **Benefit:** 75% = $2,083.00
49345	HIP, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (Anaes.) (Assist.) **Fee:** $3,295.10 **Benefit:** 75% = $2,471.35
49346	HIP, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (Anaes.) (Assist.) **Fee:** $847.35 **Benefit:** 75% = $635.55
49360	HIP, diagnostic arthroscopy of, not being a service associated with any other arthroscopic procedure of the hip (Anaes.) (Assist.) **Fee:** $343.95 **Benefit:** 75% = $258.00

49363	HIP, diagnostic arthroscopy of, with synovial biopsy, not being a service associated with any other arthroscopic procedure of the hip (Anaes.) (Assist.) **Fee:** $414.20 **Benefit:** 75% = $310.65 85% = $352.10
49366	HIP, arthroscopic surgery of, not being a service associated with any other arthroscopic procedure of the hip (Anaes.) (Assist.) **Fee:** $611.90 **Benefit:** 75% = $458.95
	KNEE
49500	KNEE, arthrotomy of, involving 1 or more of; capsular release, biopsy or lavage, or removal of loose body or foreign body (Anaes.) (Assist.) **Fee:** $376.55 **Benefit:** 75% = $282.45
49503	KNEE, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not being a service to which another item in this Group applies) – any 1 procedure (Anaes.) (Assist.) **Fee:** $489.55 **Benefit:** 75% = $367.20
49506	KNEE, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not being a service to which another item in this Group applies) – any 2 or more procedures (Anaes.) (Assist.) **Fee:** $734.40 **Benefit:** 75% = $550.80
49509	KNEE, total synovectomy or arthrodesis with synovectomy if performed (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95
49512	KNEE, arthrodesis of, with synovectomy if performed, with removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,082.70 **Benefit:** 75% = $812.05
49515	KNEE, removal of prosthesis, cemented or uncemented, including associated cement, as the first stage of a 2 stage procedure (Anaes.) (Assist.) **Fee:** $847.35 **Benefit:** 75% = $635.55
49517	KNEE, hemiarthroplasty of (Anaes.) (Assist.) **Fee:** $1,206.35 **Benefit:** 75% = $904.80
49518	KNEE, total replacement arthroplasty of (Anaes.) (Assist.) **Fee:** $1,317.80 **Benefit:** 75% = $988.35
49519	KNEE, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.) (Assist.) **Fee:** $2,315.30 **Benefit:** 75% = $1,736.50
49521	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,600.65 **Benefit:** 75% = $1,200.50
49524	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,882.95 **Benefit:** 75% = $1,412.25
49527	KNEE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,600.65 **Benefit:** 75% = $1,200.50
49530	KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, including obtaining of graft and including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,977.20 **Benefit:** 75% = $1,482.90
49533	KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to both femur and tibia, including obtaining of graft and including removal of prosthesis (Anaes.) (Assist.) **Fee:** $2,259.65 **Benefit:** 75% = $1,694.75
49534	KNEE, patello-femoral joint of, total replacement arthroplasty as a primary procedure (Anaes.) (Assist.) **Fee:** $449.55 **Benefit:** 75% = $337.20

49536	KNEE, repair or reconstruction of, for chronic instability (open or arthroscopic, or both) involving either cruciate or collateral ligaments, including notchplasty when performed, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.) **Fee:** $941.45 **Benefit:** 75% = $706.10
49539	KNEE, reconstructive surgery of cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty when performed and surgery to other internal derangements, not being a service to which another item in this Group applies or a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.) **Fee:** $941.45 **Benefit:** 75% = $706.10
49542	KNEE, reconstructive surgery to cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty, meniscus repair, extracapsular procedure and debridement when performed, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.) **Fee:** $1,317.80 **Benefit:** 75% = $988.35
49545	KNEE, revision arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95
49548	KNEE, revision of patello-femoral stabilisation (Anaes.) (Assist.) **Fee:** $941.45 **Benefit:** 75% = $706.10
49551	KNEE, revision of procedures to which item 49536, 49539 or 49542 applies (Anaes.) (Assist.) **Fee:** $1,317.80 **Benefit:** 75% = $988.35
49554	KNEE, revision of total replacement of, by anatomic specific allograft of tibia or femur (Anaes.) (Assist.) **Fee:** $1,882.95 **Benefit:** 75% = $1,412.25
49557	KNEE, diagnostic arthroscopy of (including biopsy, simple trimming of meniscal margin or plica) - not being a service associated with autologous chondrocyte implantation or matrix-induced autologous chondrocyte implantation or any other arthroscopic procedure of the knee region (Anaes.) (Assist.) *(See para T8.119 of explanatory notes to this Category)* **Fee:** $272.95 **Benefit:** 75% = $204.75
49558	KNEE, arthroscopic surgery of, involving 1 or more of: debridement, osteoplasty or chondroplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $272.95 **Benefit:** 75% = $204.75
49559	KNEE, arthroscopic surgery of, involving chondroplasty requiring multiple drilling or carbon fibre (or similar) implant; including any associated debridement or oestoplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $408.70 **Benefit:** 75% = $306.55
49560	KNEE, arthroscopic surgery of, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release – not being a service associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $551.60 **Benefit:** 75% = $413.70
49561	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release; where the procedure includes associated debridement, osteoplasty or chondroplasty – not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $674.00 **Benefit:** 75% = $505.50
49562	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release; where the procedure includes chondroplasty requiring multiple drilling or carbon fibre (or similar) implant and associated debridement or osteoplasty – not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $735.50 **Benefit:** 75% = $551.65
49563	KNEE, arthroscopic surgery of, involving 1 or more of: meniscus repair; osteochondral graft; or chondral graft (excluding autologous chondrocyte implantation or matrix-induced autologous chondrocyte implantation) –not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) *(See para T8.119 of explanatory notes to this Category)* **Fee:** $796.70 **Benefit:** 75% = $597.55
49564	KNEE, patello-femoral stabilisation of, combined arthroscopic and open procedure, including lateral release, medial capsulorrhaphy and tendon transfer, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.) **Fee:** $919.05 **Benefit:** 75% = $689.30

49566	KNEE, arthroscopic total synovectomy of, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95
49569	KNEE, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95
	ANKLE
49700	ANKLE, diagnostic arthroscopy of, including biopsy (Anaes.) (Assist.) **Fee:** $272.95 **Benefit:** 75% = $204.75
49703	ANKLE, arthroscopic surgery of, not being a service associated with any other arthroscopic procedure of the ankle (Anaes.) (Assist.) **Fee:** $611.90 **Benefit:** 75% = $458.95
49706	ANKLE, arthrotomy of, involving 1 or more of: lavage, removal of loose body or division of contracture (Anaes.) (Assist.) **Fee:** $329.60 **Benefit:** 75% = $247.20
49709	ANKLE, ligamentous stabilisation of (Anaes.) (Assist.) **Fee:** $706.05 **Benefit:** 75% = $529.55
49712	ANKLE, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95
49715	ANKLE, total joint replacement of (Anaes.) (Assist.) **Fee:** $1,129.65 **Benefit:** 75% = $847.25
49716	ANKLE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,491.15 **Benefit:** 75% = $1,118.40
49717	ANKLE, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,789.35 **Benefit:** 75% = $1,342.05
49718	ANKLE, Achilles' tendon or other major tendon, repair of (Anaes.) (Assist.) **Fee:** $376.55 **Benefit:** 75% = $282.45
49721	ANKLE, Achilles' tendon rupture managed by non-operative treatment **Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20
49724	ANKLE, Achilles' tendon, secondary repair or reconstruction of (Anaes.) (Assist.) **Fee:** $659.15 **Benefit:** 75% = $494.40
49727	ANKLE, Achilles' tendon, operation for lengthening (Anaes.) (Assist.) **Fee:** $282.35 **Benefit:** 75% = $211.80
49728	ANKLE, lengthening of the gastrocnemius aponeurosis and soleus fascia, for the correction of equinus deformity in children with cerebral palsy (Anaes.) (Assist.) **Fee:** $564.70 **Benefit:** 75% = $423.55
	FOOT
49800	FOOT, flexor or extensor tendon, primary repair of (Anaes.) **Fee:** $131.85 **Benefit:** 75% = $98.90 85% = $112.10
49803	FOOT, flexor or extensor tendon, secondary repair of (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
49806	FOOT, subcutaneous tenotomy of, 1 or more tendons (Anaes.) **Fee:** $131.85 **Benefit:** 75% = $98.90 85% = $112.10
49809	FOOT, open tenotomy of, with or without tenoplasty (Anaes.) **Fee:** $216.50 **Benefit:** 75% = $162.40
49812	FOOT, tendon or ligament transplantation of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $432.95 **Benefit:** 75% = $324.75

49815	FOOT, triple arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95
49818	FOOT, excision of calcaneal spur (Anaes.) (Assist.) **Fee:** $272.95 **Benefit:** 75% = $204.75
49821	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - unilateral (Anaes.) (Assist.) **Fee:** $432.95 **Benefit:** 75% = $324.75
49824	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - bilateral (Anaes.) (Assist.) **Fee:** $757.95 **Benefit:** 75% = $568.50
49827	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - unilateral (Anaes.) (Assist.) **Fee:** $470.70 **Benefit:** 75% = $353.05
49830	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - bilateral (Anaes.) (Assist.) **Fee:** $823.75 **Benefit:** 75% = $617.85
49833	FOOT, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - unilateral (Anaes.) (Assist.) **Fee:** $517.80 **Benefit:** 75% = $388.35
49836	FOOT, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - bilateral (Anaes.) (Assist.) **Fee:** $894.40 **Benefit:** 75% = $670.80
49837	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - unilateral (Anaes.) (Assist.) **Fee:** $647.25 **Benefit:** 75% = $485.45
49838	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - bilateral (Anaes.) (Assist.) **Fee:** $1,117.75 **Benefit:** 75% = $838.35
49839	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (Anaes.) (Assist.) **Fee:** $517.80 **Benefit:** 75% = $388.35
49842	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Anaes.) (Assist.) **Fee:** $894.40 **Benefit:** 75% = $670.80
49845	FOOT, arthrodesis of, first metatarso-phalangeal joint, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $470.70 **Benefit:** 75% = $353.05
49848	FOOT, correction of claw or hammer toe (Anaes.) **Fee:** $160.05 **Benefit:** 75% = $120.05 85% = $136.05
49851	FOOT, correction of claw or hammer toe with internal fixation (Anaes.) **Fee:** $207.00 **Benefit:** 75% = $155.25
49854	FOOT, radical plantar fasciotomy or fasciectomy of (Anaes.) (Assist.) **Fee:** $376.55 **Benefit:** 75% = $282.45
49857	FOOT, metatarso-phalangeal joint replacement (Anaes.) (Assist.) **Fee:** $348.35 **Benefit:** 75% = $261.30
49860	FOOT, synovectomy of metatarso-phalangeal joint, single joint (Anaes.) (Assist.) **Fee:** $282.35 **Benefit:** 75% = $211.80
49863	FOOT, synovectomy of metatarso-phalangeal joint, 2 or more joints (Anaes.) (Assist.) **Fee:** $423.75 **Benefit:** 75% = $317.85
49866	FOOT, neurectomy for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes.) (Assist.) **Fee:** $301.05 **Benefit:** 75% = $225.80

49878	TALIPES EQUINOVARUS, calcaneo valgus or metatarus varus, treatment by cast, splint or manipulation - each attendance (Anaes.) **Fee:** $56.50 **Benefit:** 75% = $42.40 85% = $48.05
	OTHER JOINTS
50100	JOINT, diagnostic arthroscopy of (including biopsy), not being a service to which another item in this Group applies and not being a service associated with any other arthroscopic procedure (Anaes.) (Assist.) **Fee:** $272.95 **Benefit:** 75% = $204.75 85% = $232.05
50102	JOINT, arthroscopic surgery of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $611.90 **Benefit:** 75% = $458.95
50103	JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $329.60 **Benefit:** 75% = $247.20
50104	JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $312.30 **Benefit:** 75% = $234.25 85% = $265.50
50106	JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $470.70 **Benefit:** 75% = $353.05
50109	JOINT, arthrodesis of, not being a service to which another item in this Group applies, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $470.70 **Benefit:** 75% = $353.05
50112	CICATRICIAL FLEXION OR EXTENSION CONTRACTION OF JOINT, correction of, involving tissues deeper than skin and subcutaneous tissue, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $361.05 **Benefit:** 75% = $270.80
50115	JOINT or JOINTS, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $142.95 **Benefit:** 75% = $107.25 85% = $121.55
50118	SUBTALAR JOINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $432.95 **Benefit:** 75% = $324.75
50121	GREATER TROCHANTER, transplantation of ileopsoas tendon to (Anaes.) (Assist.) **Fee:** $847.35 **Benefit:** 75% = $635.55
50127	JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies (Anaes.) (Assist.) **Fee:** $702.50 **Benefit:** 75% = $526.90
50130	JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) **Fee:** $312.30 **Benefit:** 75% = $234.25
	MALIGNANT DISEASE
50200	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.) **Fee:** $188.20 **Benefit:** 75% = $141.15 85% = $160.00
50201	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, involving neurovascular structures, open biopsy of (not including aftercare) (Anaes.) (Assist.) **Fee:** $329.50 **Benefit:** 75% = $247.15
50203	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.) (Assist.) **Fee:** $414.25 **Benefit:** 75% = $310.70 85% = $352.15
50206	BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) **Fee:** $611.90 **Benefit:** 75% = $458.95
50209	BONE TUMOUR, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95

50212	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, without reconstruction (Anaes.) (Assist.) **Fee:** $1,647.55 **Benefit:** 75% = $1,235.70
50215	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, with intercalary reconstruction (prosthesis, allograft or autograft) (Anaes.) (Assist.) **Fee:** $2,071.20 **Benefit:** 75% = $1,553.40
50218	MALIGNANT TUMOUR of LONG BONE, enbloc resection of, with replacement or arthrodesis of adjacent joint, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $2,730.30 **Benefit:** 75% = $2,047.75
50221	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of (Anaes.) (Assist.) **Fee:** $2,541.85 **Benefit:** 75% = $1,906.40
50224	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of, with reconstruction by prosthesis, allograft or autograft (Anaes.) (Assist.) **Fee:** $2,824.35 **Benefit:** 75% = $2,118.30 85% = $2,744.85
50227	MALIGNANT BONE TUMOUR, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement (Anaes.) (Assist.) **Fee:** $3,295.10 **Benefit:** 75% = $2,471.35
50230	BENIGN TUMOUR, resection of, requiring anatomic specific allograft, with or without internal fixation (Anaes.) (Assist.) **Fee:** $1,694.60 **Benefit:** 75% = $1,270.95
50233	MALIGNANT TUMOUR, amputation for, hemipelvectomy or interscapulo-thoracic (Anaes.) (Assist.) **Fee:** $2,165.35 **Benefit:** 75% = $1,624.05
50236	MALIGNANT TUMOUR, amputation for, hip disarticulation, shoulder disarticulation or proximal third femur (Anaes.) (Assist.) **Fee:** $1,694.60 **Benefit:** 75% = $1,270.95
50239	MALIGNANT TUMOUR, amputation for, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $1,129.65 **Benefit:** 75% = $847.25
	LIMB LENGTHENING AND DEFORMITY CORRECTION
50300	JOINT DEFORMITY, slow correction of, using ring fixator or similar device, including all associated attendances - payable only once in any 12 month period (Anaes.) (Assist.) **Fee:** $1,157.70 **Benefit:** 75% = $868.30
50303	LIMB LENGTHENING, 5cm or less, by gradual distraction, with application of an external fixator or intra-medullary device, in the operating theatre of a hospital - payable only once per limb in any 12 month period (Anaes.) (Assist.) **Fee:** $1,580.60 **Benefit:** 75% = $1,185.45
50306	LIMB LENGTHENING , where the lengthening is bipolar, or bone transport is performed or where the fixator is extended to correct an adjacent joint deformity, or where the lengthening is greater than 5cm (Anaes.) (Assist.) **Fee:** $2,467.90 **Benefit:** 75% = $1,850.95 85% = $2,388.40
50309	RING FIXATOR OR SIMILAR DEVICE, adjustment of, with or without insertion or removal of fixation pins, performed under general anaesthesia in the operating theatre of a hospital, not being a service to which item 50303 or 50306 applies (Anaes.) (Assist.) **Fee:** $305.05 **Benefit:** 75% = $228.80
50312	ANKLE, synovectomy of, by arthroscopic or open means - not associated with any other arthroscopic procedure of the ankle (Anaes.) (Assist.) **Fee:** $700.10 **Benefit:** 75% = $525.10
50315	TALIPES EQUINOVARUS, posterior release of (Anaes.) (Assist.) **Fee:** $693.30 **Benefit:** 75% = $520.00
50318	TALIPES EQUINOVARUS, medial release of (Anaes.) (Assist.) **Fee:** $693.30 **Benefit:** 75% = $520.00
50321	TALIPES EQUINOVARUS, combined postero-medial release of (Anaes.) (Assist.) **Fee:** $928.85 **Benefit:** 75% = $696.65

50324	TALIPES EQUINOVARUS, combined postero-medial release of, revision procedure (Anaes.) (Assist.) **Fee:** $1,324.15 **Benefit:** 75% = $993.15
50327	TALIPES EQUINOVARUS, bilateral procedures (Anaes.) (Assist.) **Fee:** $1,615.15 **Benefit:** 75% = $1,211.40
50330	TALIPES EQUINOVARUS, or talus, vertical congenital - post operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital, not being a service to which item 50315, 50318, 50321, 50324 or 50327 applies (Anaes.) **Fee:** $228.70 **Benefit:** 75% = $171.55 85% = $194.40
50333	TARSAL COALITION, excision of, with interposition of muscle, fat graft or similar graft (Anaes.) (Assist.) **Fee:** $616.85 **Benefit:** 75% = $462.65
50336	TALUS, VERTICAL, CONGENITAL, combined anterior and posterior reconstruction (Anaes.) (Assist.) **Fee:** $922.05 **Benefit:** 75% = $691.55
50339	FOOT AND ANKLE, tibialis anterior tendon (split or whole) transfer to lateral column (Anaes.) (Assist.) **Fee:** $561.55 **Benefit:** 75% = $421.20
50342	FOOT AND ANKLE, tibialis or tibialis posterior tendon transfer, through the interosseous membrane to anterior or posterior aspect of foot (Anaes.) (Assist.) **Fee:** $651.60 **Benefit:** 75% = $488.70
50345	HYPEREXTENSION DEFORMITY OF TOE, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (Anaes.) (Assist.) **Fee:** $346.65 **Benefit:** 75% = $260.00
	HIP, KNEE AND LEG PROCEDURES
50348	KNEE, deformity of, post-operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital (Anaes.) **Fee:** $228.70 **Benefit:** 75% = $171.55 85% = $194.40
50349	HIP, congenital dislocation of, treatment of, by closed reduction (Anaes.) **Fee:** $320.15 **Benefit:** 75% = $240.15 85% = $272.15
50351	HIP, developmental dislocation of, open reduction of (Anaes.) (Assist.) **Fee:** $1,597.25 **Benefit:** 75% = $1,197.95
50352	HIP, congenital dislocation of, treatment of, involving supervision of splint, harness or cast - each attendance (Anaes.) **Fee:** $56.50 **Benefit:** 75% = $42.40 85% = $48.05
50353	HIP SPICA, initial application of, for congenital dislocation of hip (excluding aftercare) (Anaes.) (Assist.) **Fee:** $354.80 **Benefit:** 75% = $266.10
50354	TIBIA, pseudarthrosis of, congenital, resection and internal fixation (Anaes.) (Assist.) **Fee:** $1,310.15 **Benefit:** 75% = $982.65 85% = $1,230.65
50357	KNEE, LEG OR THIGH, rectus femoris tendon transfer, or medial or lateral hamstring tendon transfer (Anaes.) (Assist.) **Fee:** $561.55 **Benefit:** 75% = $421.20
50360	KNEE, LEG OR THIGH, combined medial and lateral hamstring tendon transfer (Anaes.) (Assist.) **Fee:** $651.60 **Benefit:** 75% = $488.70
50363	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, unilateral (Anaes.) (Assist.) **Fee:** $499.05 **Benefit:** 75% = $374.30
50366	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, bilateral (Anaes.) (Assist.) **Fee:** $873.45 **Benefit:** 75% = $655.10
50369	KNEE, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, unilateral (Anaes.) (Assist.) **Fee:** $651.60 **Benefit:** 75% = $488.70

50372	KNEE, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, bilateral (Anaes.) (Assist.) **Fee:** $1,143.80 **Benefit:** 75% = $857.85
50375	HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, unilateral (Anaes.) (Assist.) **Fee:** $499.05 **Benefit:** 75% = $374.30
50378	HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, bilateral (Anaes.) (Assist.) **Fee:** $873.45 **Benefit:** 75% = $655.10
50381	HIP, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, unilateral (Anaes.) (Assist.) **Fee:** $651.60 **Benefit:** 75% = $488.70
50384	HIP, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, bilateral (Anaes.) (Assist.) **Fee:** $1,143.80 **Benefit:** 75% = $857.85
50387	HIP, iliopsoas tendon transfer to greater trochanter, or transfer of abdominal musculature to greater trochanter, or transfer of adductors to ischium (Anaes.) (Assist.) **Fee:** $651.60 **Benefit:** 75% = $488.70
50390	PERTHES, CEREBRAL PALSY, or other neuromuscular conditions, affecting hips or knees, application of cast under general anaesthesia, performed in the operating theatre of a hospital (Anaes.) **Fee:** $228.70 **Benefit:** 75% = $171.55 85% = $194.40
50393	PELVIS, bone graft or shelf procedures for acetabular dysplasia (Anaes.) (Assist.) **Fee:** $845.60 **Benefit:** 75% = $634.20
50394	ACETABULAR DYSPLASIA, treatment of, by multiple peri-acetabular osteotomy, including internal fixation where performed (Anaes.) (Assist.) **Fee:** $2,777.30 **Benefit:** 75% = $2,083.00
	SHOULDER, ARM AND FOREARM PROCEDURES
50396	HAND, congenital abnormalities or duplication of digits, amputation or splitting of phalanx or phalanges, with ligament or joint reconstruction (Anaes.) (Assist.) **Fee:** $464.55 **Benefit:** 75% = $348.45
50399	FOREARM, RADIAL APLASIA OR DYSPLASIA (radial club hand), centralisation or radialisation of (Anaes.) (Assist.) **Fee:** $922.05 **Benefit:** 75% = $691.55
50402	TORTICOLLIS, bipolar release of sternocleidomastoid muscle and associated soft tissue (Anaes.) (Assist.) **Fee:** $422.95 **Benefit:** 75% = $317.25
50405	ELBOW, flexorplasty, or tendon transfer to restore elbow function (Anaes.) (Assist.) **Fee:** $575.40 **Benefit:** 75% = $431.55
50408	SHOULDER, congenital or developmental dislocation, open reduction of (Anaes.) (Assist.) **Fee:** $998.25 **Benefit:** 75% = $748.70
	AMPUTATIONS OR RECONSTRUCTIONS FOR CONGENITAL DEFORMITIES
50411	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion (Anaes.) (Assist.) **Fee:** $1,310.15 **Benefit:** 75% = $982.65 85% = $1,230.65
50414	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion and rotationplasty (Anaes.) (Assist.) **Fee:** $1,767.60 **Benefit:** 75% = $1,325.70 85% = $1,688.10
50417	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the tibia by reconstruction of the knee, involving transfer of fibula or tibia, and repair of quadriceps mechanism (Anaes.) (Assist.) **Fee:** $1,310.15 **Benefit:** 75% = $982.65 85% = $1,230.65

50420	PATELLA, congenital dislocation of, reconstruction of the quadriceps (Anaes.) (Assist.) **Fee:** $1,081.35 **Benefit:** 75% = $811.05
50423	TIBIA, FIBULA OR BOTH, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes.) (Assist.) **Fee:** $998.25 **Benefit:** 75% = $748.70 85% = $918.75
	TUMOROUS CONDITIONS
50426	DIAPHYSEAL ACLASIA, removal of lesion or lesions from bone - 1 approach (Anaes.) (Assist.) **Fee:** $464.55 **Benefit:** 75% = $348.45
	SINGLE EVEN MULTILEVEL SURGERY FOR CHILDREN WITH CEREBRAL PALSY
50450	**UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following:** – Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. – Correction of muscle imbalance by tendon transfer/transfers. – Correction of femoral torsion by rotational osteotomy of the femur. – Correction of tibial torsion by rotational osteotomy of the tibia. – Correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis, with synovectomy if performed, or os calcis lengthening. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $1,226.90 **Benefit:** 75% = $920.20
50451	**UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following:** (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of femoral torsion by rotational osteotomy of the femur. (d) Correction of tibial torsion by rotational osteotomy of the tibia. (e) Correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis, with synovectomy if performed, or os calcis lengthening. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $1,226.90 **Benefit:** 75% = $920.20
50455	**BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises:** – Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. – Correction of muscle imbalance by tendon transfer/transfers. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $1,389.40 **Benefit:** 75% = $1,042.05
50456	**BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises:** (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $1,389.40 **Benefit:** 75% = $1,042.05
50460	**BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies.** – Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. – Correction of muscle imbalance by tendon transfer/transfers. – Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $2,074.45 **Benefit:** 75% = $1,555.85

50461	**BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies.** (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $2,074.45 **Benefit:** 75% = $1,555.85
50465	**BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies.** – Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. – Correction of muscle imbalance by tendon transfer/transfers. – Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. – Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $2,921.80 **Benefit:** 75% = $2,191.35
50466	**BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies.** (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. (d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $2,921.80 **Benefit:** 75% = $2,191.35
50470	**BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation.** – Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. – Correction of muscle imbalance by tendon transfer/transfers. – Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. – Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. – Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $3,705.55 **Benefit:** 75% = $2,779.20
50471	**BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation.** (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. (d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. (e) Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $3,705.55 **Benefit:** 75% = $2,779.20

50475	**SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including:** – Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. – Correction of muscle imbalance by tendon transfer/transfers. – Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation. – Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction. – Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation. – Correction of foot instability by os calcis lengthening or subtalar fusion. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $4,275.85 **Benefit:** 75% = $3,206.90
50476	**SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including:** (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation. (d) Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction. (e) Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation. (f) Correction of foot instability by os calcis lengthening or subtalar fusion. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $4,275.85 **Benefit:** 75% = $3,206.90
	TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS
50500	RADIUS OR ULNA, distal end of, ***with open growth plate***, treatment of fracture of, by closed reduction (Anaes.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $276.65 **Benefit:** 75% = $207.50 85% = $235.20
50504	RADIUS OR ULNA, distal end of, ***with open growth plate***, treatment of fracture of, by open reduction (Anaes.) (Assist.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $369.05 **Benefit:** 75% = $276.80 85% = $313.70
50508	RADIUS, distal end of, ***with open growth plate***, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $395.25 **Benefit:** 75% = $296.45 85% = $336.00
50512	RADIUS, distal end of, ***with open growth plate***, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $527.30 **Benefit:** 75% = $395.50
50516	RADIUS OR ULNA, shaft of, ***with open growth plate***, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $355.85 **Benefit:** 75% = $266.90 85% = $302.50
50520	RADIUS OR ULNA, shaft of, ***with open growth plate***, treatment of fracture of, by open reduction (Anaes.) (Assist.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $474.40 **Benefit:** 75% = $355.80
50524	RADIUS OR ULNA, shaft of, ***with open growth plate***, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital (Anaes.) (Assist.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $408.50 **Benefit:** 75% = $306.40 85% = $347.25
50528	RADIUS OR ULNA, shaft of, ***with open growth plate***, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $659.00 **Benefit:** 75% = $494.25

50532	RADIUS AND ULNA, shafts of, ***with open growth plates***, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $573.40 **Benefit:** 75% = $430.05
50536	RADIUS AND ULNA, shafts of, ***with open growth plates***, treatment of fracture of, by open reduction (Anaes.) (Assist.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $764.40 **Benefit:** 75% = $573.30
50540	OLECRANON, ***with open growth plate***, treatment of fracture of, by open reduction (Anaes.) (Assist.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $527.30 **Benefit:** 75% = $395.50
50544	RADIUS, ***with open growth plate***, treatment of fracture of head or neck of, by closed reduction of (Anaes.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $263.60 **Benefit:** 75% = $197.70 85% = $224.10
50548	RADIUS, ***with open growth plate***, treatment of fracture of head or neck of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $527.30 **Benefit:** 75% = $395.50
50552	HUMERUS, proximal, ***with open growth plate***, treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (Anaes.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $454.75 **Benefit:** 75% = $341.10 85% = $386.55
50556	HUMERUS, proximal, ***with open growth plate***, treatment of fracture of, by open reduction (Anaes.) (Assist.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $606.20 **Benefit:** 75% = $454.65
50560	HUMERUS, shaft of, ***with open growth plate***, treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (Anaes.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $474.40 **Benefit:** 75% = $355.80
50564	HUMERUS, shaft of, ***with open growth plate***, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $632.65 **Benefit:** 75% = $474.50
50568	HUMERUS, ***with open growth plate***, supracondylar or condylar, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $553.60 **Benefit:** 75% = $415.20 85% = $474.10
50572	HUMERUS, ***with open growth plate***, supracondylar or condylar, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means, undertaken in the operating theatre of a hospital (Anaes.) (Assist.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $738.10 **Benefit:** 75% = $553.60
50576	FEMUR, ***with open growth plate***, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $606.20 **Benefit:** 75% = $454.65 85% = $526.70
50580	TIBIA, ***with open growth plate***, plateau or condyles, medial or lateral, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $632.65 **Benefit:** 75% = $474.50
50584	TIBIA, distal, ***with open growth plate,*** treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $606.20 **Benefit:** 75% = $454.65
50588	TIBIA AND FIBULA, ***with open growth plates***, treatment of fracture of, by internal fixation (Anaes.) (Assist.) *(See para T8.120 and T8.121 of explanatory notes to this Category)* **Fee:** $790.70 **Benefit:** 75% = $593.05

	SPINE SURGERY FOR SCOLIOSIS AND KYPHOSIS IN PAEDIATRIC PATIENTS
50600	SCOLIOSIS OR KYPHOSIS, in a growing child, manipulation of deformity and application of a localiser cast, under general anaesthesia, in a hospital (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $434.70 **Benefit:** 75% = $326.05 85% = $369.50
50604	SCOLIOSIS or KYPHOSIS, in a child or adolescent, spinal fusion for (without instrumentation) (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $1,845.05 **Benefit:** 75% = $1,383.80
50608	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, treatment by segmental instrumentation and fusion of the spine, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $3,426.95 **Benefit:** 75% = $2,570.25
50612	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, with spinal deformity, treatment by segmental instrumentation, utilising separate anterior and posterior approaches, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $4,874.50 **Benefit:** 75% = $3,655.90
50616	SCOLIOSIS, in a child or adolescent, re-exploration for adjustment or removal of segmental instrumentation used for correction of spine deformity (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $619.35 **Benefit:** 75% = $464.55
50620	SCOLIOSIS, in a child or adolescent, revision of failed scoliosis surgery, involving more than 1 of osteotomy, fusion, removal of instrumentation or instrumentation, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $3,426.95 **Benefit:** 75% = $2,570.25
50624	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - not more than 4 levels (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $3,426.95 **Benefit:** 75% = $2,570.25
50628	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $4,233.20 **Benefit:** 75% = $3,174.90
50632	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, requiring segmental instrumentation and fusion of the spine down to and including the pelvis or sacrum, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $3,558.65 **Benefit:** 75% = $2,669.00
50636	SCOLIOSIS, in a child or adolescent, requiring anterior decompression of the spinal cord with vertebral resection and instrumentation in the presence of spinal cord involvement, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $3,954.10 **Benefit:** 75% = $2,965.60
50640	SCOLIOSIS, in a child or adolescent, congenital, resection and fusion of abnormal vertebra via an anterior or posterior approach, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $2,185.80 **Benefit:** 75% = $1,639.35
50644	SPINE, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $2,108.95 **Benefit:** 75% = $1,581.75

	TREATMENT OF HIP DYSPLASIA OR DISLOCATION IN PAEDIATRIC PATIENTS
50650	HIP DYSPLASIA or DISLOCATION, in a child, examination, manipulation and arthrography of the hip under anaesthesia (Anaes.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $414.75 **Benefit:** 75% = $311.10 85% = $352.55
50654	HIP DYSPLASIA or DISLOCATION, in a child, application or reapplication of a hip spica, including examination of the hip (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $496.65 **Benefit:** 75% = $372.50
50658	HIP DYSPLASIA or DISLOCATION, in a child, examination and manipulation of the hip under anaesthesia (Anaes.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $197.75 **Benefit:** 75% = $148.35 85% = $168.10
	SUBGROUP 16 - RADIOFREQUENCY ABLATION
50950	NONRESECTABLE HEPATOCELLULAR CARCINOMA, destruction of, by percutaneous radiofrequency ablation, including any associated imaging services, not being a service associated with a service to which item 30419 or 50952 applies (Anaes.) **Fee:** $817.10 **Benefit:** 75% = $612.85 85% = $737.60
50952	NONRESECTABLE HEPATOCELLULAR CARCINOMA, destruction of, by open or laparoscopic radiofrequency ablation, where a multi-disciplinary team has assessed that percutaneous radiofrequency ablation cannot be performed or is not practical because of one or more of the following clinical circumstances: - percutaneous access cannot be achieved; - vital organs/tissues are at risk of damage from the percutaneous RFA procedure; or - resection of one part of the liver is possible however there is at least one primary liver tumour in a non-resectable region of the liver which is suitable for radiofrequency ablation, including any associated imaging services, not being a service associated with a service to which item 30419 or 50950 applies (Anaes.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $817.10 **Benefit:** 75% = $612.85 85% = $737.60

	GROUP T9 - ASSISTANCE AT OPERATIONS
51300	Assistance at any operation identified by the word "Assist." for which the fee does not exceed $558.30 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed $558.30 *(See para T9.1 and T9.2 of explanatory notes to this Category)* **Fee:** $86.30 **Benefit:** 75% = $64.75 85% = $73.40
51303	Assistance at any operation identified by the word "Assist." for which the fee exceeds $558.30 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds $558.30. *(See para T9.1 and T9.3 of explanatory notes to this Category)* **Derived Fee:** one fifth of the established fee for the operation or combination of operations
51306	Assistance at a delivery involving Caesarean section *(See para T9.1 of explanatory notes to this Category)* **Fee:** $124.65 **Benefit:** 75% = $93.50 85% = $106.00
51309	Assistance at a series or combination of operations which have been identified by the word "Assist." and assistance at a delivery involving Caesarean section *(See para T9.1 and T9.4 of explanatory notes to this Category)* **Derived Fee:** one fifth of the established fee for the operation or combination of operations (the fee for item 16520 being the Schedule fee for the Caesarean section component in the calculation of the established fee)
51312	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615, 16627 and 16633 *(See para T9.1 of explanatory notes to this Category)* **Derived Fee:** one fifth of the established fee for the procedure or combination of procedures
51315	Assistance at cataract and intraocular lens surgery covered by item 42698, 42701, 42702, 42704 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42725, 42746, 42749, 42752, 42776 or 42779 *(See para T9.1 of explanatory notes to this Category)* **Fee:** $272.40 **Benefit:** 75% = $204.30 85% = $231.55
51318	Assistance at cataract and intraocular lens surgery where patient has: - total loss of vision, including no potential for central vision, in the fellow eye; or - previous significant surgical complication in the fellow eye; or - pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, corneal scarring, pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan's syndrome, homocysteinuria or previous blunt trauma causing intraocular damage *(See para T9.1 and T9.5 of explanatory notes to this Category)* **Fee:** $179.75 **Benefit:** 75% = $134.85 85% = $152.80

INDEX

A

Abbe flap, reconstruction of cleft lip 45701
reconstruction of lip or eyelid 45671
Abdomen, burst, repair of 30403
closure of and repair of musculoaponeurotic layer 45570
closure of, in conjunction with free tissue transfer or breast reconstruction 45569
abdominal aortic aneurysm, endovascular repair 33116,33119
Abdominal apron, wedge excision 30165,30168,30171
aortic aneurysm, endovascular repair of 33116,33119
musculature transfer to greater trochanter 50387
paracentesis 30406
viscera, operations involving laparotomy 30387
wall vitello intestinal remnant, excision of 43942
Abdomino-perineal resection, rectum and anus 32039,32042,32045 32046
Abdomino-vaginal op for stress incontinence 35602,35605
Abdominoplasty, Pitanguy type 30177
Abortion, threatened, treatment of 16505
Abrasive therapy 45021,45024
Abscess, anal, drainage of 32174,32175
appendiceal, laparotomy for drainage 30394
Bartholin's, incision of 35520
breast, exploration and drainage 31551
deep, percutaneous drainage 30224
drainage tube, exchange of 30225
extradural, laminectomy for 40309
intra-orbital, drainage of 42572
intracranial, excision of 39903
ischio-rectal, drainage of 32174,32175
laparotomy for drainage of 30394
large, incision and drainage, with GA 30223
liver, open abdominal drainage of 30431
middle ear, operation for 41626
pancreatic, laparotomy, external drainage 30575
pelvic, laparotomy for drainage of 30394
peritonsillar, incision of 41807
prostate, drainage of 37212,37221
retroperitoneal, drainage of 30402
small, incision, drainage, without GA 30219
subperiosteal 43500,43503,43506 43509,43512,43515,43518,43521,43524
subphrenic, laparotomy for drainage 30394
Accessory bone, osteotomy or osteectomy of 48400
Acetabular dysplasia, pelvis, bone graft/shelf procedure 50393
Acetabulum, treatment of fracture of 47492,47495,47498 47501,47504,47507,47510
Achilles' tendon, operation for lengthening 49727
tendon, repair of 49718,49721,49724
Acoustic neuroma, removal of 41575,41576,41578 41579
Adductors to ischium transfer 50387
Adenoids and tonsils, removal of 41788,41789,41792 41793
removal of 41800,41801
Adhesions, division of, via laparoscope 31450,31452,35637
division of, with laparoscopy 30393
division of, with laparotomy 30376,30378,30379
liver, destruction of by cryotherapy 30419
nasal, division of 41683
pharyngeal, division of 41758
Administration of 16018
Adrenal gland, excision of 36500
gland tumour, excision of 30324
hyperplasia, congenital, vaginoplasty for 37851
Alcohol, injection of trigeminal nerve/s 39100
retrobulbar injection of 42824
Alimentary continuity, primary restoration 41843
obstruction, neonatal, laparotomy for 43825
Alopecia, hair transplantation for 45560
Alveolar ridge augmentation 45841,45843
Amnio-infusion 16621
Amniocentesis, diagnostic 16600
therapeutic 16618
Amputation, limb, digit etc. 44325,44328,44331 44334,44338,44342,44346,44350,44354,44358,44359 44361,44364,44367,44370,44373,44376
stump, reamputation of 44376
stump, revision of 46483
Anaesthetic, Relative Value Guide 20100,20102,20104 20120,20124,20140,20142-20148,20160,20162,20164 20170,20172,20174,20176,20190,20192,20210,20212 20214,20216,20220,20222,20225,20230,20300,20305 20320,20321,20330,20350,20352,20355,20400-20406 20410,20420,20440,20450,20452,20470,20472,20474 20475,20500,20520,20522,20524,20526,20528,20540 20542,20546,20548,20560,20600,20604,20620,20622 20630,20632,20634,20670,20680,20690,20700 20702-20706,20730,20740,20745,20750,20752,20754 20756,20770,20790-20794,20798-20800,20802-20806 20810,20815,20820,20830,20832,20840-20842 20844-20848,20850,20855,20860,20862-20864 20866-20868,20880,20882,20884,20886,20900,20902 20904-20906,20910-20912,20914,20916,20920,20924 20926,20928,20930,20932,20934,20936,20938,20940 20942-20944,20946,20948,20950,20952-20954,20956 20958,20960,21100,21110,21112,21114,21116,21120 21130,21140,21150,21155,21160,21170,21195,21199 21200,21202,21210,21212,21214,21216,21220,21230 21232,21234,21260,21270,21272,21274,21275,21280 21300,21321,21340,21360,21380,21382,21390,21392 21400,21402-21404,21420,21430,21432,21440,21445 21460-21462,21464,21472,21474,21480,21482,21484 21486,21490,21500,21502,21520,21522,21530,21532 21535,21600,21610,21620,21622,21630,21632,21634 21636,21638,21650,21652,21654,21656,21670,21680 21682,21685,21700,21710,21712,21714,21716,21730 21732,21740,21756,21760,21770,21772,21780,21785 21790,21800,21810,21820,21830,21832,21834,21840 21842,21850,21860,21865,21870,21872,21878-21887 21900,21906,21908,21910,21912,21914-21916,21918 21922,21925-21927,21930,21935,21936,21939 21941-21943,21945,21949,21952,21955,21959,21962 21965,21969,21970,21973,21976,21980,21981,21990 21992,21997,22001,22002,22007,22008,22012,22014 22015,22018,22020,22025,22031,22036,22040,22045 22050,22051,22055,22060,22065,22070,22075,22900 22905,23010,23021-23023,23031-23033,23041-23043 23051-23053,23061-23063,23071-23073,23081-23083 23091,23101,23111-23119,23121,23170,23180,23190 23200,23210,23220,23230,23240,23250,23260,23270 23280,23290,23300,23310,23320,23330,23340,23350 23360,23370,23380,23390,23400,23410,23420,23430 23440,23450,23460,23470,23480,23490,23500,23510 23520,23530,23540,23550,23560,23570,23580,23590 23600,23610,23620,23630,23640,23650,23660,23670 23680,23690,23700,23710,23720,23730,23740,23750 23760,23770,23780,23790,23800,23810,23820,23830 23840,23850,23860,23870,23880,23890,23900,23910 23920,23930,23940,23950,23960,23970,23980,23990 24100-24136,25000,25005,25010,25015,25020,25025

25030,25050,25200,25205
abdomen, lower 20800,20802-20806,20810 20815,20820,20830,20832,20840-20842,20844-20848 20850,20855,20860,20862-20864,20866-20868,20880 20882,20884
abdomen, upper 20700,20702-20706,20730 20740,20745,20750,20752,20754,20756,20770 20790-20794,20798,20799
anaesthesia in connection with burns 21878-21887
anaesthesia in connection with dental services 22900,22905
anaesthesia in connection with radiological diagnostic or therapeutic procedures 21900,21906,21908 21910,21912,21914-21916,21918,21922,21925-21927 21930,21935,21936,21939,21941-21943,21945,21949 21952,21955,21959,21962,21965,21969,21970,21973 21976,21980
anaesthesia modifiers 25000,25005,25010 25015,25020,25025,25030
anaesthesia time 23010,23021-23023,23031-23033 23041-23043,23051-23053,23061-23063,23071-23073 23081-23083,23091,23101,23111-23119,23121,23170 23180,23190,23200,23210,23220,23230,23240,23250 23260,23270,23280,23290,23300,23310,23320,23330 23340,23350,23360,23370,23380,23390,23400,23410 23420,23430,23440,23450,23460,23470,23480,23490 23500,23510,23520,23530,23540,23550,23560,23570 23580,23590,23600,23610,23620,23630,23640,23650 23660,23670,23680,23690,23700,23710,23720,23730 23740,23750,23760,23770,23780,23790,23800,23810 23820,23830,23840,23850,23860,23870,23880,23890 23900,23910,23920,23930,23940,23950,23960,23970 23980,23990,24100-24136
arm, upper (and elbow) 21700,21710,21712 21714,21716,21730,21732,21740,21756,21760,21770 21772,21780,21785,21790
assistance at anaesthesia 25200,25205
assistance time 23010,23021-23023,23031-23033 23041-23043,23051-23053,23061-23063,23071-23073 23081-23083,23091,23101,23111-23119,23121,23170 23180,23190,23200,23210,23220,23230,23240,23250 23260,23270,23280,23290,23300,23310,23320,23330 23340,23350,23360,23370,23380,23390,23400,23410 23420,23430,23440,23450,23460,23470,23480,23490 23500,23510,23520,23530,23540,23550,23560,23570 23580,23590,23600,23610,23620,23630,23640,23650 23660,23670,23680,23690,23700,23710,23720,23730 23740,23750,23760,23770,23780,23790,23800,23810 23820,23830,23840,23850,23860,23870,23880,23890 23900,23910,23920,23930,23940,23950,23960,23970 23980,23990,24100-24136
assistance, modifiers 25000,25005,25010 25015,25020,25025,25030
forearm, wrist & hand 21800,21810,21820 21830,21832,21834,21840,21842,21850,21860,21865 21870,21872
head 20100,20102,20104 20120,20124,20140,20142-20148,20160,20162,20164 20170,20172,20174,20176,20190,20192,20210,20212 20214,20216,20220,20222,20225
intrathoracic 20500,20520,20522 20524,20526,20528,20540,20542,20546,20548,20560
knee & popliteal area 21300,21321,21340 21360,21380,21382,21390,21392,21400,21402-21404 21420,21430,21432,21440
leg, lower (below knee) 21460-21462,21464,21472 21474,21480,21482,21484,21486,21490,21500,21502 21520,21522,21530,21532
leg,upper (except knee) 21195,21199,21200 21202,21210,21212,21214,21216,21220,21230,21232 21234,21260,21270,21272,21274,21275,21280
neck 20300,20305,20320 20321,20330,20350,20352
pelvis (except hip) 21100,21110,21112 21114,21116,21120,21130,21140,21150,21155,21160 21170
perfusion, modifiers 25000,25005,25010 25015,25020,25050
perfusion, time 23010,23021-23023,23031-23033 23041-23043,23051-23053,23061-23063,23071-23073 23081-23083,23091,23101,23111-23119,23121,23170 23180,23190,23200,23210,23220,23230,23240,23250 23260,23270,23280,23290,23300,23310,23320,23330 23340,23350,23360,23370,23380,23390,23400,23410 23420,23430,23440,23450,23460,23470,23480,23490 23500,23510,23520,23530,23540,23550,23560,23570 23580,23590,23600,23610,23620,23630,23640,23650 23660,23670,23680,23690,23700,23710,23720,23730 23740,23750,23760,23770,23780,23790,23800,23810 23820,23830,23840,23850,23860,23870,23880,23890 23900,23910,23920,23930,23940,23950,23960,23970 23980,23990,24100-24136
perfusion, whole body, cardiac bypass 22060
perineum 20900,20902,20904-20906 20910-20912,20914,20916,20920,20924,20926,20928 20930,20932,20934,20936,20938,20940,20942-20944 20946,20948,20950,20952-20954,20956,20958,20960
shoulder & axilla 21600,21610,21620 21622,21630,21632,21634,21636,21638,21650,21652 21654,21656,21670,21680,21682
spine & spinal cord 20600,20604,20620 20622,20630,20632,20634,20670,20680,20690
thorax 20400-20406,20410,20420 20440,20450,20452,20470,20472,20474
Anal canal, laser therapy (restriction) 35539,35542,35545
fissure, operation for, including excision 32150
fistula, excision/repair 32156,32159,32162 32165
fistula, readjustment of Seton 32166
graciloplasty 32203
graciloplasty, insertion of stimulator & electrode 32209
incontinence, Parks' procedure 32126
skin tags or polyps, excision of 32142,32145
sphincter, direct repair of 32129
sphincterotomy, independent, Hirschsprung's 43999
stricture, anoplasty for 32123
warts, removal under GA or nerve block 32177,32180
Anastomosis, aorta, congenital heart disease 38706,38709
arterial/venous, independent 32766
arterial/venous, with other operation 32769
arteriovenous, upper or lower limb 34503,34509
facio-hypoglossal/accessory nerve 39503
ileo-rectal, with total colectomy 32012
intrathoracic, congenital heart disease 38727,38730
microvascular, in plastic surgery 45502
oesophageal atresia, neonatal 43855
saphenous vein, for femoral vein bypass 34809
vena cava, for congenital heart disease 38721,38724
Aneurysm, cerebrovascular, clipping/reinforcement 39800
intracranial proximal artery clipping 39806
intracranial, ligation cervical vessels 39812
left ventricular, plication of 38506
left ventricular, resection 38507,38508
major artery, replacement/repair 33050,33055,33070 33075,33080,33100,33103,33109,33112,33115,33116 33118,33119,33121,33124,33127,33130,33133,33136 33139,33142,33145,33148,33151,33154,33157,33160 33163,33166,33169,33172,33175,33178,33181
Angiofibroma, face/neck, removal by laser excision 30190
nasopharyngeal, removal 41767
angiography, selected coronary 38215,38218,38220 38222,38225,38228,38231,38234,38237,38240,38241 38243,38246

Angioma, cauterisation/injection into 45027
excision of 45030,45033,45035
45036
Angioplasty, peripheral laser 35315
transluminal balloon 35300,35303
Angioscopy 35324,35327
Ankle, achilles tendon, operation for lengthening 49727
achilles tendon, repair of 49718,49721,49724
and foot, tibialis tendon transfer 50339,50342
arthrodesis of 49712
arthroscopic surgery of 49703
arthroscopy of, diagnostic 49700
arthrotomy of 49706
dislocation, treatment of 47063,47066
fracture, treatment of 47594,47597,47600
47603
gastrocnemius aponeurosis, operation for lengthening 49728
ligamentous stabilisation of 49709
major tendon repair 49718
revision arthroplasty 49716,49717
synovectomy of 50312
tibialis tendon transfer 50339,50342
total joint replacement 49715
Annuloplasty, heart valve 38475,38477,38478
Anophthalmic orbit, insertion cartilage/implant 42518
orbit, placement of motility integrating peg 42518
orbit, removal of implant from socket 42518
socket, treatment as secondary procedure 42521
Anoplasty for anal stricture 32123
Anorectal carcinoma, excision of 32105
application of formalin 32212
examination, under GA 32171
malformation, neonatal, laparotomy and colostomy 43822
malformation, paediatric, operations 43960,43963,43966
Anorectoplasty of anorectal malformation 43963,43966
Antenatal cardiotocography (restriction) 16514
care, independent of confinement 16500
service provided by a midwife, nurse or ATSI health
practitioner 16400
Antepartum haemorrhage, treatment of 16509
Anterior chamber, irrigation of blood from 42743
resection of rectum 32024,32025
section of corpus callosum for epilepsy 40700
synechiae, division of 42761
vaginal repair 35570-35573,35577,35578
Antireflux operations 30527,30529,30530
operation by fundoplasty 31464,31466
Antrectomy and/or vagotomy 30497,30503
Antrobuccal fistula operation 41722
Antroscopy of temporomandibular joint 45855,45857
Antrostomy, radical 41710,41713
Antrum, drainage of, through tooth socket 41719
intranasal, operation on 41716
maxillary, lavage of 41704
maxillary, proof puncture, lavage 41698,41701
removal of foreign body from 41716
Anus, dilatation of (Lord's procedure) 32153
Aorta, anastomosis, congenital heart disease 38706,38709
thoracic, management of rupture/dissection 38572
thoracic, repair/replacement procedures 38550,38553,38556
38559,38562,38565,38568,38571
Aortic bypass 32708,32710,32711
endarterectomy 33509
interruption, repair of 38712
valve leaflet/s, decalcification of 38483
Aorto-duodenal fistula, repair of 34160,34163,34166
Aorto-femoral endarterectomy 33515
Aorto-iliac endarterectomy 33512
Aortopexy for tracheomalacia 43909
Appendiceal abscess, laparotomy for drainage 30394
Appendicectomy 30571,30572,30574
30645
Appendicectomy, laparoscopic 30646
Appendix, ruptured, laparotomy for drainage 30394
Arachnoidal cyst, craniotomy for 39718
Arch Bars, to maxilla or mandible, removal of 45823
Areola, reconstruction of 45545,45546
Arm, amputation or disarticulation of 44328
Arnold Chiari malformation, decompression of 40106
Arrhythmia ablation 38287,38290,38293
surgery 38390,38393,38512
38515,38518
Arterial anastomosis, not otherwise covered 32766,32769
atherectomy, peripheral 35312
cannulation for infusion chemotherapy, open 34524
catheterisation, peripheral 35317,35319-35321
line for blood pressure monitoring 13876
puncture and blood collection, diagnostic 13839
Arteries, major, access as part of re-operation 35202
Arteriography, operative 35200
Arteriography, preparation for 38215
Arteriography, preparation for 38218
Arteriovenous access device, insertion of 34512
access device, prosthetic, correction of 34518
access device, thrombectomy of 34515
anastomosis of upper or lower limb 34503,34509
fistula extremity, surgically created, closure 34130
fistula, dissection and ligation/repair 34112,34115,34118
34121,34124,34127
fistula, ligation of cervical vessel/s 39812
fistula, stenosis of, correction of 34518
malformation, excision of 45039,45042,45045
malformation, intracranial artery clipping of 39806
malformation, intracranial, excision of 39803
malformation, laminectomy, radical excision of 40318
shunt, declotting of 13106
shunt, external, insertion/removal 34500,34506
Artery, anastomosis of, microvascular 45502
bypass grafting, occlusive arterial disease 32700,32703,32708
32710-32712,32715,32718,32721,32724,32730,32733
32736,32739,32742,32745,32748,32751,32754,32757
32760,32763
coeliac, decompression of 34142
coronary, bypass operations 38497,38498,38500
38501,38503,38504
embolectomy of 33800,33803,33806
endarterectomy of 33500,33506,33509
33512,33515,33518,33521,33524,33527,33530,33533
33536,33539,33542
ethmoidal, transorbital ligation of 41725
great, ligation/exploration, other 34103
harvesting for coronary bypass 38496
ligation/exploration not otherwise covered 34106
major, of neck, ligation/exploration, other 34100
major, repair of wound of 33815,33818,33821
33824,33827,33830,33833,33836,33839
maxillary, transantral ligation of 41707
neck, reoperation for bleeding/thrombosis 33842
patch grafting to 33545,33548
popliteal, exploration for popliteal entrapment 34145
temporal, biopsy of 34109
thrombectomy of 33803,33806
Arthrectomy, hip 49309,49312
rotational,coronary artery 38309,38312,38315
38318
Arthrocentesis. with irrigation of temporomandibular
joint 45865
Arthrodesis, ankle 49712
elbow 49106
finger/hand 46300,46303
foot 49815,49845
hip 49306

joint, other 50109
knee 49509,49512,49545
sacro-iliac joint 49300
shoulder 48939,48942
subtalar joint 50118
wrist 49200,49203
Arthroplasty, ankle 49715
carpal bone 46324,46325
finger/hand 46306,46307,46309 46312,46315,46318,46321
foot 49839,49842
hip 49309,49312,49315 49318,49319,49321,49324,49327,49330,49333,49346
joint, other 50127
knee 49518,49519,49521 49524,49527,49530,49533,49534
shoulder 48915,48918,48921 48924
temporomandibular joint 45758
wrist 49209
Arthroscopy, ankle 49700,49703
elbow 49118,49121
hip 49360,49363,49366
joint, other 50100,50102
knee 49557-49564,49566
shoulder 48945,48948,48951 48954,48957,48960
wrist 49218,49221,49224 49227
Arthrotomy, ankle 49706
elbow 49100
finger/hand 46327,46330
hip 49303
joint, other 50103
knee 49500
shoulder 48912
wrist 49212
Artificial erection device, insertion of 37426,37429
erection device, revision or removal of 37432
insemination services 13203,13209,13221
lens, insertion of 42701
lens, removal of 42704
lens, removal, replacement different lens 42707
lens, repositioning of, open operation 42704
urinary sphincter, insertion 37381,37384,37387
urinary sphincter, revision/removal 37390
Arytenoidectomy with microlaryngoscopy 41867
Aspiration biopsy, bone marrow 30087
biopsy, deep organ, imaging guided 30094
of bladder, needle 37041
of haematoma 30216
of thoracic cavity 38800,38803
one or more jaw cysts 45799
Assistance at operations 51300,51303,51306 51309,51312,51315,51318
Assisted reproductive technologies 13200,13203,13206 13209,13212,13215,13218,13221
Atherectomy, peripheral arterial 35312
Atresia, choanal, repair/correction 45645,45646
external auditory canal, reconstruction 45662
Atrial chamber/s, operations for arrhythmia 38512,38515
septal defect closure, surgical 38742
septal defect closure, transcatheter approach 38272
septectomy 38739
Attendance, acupuncture
antenatal 16500
intensive care unit (specialist) 13870,13873
Atticotomy 41533,41536
Auditory canal, external 41524
- reconstruction, congenital atresia 45662
- removal of foreign body, incision 41503
canal external, blind sac closure 41564
canal stenosis, correction of, with meatoplasty 41521
meatus, external, removal of exostoses in 41518
meatus, internal, exploration 41599
Augmentation mammaplasty 45524,45527,45528
Aural polyp, removal of 41506
Autoconjunctival transplant 42641
Avulsion, penis, repair of 37411
Axilla, lymph glands, excision of 30332
lymph nodes, excision of 30335,30336
Axillary hyperhidrosis, excision for 30180,30183
to femoral bypass grafting 32715
vessel, ligation/exploration, other 34103
Axillofemoral graft, infected, excision of 34172

B

Baker's cyst, excision of 30114
Balloon catheter, right heart, insertion of 13818
intubation, gastro-oesophageal 13506
valvuloplasty or septostomy 38270
Balloon enteroscopy 30680,30682,30684 30686
Bariatric Surgery 31569,31572,31575 31578,31581,31584
Bariatric surgery, surgical reversal of 31584
Bartholin's abscess, incision of 35520
cyst or gland, marsupialisation of 35516,35517
cyst, excision of 35512,35513
Barton's fracture of radius, treatment of 47369,47372,47375
Basal cell carcinoma, removal of31255-31258,31260-31263,31265-31268 31270-31273,31275-31278,31280-31283,31285-31288 31290-31293,31295
in oral & maxillofacial, complicated, removal 45811,45813
in oral & maxillofacial, uncomplicated, removal of45801,45803,45805 45807,45809
Bat ear or similar deformity, correction of 45659
Bicornuate uterus, plastic reconstruction for 35680
Bile duct, common, radical resection 30461,30463,30464
duct, common, repair of 30472
duct, endoscopic stenting of 30491
Biliary atresia, paediatric, portoenterostomy for 43978
bypass 30460,30466,30467
dilatation, endoscopic 30494
dilatation, percutaneous 30495
drainage tube exchange, imaging guided 30451
manometry 30493
stenting, percutaneous 30492
stricture, repair of 30469
Biopsy, aggressive bone/deep tissue tumour 50200,50201
biopsy, using ABBI 31539,31545
bone marrow 30081,30084,30087
breast 31530,31533,31548
cervix, cone 35617,35618
cervix, punch 35608
conjunctiva 42676
drill, lymph gland, deep tissue/organ 30078
endometrial, for suspected malignancy 35620
laparoscopic 30391
liver 30409,30411
lung, percutaneous needle 38812
lymph gland, muscle, other deep tissue/organ 30074,30075
lymph node of neck 31420
myocardial, by cardiac catherterisation 38275
percutaneous aspiration, deep organ 30094
pleura 30090
prostate 37212,37215,37218
punch, of synovial membrane 30087
rectum, full thickness 32096
renal (closed) 36561
scalene node 30096

sentinel lymph node, for breast cancer 30299,30300,30302 30303
skin or mucous membrane 30071
vertebra, needle 30093
Bladder, aspiration of, by needle 37041
biopsy of, with cystoscopy 36836
catheterisation of 36800
cystostomy or cystotomy 37008
diverticulum of, excision or obliteration 37020
ectopic, 'turning-in' operation 37842
enlargement of, using intestine 37047
excision of 37000,37014
exstrophy closure 37050
exstrophy of, repair of 37842
neck reconstruction, prostatectomy 37210,37211
neck resection, endoscopic 36854
repair of rupture 37004
stress incontinence, sling procedure 37042
stress incontinence, Stamey or similar 37043
stress incontinence, suprapubic procedure 37044
transection, with re-anastomosis to trigone 37053
tumour/s, diathermy/resection 36840,36845
tumour/s, laser destruction with cystoscopy 36840
Blood, administration of
arterial, collection for pathology 13839,13842
collection of, for transfusion 13709
collection of, in infants, for pathology 13312
peripheral, invitro processing, cryopreservation 13760
pressure monitoring, indwelling catheter (ICU only) 13876
retrograde admin for cardioplegia 38588
sampling, fetal 16606
transfusion 13703,13706
transfusion, fetal 16609,16612,16615
transfusion, paediatric/neonatal 13306,13309
Bone, cysts, injection into or aspiration of 47900
bone conduction hearing system 41603,41604
flap, infected, craniectomy for 39906
graft to femur 48200,48203
graft to humerus 48212,48215
graft to other bones 48239
graft to phalanx or metacarpal 46402,46405
graft to radius and ulna 48221
graft to radius or ulna 48218,48224,48227
graft to scaphoid 48230,48233,48236
graft to spine 48642,48645,48648 48651
graft to tibia 48206,48209
graft, harvesting of 47726,47729,47732
graft, with internal fixation 48242
growth stimulator 45821
lesion/s, removal, diaphyseal aclasia 50426
marrow, administration of 13706
marrow, aspiration biopsy of 30087
marrow, harvesting of for transplantation 13700
marrow, in vitro processing/cryopreservation 13760
tumour, benign, resection of 50230
tumour, innocent, excision of 30241
tumour, malignant, operations for 50200,50201,50203 50206,50209,50212,50215,50218,50221,50224,50227 50230,50233,50236,50239
Botulinum toxin, injection for 18350,18351,18353 18354,18360,18362,18365,18366,18368-18370,18372 18374,18377,18379
blepharospasm 18369,18370,18372 18374
dynamic equinus foot deformity 18354
foot deformities due to spasticity 18354
hemifacial spasm 18350,18351
Boutonniere deformity, reconstruction of 46444,46447
Bowel, colectomy, total 30608,30622,32009 32012,32015,32018,32021
hemicolectomy 32000,32003,32006
ileostomy closure/reservoir 32060,32063,32066 32069
large, resection of 32000,32003
large, subtotal colectomy 32004,32005
perineal proctectomy 32047
rectosigmoidectomy (Hartmann's op) 32030
rectum and anus, resection 32039,32042,32045 32046
rectum, resection of 32024-32026,32028
resection for enterocolitis stricture, neonatal 43834
resection for jejunal atresia, neonatal 43810
restoration following Hartmann's op 32029,32033
ruptured, repair 30375
small, intubation 30487,30488
small, resection of 30565,30566
small, strictureplasty 30564
Brachial fistula 43832
Brachial plexus, exploration of 39333
vessel, ligation/exploration, other 34106
Brachycephaly, cranial vault reconstruction for 45785
Brachytherapy planning 15536
For prostate cancer 15338,15513,15539 37220
Brain stem evoked response audiometry
stem tumour, craniotomy for removal 39709
Branchial cyst, removal of 30286,30287
Brachial, removal of 30287
fistula, removal of 30289
Breast, biopsy, fine needle, imaging guided 31533
abnormality detected by mammography 31506
benign lesion 31500,31503
biopsy of solid tumour, vacuum-assisted, image guided 31530
central ducts, excision for benign condition 31557
core biopsy of solid tumour or tissue 31548
exploration/drainage, operating theatre 31551
lesion, pre-op localisation, for ABBI 31542
lesion, pre-op localisation, imaging guided 31536
malignant tumour 31509,31512
mammaplasty 45524,45527,45528
microdochotomy 31554
nipple, accessory, excision of 31566
prosthesis operations 45548,45551-45554
pstosis, correction of (unilateral) 45556,45557
ptosis, correction of (bilateral) 45558
reconstruction 45530,45533,45536 45539,45542
silicone prosthesis, removal of 45555
tissue, accessory, excision of 31560
tubuerous, tubular or constricted, correction of 45559
tumour site, re-excision 31515
Breast, malignant tumour, targeted intraoperative radiotherapy 15900
Breast, malignant tumuor, complete local excision 31516
Broad ligament cyst/tumour, excision/removal 35712,35713,35716 35717
Brodie's abscess, operation for 43515
Bronchial tree, intrathoracic operation on, other 38456
Bronchoscopy, as an independent procedure 41889
with biopsy or other procedure 41892
with dilatation of tracheal stricture 41904
with transbronchial lung biopsy 41898
Bronchus, dilatation of stricture and stent insertion 41905
operations on 41889,41892,41895
removal of foreign body in 41895
Broviac catheter, insertion of, for chemotherapy 34527,34528,34540
catheter, removal of 34530,34540
Bubonocele operation 30614
Bunion, excision of 47933
Burch colposuspension 37044
Burns, dressing of (not involving grafting) 30003,30006,30009

30010,30013,30014
excision of under GA (not involving grafting) 30017,30020
free grafting 45406,45409,45412 45415,45418,45439,45442,45445,45448,45451 45460-45462,45464-45466,45468,45469,45471,45472 45474,45475,45477,45478,45480,45481,45483-45494
scars, excision of 45519
Burr-hole craniotomy, intracranial haemorrhage 39600
placement of intracranial electrodes 40709
single, preparatory to ventricular puncture 39012
Bursa, incision of
large, excision of 30110,30111
semimembranosus, excision of 30114
small, excision of 30106,30107
Burst abdomen, repair of 30403
Bypass, extracranial to intracranial 39818
graft, infected, of extremities, excision of 34175
graft, infected, of neck, excision of 34157
graft, infected, of trunk, excision of 34169
grafting for aneurysm 33050,33055
grafting, arterial, for occlusive arterial disease 32700,32703,32708 32710-32712,32715,32718,32721,32724,32730,32733 32736,32739,32742,32745,32748,32751,32754,32757 32760,32763
grafting, cross leg, saphenous to iliac or femoral vein 34806

C

Caecostomy, 30375,30637
closure of 30562
Caesarean section 16520,16522
Calcaneal spur, of foot, excision of 49818
Calcanean bursa, excision of 30110,30111
Calcaneum fracture, treatment of 47606,47609,47612 47615,47618
Calculus, biliary, extraction of 30454,30455,30457 30458
biliary/renal tract, extraction of 30450
bladder, removal of 36863
kidney, removal of 36540,36543
renal, extraction of 36627,36630,36633 36636,36639,36642,36645,36648
staghorn, nephrolithotomy and/or pyelolithotomy 36543
sublingual/salivary gland duct, removal of 30265,30266
ureter, removal of 36549
ureteric, endoscopic removal/manipulation 36857
Caldwell-Luc operation 41710
Calf, decompression fasciotomy of 47975,47978,47981
Cancer of skin/mucous membrane, removal 30196,30197,30202 30203,30205
Cannulae, membrane oxygenation 38627
bypass 38627
ventricular assist 38627
Cannulation, arterial, for infusion chemotherapy 34524
central vein 13318,13815
central vein, subcutaneous tunnel 34527
coronary sinus, for admin of blood or crystalloid 38588
for cardiopulmonary bypass 38600,38603
for retrograde cerebral perfusion 38577
intra-abdominal vessel, for chemotherapy 34521
peripheral arterial 35317,35319-35321
peripheral venous 35317,35319,35320
pulmonary artery 13818
umbilical artery 13303
umbilical/scalp vein in neonate 13300
Canthoplasty 42590
Capsulectomy 42719,42731
of finger joints 46336
Capsulotomy, laser 42788,42789
other than laser 42734
Carbon dioxide laser resurfacing, face or neck 45025,45026
Carbuncle, incision and drainage, with GA 30223
Cardiac by-pass, whole body perfusion 22060
catheterisation 38200,38203,38206 38209,38212,38213,38215,38218,38220,38222
catheterisation - for myocardial biopsy 38275
deep hypothermic circulatory arrest 22075
electrophysiological studies 38209,38212,38213
operation (intrathoracic), other 38456
pacemaker, insertion/replacement 38353
resynchronisation therapy 38365,38368,38371 38654
rhythm, restoration, electrical stimulation 13400
surgery, for congenital heart disease 38700,38703,38706 38709,38712,38715,38718,38721,38724,38727,38730 38733,38736,38739,38742,38745,38748,38751,38754 38757,38760,38763,38766
surgery, re-operation via median sternotomy 38640
tumour, excision of 38670,38673,38677 38680
Cardiopexy, antireflux operation 30530
Cardioplegia, retrograde administration of 22070
Cardiopulmonary bypass, cannulation for 38600,38603
support procedures 13815,13818,13830 13839,13842,13847,13848,13851,13854,13857
Cardiotocography, antenatal (restriction) 16514
Cardioversion 13400
Carotid artery, aneurysm, graft replacement 33100
artery, internal, transection/resection 32703
body tumour, resection of 34148,34151,34154
cavernous fistula, obliteration of 39815
percutaneous transluminal angioplasty with stenting 35307
percutaneous transluminal angioplasty with stenting 35307
Carpal bone, replacement arthroplasty 46324,46325
ligament, transverse, division of 39331
resection arthroplasty 46325
scaphoid, fracture, treatment of 47354,47357
tunnel release 39331
Carpometacarpal joint, arthrodesis of 46303
joint, dislocation, treatment of 47030,47033
joint, synovectomy of 46342
Carpus dislocation, treatment of 47030,47033
fracture, treatment of 47348,47351
operation on, acute osteomyelitis 43503,46462
operation on, chronic osteomyelitis 43512,46462
osteectomy/osteotomy of 48406,48409
Caruncle, urethral, cauterisation of 35523
urethral, excision of 35526,35527
Cataract, juvenile, removal of 42716
surgery 42702
Catheter, peritoneal insertion and fixation 13109
epidural, insertion of 39140
placement of catheters and injection of opaque material 38243
tenckhoff peritoneal dialysis, removal of 13110
Catheterisation, bladder, independent procedure 36800
blood pressure monitoring 13876
cardiac 38200,38203,38206 38209,38212,38213,38215,38218,38220,38222
central vein 13318,13319,13815
central vein, subcutaneous tunnel 34527,34528
central vein, tunnelled cuffed 34538
eustachian tube 41755
frontal sinus 41740
intracranial, for pressure monitoring 13830
peripheral arterial 35317,35319-35321
peripheral venous 35317,35319,35320
peritoneal, for dialysis 13109,13110
pulmonary artery 13818
right heart balloon 13818
umbilical artery 13303
umbilical or scalp vein in a neonate 13300
ureteric, with cystoscopy 36824

cauterisation of, for ectropion or entropion 42581
coalition, excision of 50333
cyst, extirpation of 42575
Cauterisation, angioma (restriction applies) 45027
cervix 35608
perforation of tympanum 41641
septum/turbinates/pharynx 41674
tarsus, for ectropian/entropian 42581
urethra or urethral caruncle 35523
Cautery, conjunctiva, including treatment of pannus 42677
nasal, for arrest of haemorrhage 41677
Cavernous sinus, tumour or vascular lesion, excision 39660
Cavopulmonary shunt, creation of 38733,38736
Cellulitis, incision with drainage, under GA 30223
Central cannulation for cardiopulmonary bypass 38600
vein catheterisation 13318,13319,13815
vein catheterisation, via subcutaneous tunnel 34527,34528
Cerebello-pontine angle tumour 41575,41576,41578 41579
- retromastoid removal of 41575,41576,41578 41579
- translabyrinthine removal 41575,41576,41578 41579
- transmastoid removal 41575,41576,41578 41579
Cerebral palsy, hips or knees, application of cast under GA 50390
perfusion, retrograde, cannulation for 38577
single event multilevel surgery 50450,50451,50455 50456,50460,50461,50465,50466,50470,50471,50475 50476
tumour, craniotomy for removal 39712
ventricle, puncture of 39006
Cerebrospinal fluid drain, lumbar, insertion of 40018
fluid reservoir, insertion of 39018
Cervical decompression of spinal cord 40331-40335
discectomy (anterior), without fusion 40333
oesophagectomy 30294
oesophagostomy, closure or plastic repair of 30293
re-exploration for hyperparathyroidism 30317
rib, removal of 34139
sympathectomy 35003,35006
Cervix, amputation or repair of 35617,35618
cauterisation of, other than by chemical means 35608
colposcopic examination of 35614
colposcopy with biopsy and diathermy 35646
cone biopsy of 35617,35618
diathermy of 35608,35646
electrocoagulation diathermy 35644,35645
ionisation of 35608
large loop excision 35647,35648
laser therapy (restriction applies) 35539,35542,35545
punch biopsy 35608
purse string ligation 16511
removal of polyp from 35611
removal of purse string ligature 16512
repair of extensive laceration/s 16571
repair of, not otherwise covered 35617,35618
residual stump, removal of, abdominal approach 35612
residual stump, removal of, vaginal approach 35613
Chalazion, extirpation of 42575
Chemical peel, full face 45019,45020
Chemotherapy 13915,13918,13921 13924,13927,13930,13933,13936,34529,34534
device for drug delivery, loading of 13939,13942,13945
device, insertion, central vein catheterisation 34527-34529,34534
device, removal of 34530
infusion, cannulation for 34521,34524
Chest, or limb, decompression escharotomy 45054
Chloasma, full face chemical peel 45019,45020
Choanal atresia, repair/correction 45645,45646
Cholangiogram, percutaneous transhepatic 30440
Cholangiography, operative 30439
Cholangiopancreatography 30484
Cholecystectomy 30443,30445,30446 30448,30449
Cholecystoduodenostomy 30460,31472
Cholecystoenterostomy 30460,31472
Cholecystostomy 30375
Choledochal cyst, resection of 43972,43975
Choledochoduodenostomy 30460,30461
Choledochoenterostomy 30460,30461
Choledochogastrostomy 30461
Choledochojejunostomy 30460,30461
Choledochoscopy 30442,30452
Choledochotomy 30454,30455,30457
Chondro-cutaneous or chondro-mucosal graft 45656
Chondroplasty of knee 49503,49506
Chordee, correction of 37417
Chorionic villus sampling 16603
Chymopapain (Discase), intradiscal injection of 40336
Cicatricial flexion/extension contracture, joint, correction 50112
Ciliary body and/or iris, excision of tumour 42767
Circulatory support device, management of 13851,13854
support procedures 38362,38600,38603 38609,38612,38613,38615,38618,38621,38624
Circumcision 30649,30653,30656 30659,30660
arrest of post-operative haemorrhage 30663
Cisternal puncture 39003
shunt diversion, insertion of 40003
shunt, revision or removal of 40009
Clavicle, dislocation, treatment of 47003,47006
fracture, treatment of 47462,47465
operation for acute osteomyelitis 43503
operation for chronic osteomyelitis 43512
osteectomy/osteotomy 48406,48409
Claw toe, correction of 49848
Cleft lip, operations for 45677,45680,45683 45686,45689,45692,45695,45698,45701,45704
palate, correction of 45707,45710,45713
Clitoris, amputation of, medically indicated 35530
Clitoroplasty, reduction, ambiguous genitalia 37845,37848
Clival tumour, removal of 39653,39654,39656 39658
Cloaca, persistent, correction of 43969
Cloacal exstrophy, neonatal, operation for 43882
Club hand, radial, centralisation/radialisation 50399
Coccyx, excision of 30672
Cochlear implant, insertion with mastoidectomy 41617
Cochleotomy, or repair of round window 41614
Coeliac artery, decompression of 34142
Colectomy, subtotal, of large intestine 32004,32005
total, for Hirschsprung's, paediatric 43996
total, with excision rectum/anastomosis 32051,32054,32057
total, with excision rectum/ileostomy 32015,32018,32021
total, with ileo-rectal anastomosis 32012
total, with ileostomy 32009
Colles' fracture of radius, treatment of 47369,47372,47375
treatment of paediatric 50508,50512
Colonic atresia, neonatal, laparotomy for 43816
lavage, total, intra-operative 32186
reservoir, construction of 32029
Colonic stent, insertion of 32023
Colonoscopy, fibreoptic 32084,32087,32090 32093
Colorectal strictures, endoscopic dilatation of 32094
Colostomy, closure of 30562,30639
colostomy 30375
entero- 30515
refashioning of 30563

with laparotomy, neonatal anorectal malformation 43822
Colotomy 30375
Colpoperineorrhaphy 35571,35573
Colpopexy, sacral 35597
sacrospinous 35568
Colposcopy, using Hinselmann-type instrument 35614
with other procedures 35644-35647
Colpotomy 35572
Composite graft to nose, ear or eyelid 45656
Condylectomy 45611,48406,48424
of mandible 45611
Condylectomy/condylotomy 45863
Cone biopsy of cervix 35617,35618
Confinement 16515,16518-16520,16522
16525
Congenital absence of vagina, reconstruction for 35565
atresia, auditory canal reconstruction 45662
heart disease, operations for 38700,38703,38706
38709,38712,38715,38718,38721,38724,38727,38730
38733,38736,38739,38742,38745,38748,38751,38754
38757,38760,38763,38766
Conjunctiva, cautery of 42677
biopsy of 42676
cryotherapy to 42680
Conjunctival cysts, removal of 42683
graft over cornea 42638
lacerations not involving sclera 30032
peritomy 42632
Conjunctivorhinostomy 42629
Contour reconstruction, insertion of foreign implant 45051
restoration of face, autologous bone/cartilage graft 45647
Contraceptive device, intra-uterine, introduction of 35503
device, intra-uterine, removal under GA 35506
Contracted socket, reconstruction 42527
Contracture, cicatricial flexion/extension of joint,
correction 50112
Dupuytren's, subcutaneous fasciotomy for 46366
flexor/extensor, digits of hand, correction of 46492
Cordotomy, laminectomy for 39124
percutaneous 39121
Cornea, conjunctival graft over 42638
epithelial debridement for corneal ulcer/erosion 42650
epithelial debridement for keratoplasty 42651
removal of imbedded foreign body 42644
removal of superficial foreign body 30061
transplantation of 42653,42656
Corneal, laser coagulation of blood vessels
additional incisions for astigmatism 42673
incisions for astigmatism 42672
keratoplasty, epithelial debridement for 42651
perforations, sealing of 42635
scars, excision of 42647
suture, running, manipulation of 42667
sutures, removal of 42668
ulcer, epithelial debridement of cornea for 42650
Coronary artery bypass operations 38497,38498,38500
38501,38503,38504
angiography, selective 38215,38218,38220
38222,38225,38228,38231,38234,38237,38240,38241
38243,38246
artery bypass vein graft, dissection 38637
endarterectomy, open operation 38505
Coronary pressure wire 38241
Corpus callosum, anterior section of, for epilepsy 40700
Corticectomy, for epilepsy 40703
Corticolysis of lens material 42791,42792
Costo-transverse joint, injection into 39013
Counterpulsation, intra-aortic balloon, management 13847,13848
Cranial nerve, intracranial decompression of 39112
shunt diversion, insertion of 40003
shunt, revision or removal of 40009
vault reconstruction 45785
Craniectomy and removal of haematoma 39603
for osteomyelitis/removal infected bone 39906
Craniocervical junction lesion, transoral approach for 40315
Craniopharyngioma, craniotomy for removal of 39712
Cranioplasty and repair of fractured skull 39615
reconstructive 40600
Craniostenosis, operations for 40115,40118
Craniotomy and tumour removal 39709,39712
burr-hole for intracranial haemorrhage 39600
for arachnoidal cyst 39718
for hydromyelia (with laminectomy) 40342
for reopening post-op for haemorrhage/swelling 39721
Cricopharyngeal myotomy 41776
Cricothyrostomy 41884
Cruciate ligaments, reconstruction/repair 49536,49539,49542
Cryotherapy for detached retina 42773
for trichiasis 42587
hepatic, destruction of liver tumours 30419
of peripheral nerves 39323
of skin lesions 30189,30192,30195
to haemorrhoids with rubber band ligation 32135
to nose, for haemorrhage 41680
to retina, independent procedure 42818
Crystalloid, retrograde admin for cardioplegia 38588
Curettage, for evacuation of gravid uterus 35643
uterus (D and C) 35639,35640
Cutaneous neoplastic lesions, treatment of 30195
nerve, nerve graft to 39318
nerve, repair of 39300,39303
ureterostomy, closure of 36621
vesical fistula, operation for 37023
vesicostomy, establishment of 37026
Cyclodestructive procedures treatment of glaucoma 42770
Cyst, arachnoidal, craniotomy for 39718
Baker's, excision of 30114
Bartholin's, cautery destruction of 35516,35517
Bartholin's, excision of 35512,35513
Bartholin's, marsupialisation of 35516,35517
bone, injection into or aspiration of 47900
brain, operations for 39703
branchial, removal of 30286
broad ligament, excision of 35712,35713,35716
35717
bronchgenic, thoracotomy and excision 43912
choledochal, resection of 43972,43975
enterogenous, thoracotomy and excision 43912
epididymal, removal of 37601
fimbrial, excision of 35712,35713,35716
35717
hydatid, liver, treatment of 30434,30436-30438
hydatid, lungs, enucleation of 38424
intracranial, needling and drainage of 39703
kidney, removal from 36558
liver, laparoscopic marsupialisation 30416,30417
mucous, of mouth, removal 30282,30283
not otherwise covered, removal of (OMS) 45801,45803,45805
45807,45809
other, removal of 31200,31205,31210
31215,31220,31225,31230,31235,31240
ovarian, aspiration of 35518
ovarian, excision of, with laparotomy 35712,35713,35716
35717
pancreatic, anastomosis 30586,30587
parovarian, excision of, with laparotomy 35712,35713,35716
35717
pharyngeal, removal of 41813
pilonidal, excision of 30675,30676
renal, excision of 36558
skin/subcutaneous/mucous membrane, removal of 31200,31205,31210
31215,31220,31225,31230,31235,31240

tarsal, extirpation of 42575
thyroglossal, removal of 30313,30314
vaginal, excision of 35557
vallecular, removal of 41813
Cystadenomatoid malformation, neonatal, thoracotomy 43861
Cystocoele, repair of 35570
Cystoscopy, with 36836
- controlled hydrodilatation of bladder 36827
- diathermy or resection of bladder tumour/s 36845
- endoscopic incision/resection 36825,36854
- injection into bladder wall 36851
- insertion of ureteric stent, or brush biopsy 36821
- insertion of urethral prosthesis 36811
- laser destruction of bladder tumours 36840
- lavage of blood clots from bladder 36842
- removal of foreign body 36833
- resection of ureterocele 36848
- ureteric catheterisation 36818,36824
- ureteric meatotomy 36830
- urethroscopy with/without urethral dilatation 36812
- without litholapaxy 36863
- without urethroscopy 36815
Cystostomy, suprapubic 37008
Cystotomy, suprapubic 37008,37011
Cytotoxic agent, instillation into body cavity 13948

D

D and C 35639,35640
Dacryocystectomy 42596
Dacryocystorhinostomy 42623,42626
Debridement of contaminated wound 30023
of tissue, ischaemic limb 35100,35103
Debulking operation, gynaecological malignancy 35720
Decompression fasciotomy, calf/forearm 47975,47978,47981
fasciotomy, hand 47981
of Arnold-Chiari malformation 40106
of facial nerve, mastoid portion 41569
of intracranial tumour 39706
operation for priapism 37393
subtemporal 40015
Deep organ, percutaneous aspiration biopsy 30094
tissue or organ, biopsy of 30074,30075,30078
Defibrillator generator, insertion/replacement 38393
insertion of patches for 38390
Delorme procedure 32111
Dermabrasion 45021,45024
Dermo-fat or fascia graft 45018
Dermoid, excision of 42576
nasal, excision of 41729
oral and maxillofacial region 45801,45803,45805 45807
orbital, excision of 42574
periorbital, excision of 42573,42576
Detached retina, diathermy/cryotherapy 42773
retina, removal of silicone band 42812
retina, resection/buckling/revision 42776
device for delivery of therapeutic agents 14221,14224,14227 14230,14233,14236,14239,14242
drug delivery system 39125,39126,39128 39133
drug delivery system for spasticity management 14227,14230,14233 14236,14239,14242
pump or reservoir, loading of 14218
Dialysis, peritoneal 13112
supervision in home 13104
supervision in hospital 13100,13103
Diaphragm, plication of for eventration 43915
Diaphragmatic hernia, neonatal, repair of 43837,43840
hernia, repair of 30600,30601
Diaphyseal aclasia, removal of lesion/s from bone 50426
Diastematomyelia, tethered cord, release of 40112
Diathermy of bladder tumours 36840,36845
cervix 35608,35646
detached retina 42773
electrocoagulation, of cervix 35644,35645
palmar or plantar wart 30186
perforation of tympanum 41641
pharynx 41674
rectal polyps with sigmoidoscopy 32078
salivary gland duct 30262
septum 41674
starburst vessels, head or neck 30213,30214
telangiectases, head or neck 30213,30214
turbinates 41674
urethra 37318
Digit, amputation of 46464,46465,46468 46471,46474,46477,46480
distal, excision of ganglion/mucous cyst 46495
extra, amputation of 46464
flexor/extensor contracture, correction of 46492
or ray, transposition/transfer, vascular pedicle 46507
synovectomy of tendon/s 46348,46351,46354 46357,46360
transposition/transfer, vascular pedicle 46507
Digital nail, toe, removal of 47904,47906
nerve, nerve graft to 39318
nerve, repair of 39300,39303
Direct flap repair 45209,45212,45215 45218,45221,45224
Disc, intervertebral, laminectomy for removal 40300
intervertebral, microsurgical discectomy of 40301
lesion, recurrent, laminectomy for 40303
lumbar intervertebral, total artificial replacement 48691-48693
Discectomy, cervical (anterior), without fusion 40333
microsurgical, of intervertebral disc/s 40301
percutaneous lumbar 48636
discontinuation of surgical procedure on medical groups 30001
Disimpaction of faeces under GA 32153
Dissection, lymph nodes of neck 30618,31423,31426 31429,31432,31435,31438
Diverticulum, bladder, excision/obliteration 37020
Meckel's, removal of 30375
urethral, excision of 37372
Dohlman's operation 41773
Donald-Fothergill operation 35577
Donor haemapheresis 13755
Double vagina, excision of septum 35566
Drez lesion, operation for 39124
Drill biopsy of lymph gland/deep tissue/organ 30078
Drug delivery device, loading of 13939,13942,13945
drug delivery system for spasticity management 14227,14230,14233 14236,14239,14242
Duct, salivary gland, diathermy/dilatation 30262
salivary gland, major, transposition of 41910
salivary gland, marsupialisation 30265,30266
salivary gland, meatotomy 30265,30266
salivary gland, removal of calculus 30265,30266
Ducts submandibular, removal of 30255
Duodenal atresia, duodeno-duodenostomy/jejunostomy 43807
intubation 30487,30488
stenosis, duodeno-duodenostomy/jejunostomy 43807
ulcer, perforated, suture 30375
Duodenoduodenostomy for duodenal atresia/stenosis 43807
Duodenojejunostomy for duodenal atresia/stenosis 43807
Duodenoscopy 30473,30476,30478
Dupuytren's contracture, operations for 46366,46369,46372 46375,46378,46381,46384,46387,46390,46393
Dysthyroid eye disease, decompression of orbit 42545

E

E.C.T. 14224
Ear, composite graft to 45656
drum perforation, excision of rim 41644
external, complex total reconstruction of 45660,45661
full thickness laceration, repair of 30052
full thickness wedge excision of 45665
lop, bat or similar deformity, correction of 45659
middle, clearance of 41635,41638
middle, exploration of 41629
middle, insertion of tube for drainage of 41632
middle, operation for abscess or inflammation of 41626
removal of foreign body from 41500,41503
toilet, using operating microscope 41647
Eclampsia, treatment of 16509
Ectopic bladder, 'turning-in' operation 37842
pregnancy, removal of 35676-35678
pregnancy, ultrasound guided needling and injection 35674
Ectropion, correction of 45626
tarsal cauterisation for 42581
Elbow, arthrodesis of 49106
arthroscopic surgery of 49121
arthroscopy of, diagnostic 49118
arthrotomy of 49100
dislocation, treatment of 47018,47021
flexorplasty/tendon transfer to restore function 50405
ligamentous stabilisation of 49103
radial head, replacement of 49112
revision arthroplasty 49116,49117
total replacement of 49115
total synovectomy of 49109
Electrical stimulation, maximal perineal stimulation, restoration cardiac rhythm 13400
Electroconvulsive therapy 14224
Electrode(s), epidural, insertion by laminectomy 39139
epidural, percutaneous insertion of 39130
epidural, percutaneous, management of 39131
graciloplasty, insertion of 32206
intracranial placement 40709,40712
myocardial, permanent, insertion, thoracotomy 38470
pacemaker, permanent, insertion sub xyphoid 38473
transvenous, insertion of 38256,38356
Electrolysis epilation, for trichiasis 42587
Electrophysiological studies, cardiac 38209,38212,38213
Embolectomy 33803,33806
Embolus, removal from artery of neck 33800
Emphysema, lobar, neonatal, thoracotomy & lung resection 43861
Empyema, intercostal drainage of 38806,38809
radical operation for 38415
Enbloc resection of tumour 50212,50215,50218 50221,50224,50227
Encephalocoele, excision and closure of 40109
Endarterectomy 33500,33506,33509 33512,33515,33518,33521,33524,33527,33530,33533 33536,33539,33542
coronary, open operation 38505
to prepare bypass site for anastomosis 33554
Endobronchial tumour, endoscopic laser resection 41901
endobronchial ultrasound, lung tumours 30710
Endocarditis, operative management of 38493
Endocrine tumour, exploration of 30578,30580,30581
Endolymphatic sac, transmastoid decompression 41590
Endometrial biopsy for suspected malignancy 35620
Endometriosis, laparoscopic ablation 35638
Laparoscopic resection of 35641
Endometrium, ablation of, endoscopic 35622
ablation of, by radiofrequency electrosurgery 35616
biopsy of for suspected malignancy 35620
biopsy of with hysteroscopy 35630
biopsy of, with IUD insertion for idiopathic menorrhagia 35502
endoscopic examination and ablation by microwave or thermal balloon 35616
Endoscopic biliary dilatation 30494
cholangio-pancreatography 30484
dilatation of colorectal strictures 32094
examination of intestinal conduit/reservoir 36860
examination of small bowel 30569,32095
gastrostomy, percutaneous 30481,30482
incision/resection, external sphincter/bladder neck 36854
laser ablation of prostate 37207,37208
laser resection of endobronchial tumours 41901
laser therapy of gastrointestinal tract 30479
manipulation/extraction of ureteric calculus 36857
prostatectomy 37203,37206
resection of pharyngeal pouch 41773
sphincterotomy 30485
stenting of bile duct 30491
transanal endoscopic microsurgery 32103,32104,32106
ultrasound 30688,30690,30692 30694
Endoscopic ultrasound fine needle aspiration 30696
Endoscopy with balloon dilatation gastric stricture 30475
Enterocoele, repair of 35571
Enterocolitis, acute neonatal necrotising, laparotomy 43828,43831
necrotising stricture, bowel resection 43834
Enterocolostomy 30515
Enterocutaneous fistula, radical repair of 30382
Enteroenterostomy 30515
Enterostomy, closure of 30562
enterostomy 30375
Enterotomy, intra-operative, for endoscopy 30568
enterotomy 30375
Entropion, correction of 45626
repair of 42866
Enucleation of eye 42506,42509
hydatid cysts of lung 38424
Epicondylitis, open operation for 47903
Epididymal cyst, excision of 37601
Epididymectomy 37613
Epidural blood patch 18233
catheter, insertion of 39140
electrode, insertion 39130,39139
electrode, management, adjustment etc. 39131
implant, removal of 39136
stimulator, revision of 39133
Epigastric hernia, repair of 30620,30621
Epilation electrolysis, for trichiasis 42587
Epilepsy, operations for 40700,40703,40706 40709,40712
Epiphyseal arrest 48500,48503,48506 48509
plate, prevention of closure 48512
Epiphysiodesis, femur/fibula/tibia 48500,48503,48506
staple arrest of hemi-epiphysis 48509
Epiphysiolysis, to prevent closure of plate 48512
Epispadias, repair of 37836,37839,37842
Epistaxis, treatment of 41656,41677,41680
Epithelial debridement for corneal ulcer/erosion 42650
debridement/eliminating band keratyoplasty 42651
ESWL 36546
Ethmoidal artery, transorbital ligation of 41725
sinuses, operation on 41737,41749
Ethmoidectomy, fronto-nasal 41731
fronto-radical 41734
transantral, with radical antrostomy 41713
Etonogestral, subcutaneous implant, removal of 30062
Eustachian tube, catheterisation of 41755
obliteration of 41564
Evacuation of retained products of conception 16564
Eventration, plication of diaphragm for 43915
Evisceration of globe of eye 42512,42515

excision of, with melanoma 31340
Exenteration of orbit of eye 42536
Exomphalos, neonatal, operations for 43870,43873
Exostoses in external auditory meatus, removal 41518
Exostosis, excision of 47933,47936
mandibular or palatal 45825
Exstrophy, cloacal, neonatal, operation for 43882
of bladder, closure 37050
of bladder, repair of 37842
Extensor tendon of hand or wrist, repair of 46420,46423
tendon of hand, tenolysis of 46450
tendon, synovectomy of 46339
External auditory canal, reconstruction 41524,45662
auditory meatus, removal of exostoses 41518
cephalic version 16501
ear, complex total reconstruction of 45660,45661
fixation, orthopaedic, removal 47948,47951
stent, application 34824,34827,34830
34833
External cephalic version 16501
Extra digit, amputation of 46464
Extracardiac conduit, insertion/replacement 38757,38760
Extracorporeal shock wave lithotripsy 36546
Extracranial to intracranial bypass 39818,39821
Extradural tumour or abscess, laminectomy for 40309
Eye, capsulotomy, laser 42788,42789
conjunctiva, cautery of 42677
conjunctival graft 42638
corticolysis, laser, of lens material 42791,42792
dermoid, excision of 42573,42574
division of suture, laser 42794
enucleation of 42506,42509,42510
fibrinolysis 42791,42792
foreign body in cornea or sclera, removal of 42644
foreign body in, removal of 42563,42569
foreign body in, superficial, removal of 30061
globe of, evisceration of 42512
iridotomy, laser 42785,42786
iris tumour, laser photocoagulation 42806
laser photocoagulation 42806
orbit, insert/remove implant 42518
paracentesis 42734
phototherapeutic keratectomy, laser 42810
pinguecula, surgical excision 42689
radioactive plaques, construction,insertion & removal42801,42802
tantalum marker, insertion and removal 42805
trabeculoplasty, laser 42782
vitreolysis, laser, of lens material 42791
Eyeball, repair of perforating wound 42551,42554,42557
Eyebrow, elevation of 42872
Eyelashes, ingrowing, operation for 45626
Eyelid closure in facial nerve paralysis, implant
insertion 42869
composite graft to 45656
ectropion or entropion, correction of 45626
full thickness laceration, repair of 30052
full thickness wedge excision of 45665
grafting for symblepharon 45629
ptosis, correction of 45623
reconstruction of, whole thickness 45614,45671,45674
reduction of 45617,45620
removal of cyst from 42575
tarsorrhaphy 42584
upper recession of 42863

F

Face, injections of poly-L-Lactic acid 14201
Face, repair of complex fractures 45753,45754
chemical peel 45019,45020
Facet joint denervation by percutaneous neurotomy 39118
Facial, nerve, decompression of 41569
nerve palsy, excision of tissue for 45581
nerve paralysis, plastic operation for 45575,45578
scar, revision of (restriction applies) 45506,45512
Facio-hypoglossal/accessory nerve, anastomosis of 39503
Faecal incontinence, sacral nerve stimulation for 32213-32218
Fallopian tubes, catheterisation, with hysteroscopy 35633
tubes, hydrotubation of 35703,35709
tubes, implantation of, into uterus 35694,35697
tubes, microsurgical anastomosis 35700
tubes, Rubin test for patency 35706
tubes, sterilisation 35687,35688
tubes, sterilisation with Caesarean section 35691
Falloposcopy, unilateral/bilateral 35710
Fascia, deep, repair of, for herniated muscle 30238
graft 45018
Fasciectomy, for Dupuytren's Contracture 46369,46372,46375
46378,46381,46384,46387,46390,46393
Fasciotomy, forearm or calf 47975,47978,47981
interosseous muscle space of hand 47981
muscle 30226
plantar, radical 49854
subcutaneous, Dupuytren's contracture 46366
Femoral hernia, repair of 30609,30614
vein puncture in infants, blood collection 13312
vessel, ligation/exploration, other 34103
Femoro-femoral crossover bypass grafting 32718
graft, infected, excision of 34172
Femur, bone graft to 48200,48203
congenital deficiency, treatment of 50411,50414
drill decompression of head/neck or both 47982
epiphyseodesis 48500,48506
fracture, treatment of 50576
fracture, treatment of 47516,47519,47522
47525,47528,47531,47534,47537,49336
operation on, for osteomyelitis 43506,43515
osteectomy/osteotomy 48424,48427
Fetal blood sampling 16606
fluid filled cavity, drainage of 16624
intraperitoneal blood transfusion 16612,16615
intravascular blood transfusion 16609
Feto-amniotic shunt, insertion of 16627
Fibreoptic bronchoscopy 41898
colonoscopy 32084,32087,32090
32093
Fibrinolysis 42791,42792
Fibula, congenital deficiency, transfer fibula to tibia 50423
epiphyseodesis 48503,48506
fracture, treatment of 47576
fracture, treatment of paediatric 50588
operation on, for osteomyelitis 43503,43512
osteectomy/osteotomy 48406,48409
Filtering and allied operations for glaucoma 42746
Fimbrial cyst, removal of 35712,35713,35716
35717
Finger, amputation of 46465,46468,46471
46474,46477,46480,46483
digital nail, removal of 46513,46516
dislocation, treatment of 47036,47039
flexor tendon sheath, open operation 46522
fracture, treatment of 47300,47303,47306
47309,47312,47315,47318,47321,47324,47327,47330
47333
ingrowing nail, resection of 46528,46531
mallet, fixation/repair 46438,46441
percutaneous tenotomy of 46456
trigger, correction of 46363
Fissure in ano, operation for 32150
Fistula, alimentary, repair of 35596,37834
anal, excision/repair 32159,32162,32165
32166

antrobuccol, operation for 41722
aorto-duodenal, repair of 34160,34163,34166
arteriovenous, dissection, ligation 34112,34115,34118
arteriovenous, dissection, repair 34121,34124,34127 34130
arteriovenous, ligation cervical vessel/s 39812
branchial, removal of 30289
carotid-cavernous, obliteration of 39815
cutaneous, salivary gland, repair of 30269
enterocutaneous, radical resection 30382
genito-urinary, repair 35596
in ano, subcutaneous, excision of 32156
oro-antral, plastic closure of 41722
parotid gland, repair of 30269
sacrococcygeal, excision of 30675,30676
thyroglossal, radical removal of 30314
tracheo-oesophageal, division and repair 43900
urethral, closure of 37833
urethro-rectal 37336
urethro-vaginal 37333
vesical, cutaneous, operation for 37023
vesico-intestinal, closure of 37038
vesico-vaginal, closure of 37029
wound, review under GA, independent 32168
Fixation, external, removal of 47948,47951
internal, of spine 48678,48681,48684 48687,48690
Flap
abbe 45701,45704
direct, indirect or local, revision of 45239,45240
free tissue transfer, revision of 45496-45499
indirect 45227,45230,45233 45236
myocutaneous, delay of 45015
myocutaneous, for breast reconstruction 45530
neurovascular island 45563,46504
pharyngeal, for velo-pharyngeal incompetence 45716
repair - H-flap or double advancement 45207
repair, direct 45209,45212,45215 45218,45221,45224
repair, local, single stage 45200,45203,45206
repair, muscle, single stage 45000,45003,45006 45009,45012
revision of, by incision and suture 45239
revision of, by liposuction 45240
Flexor tendon, hand, repair of 46426,46429,46432 46435
tendon pulley, reconstruction 46411
tendon sheath, finger or thumb, open operation 46522
tendon, hand, tenolysis of 46453
tendon, hand/wrist, synovectomy of 46339
tendon, wrist, repair of 46426,46429
tendon/s, digit, synovectomy of 46348,46351,46354 46357,46360
Flexorplasty to restore elbow function 50405
Fluid Filled Cavity, drainage of 16624
Foot, amputation or disarticulation of 44359,44361,44364
and ankle, tibialis tendon transfer 50339,50342
arthrodesis of 49815,49845
calcaneal spur, excision of 49818
claw or hammer toe, correction of 49848,49851
hallux valgus or hallux rigidus, correction of 49821,49824,49827 49830,49833,49836-49839,49842
metatarso-phalangeal joint, replacement of 49857
metatarso-phalangeal joint, synovectomy of 49860,49863
neurectomy for plantar digital neuritis 49866
paronychia of, pulp space infection, incision 47912
radical plantar fasciotomy or fasciectomy of 49854
tendon of, repair of 49800,49803
tendon or ligament transplantation of 49812
tenotomy of 49806,49809
tibialis tendon transfer 50339,50342
For anaesthesia 20100,20102,20104 20120,20124,20140,20142-20148,20160,20162,20164 20170,20172,20174,20176,20190,20192,20210,20212 20214,20216,20220,20222,20225,20230,20300,20305 20320,20321,20330,20350,20352,20355,20400-20406 20410,20420,20440,20450,20452,20470,20472,20474 20475,20500,20520,20522,20524,20526,20528,20540 20542,20546,20548,20560,20600,20604,20620,20622 20630,20632,20634,20670,20680,20690,20700 20702-20706,20730,20740,20745,20750,20752,20754 20756,20770,20790-20794,20798-20800,20802-20806 20810,20815,20820,20830,20832,20840-20842 20844-20848,20850,20855,20860,20862-20864 20866-20868,20880,20882,20884,20886,20900,20902 20904-20906,20910-20912,20914,20916,20920,20924 20926,20928,20930,20932,20934,20936,20938,20940 20942-20944,20946,20948,20950,20952-20954,20956 20958,20960,21100,21110,21112,21114,21116,21120 21130,21140,21150,21155,21160,21170,21195,21199 21200,21202,21210,21212,21214,21216,21220,21230 21232,21234,21260,21270,21272,21274,21275,21280 21300,21321,21340,21360,21380,21382,21390,21392 21400,21402-21404,21420,21430,21432,21440,21445 21460-21462,21464,21472,21474,21480,21482,21484 21486,21490,21500,21502,21520,21522,21530,21532 21535,21600,21610,21620,21622,21630,21632,21634 21636,21638,21650,21652,21654,21656,21670,21680 21682,21685,21700,21710,21712,21714,21716,21730 21732,21740,21756,21760,21770,21772,21780,21785 21790,21800,21810,21820,21830,21832,21834,21840 21842,21850,21860,21865,21870,21872,21878-21887 21900,21906,21908,21910,21912,21914-21916,21918 21922,21925-21927,21930,21935,21936,21939 21941-21943,21945,21949,21952,21955,21959,21962 21965,21969,21970,21973,21976,21980,21981,21990 21992,21997,22001,22002,22007,22008,22012,22014 22015,22018,22020,22025,22031,22036,22040,22045 22050,22051,22055,22060,22065,22070,22075,22900 22905,23010,23021-23023,23031-23033,23041-23043 23051-23053,23061-23063,23071-23073,23081-23083 23091,23101,23111-23119,23121,23170,23180,23190 23200,23210,23220,23230,23240,23250,23260,23270 23280,23290,23300,23310,23320,23330,23340,23350 23360,23370,23380,23390,23400,23410,23420,23430 23440,23450,23460,23470,23480,23490,23500,23510 23520,23530,23540,23550,23560,23570,23580,23590 23600,23610,23620,23630,23640,23650,23660,23670 23680,23690,23700,23710,23720,23730,23740,23750 23760,23770,23780,23790,23800,23810,23820,23830 23840,23850,23860,23870,23880,23890,23900,23910 23920,23930,23940,23950,23960,23970,23980,23990 24100-24136,25000,25005,25010,25015,25020,25025 25030,25050,25200,25205
Foramen Magnum, tumour or vascular lesion, excision 39662
Forearm, amputation or disarticulation of 44328
decompression fasciotomy of 47975,47978,47981
fracture, treatment of 47378,47381,47384-47387 47390,47393
fracture, treatment of paediatric 50500,50504,50508 50512,50516,50520,50524,50528,50532,50536,50540 50544,50548
radial aplasia/dysplasia, centralisation/radialisation 50399
Foreign body, antrum, removal of 41716
bladder, cystoscopic removal of 36833
bronchus, removal of 41895
cornea or sclera, imbedded, removal of 42644
cornea or sclera, superficial, removal of 30061
ear, removal of 41500,41503
implant, contour reconstruction, insertion 45051
intra-ocular, removal of 42563,42569

maxillary sinus, removal of 41716
muscle/deep tissue, removal of 30067,30068
nose, removal of 41659
oesophagus, removal of 41825
subcutaneous, removal of 30064
superficial, removal of 30061
tendon, removal of 30067,30068
trachea, removal of 41886
urethra, removal of 37318
Free grafts 45400,45403,45406 45409,45412,45415,45418,45439,45442,45445,45448 45451,45460-45462,45464-45466,45468,45469,45471 45472,45474,45475,45477,45478,45480,45481 45483-45494
split skin, to burns 45460-45462,45464-45466,45468 45469,45471,45472,45474,45475,45477,45478,45480 45481,45483-45493
transfer of tissue 45562-45565
transfer of tissue, anastomosis artery/vein 45502
Frenulum, mandibular or maxillary, repair 30281
Frontal sinus, catheterisation of 41740
sinus, intranasal operation on 41737
sinus, radical obliteration of 41746
sinus, trephine of 41743
Fronto-ethmoidectomy, radical 41734
Fronto-nasal ethmoidectomy 41731
Fronto-orbital advancement 45782,45785
Full thickness grafts, free 45451
thickness wedge excision of lip, eyelid or ear 45665
Fundoplasty/plication, antireflux operation 30527,30529,30530
antireflux operation by 31464,31466
Funnel chest, elevation of 38457,38458
Furuncle, incision with drainage of 30219,30223
Fusion, spinal, cervical/thoracic/lumbar 48660,48663,48666 48669,48672,48675
spinal, posterior interbody 48654,48657
vertebral body, diseases of 48640

G

Gallbladder, drainage of 30375
excision of 30443,30445,30446 30448,30449
Galvanocautery of skin lesions 30192
Gamete intra-fallopian transfer 13200,13203,13206 13209,13212,13215,13218,13221
Ganglion, excision of 30106,30107
hand, excision of 46494,46495,46498
wrist joint, excision of 46500-46503
Gangliotomy, radiofrequency trigeminal 39109
Gangrenous tissue, debridement of 35100,35103
Gartner duct cyst, removal of 35557
Gastrectomy, partial 30518
sub-total, radical, for carcinoma 30523
total 30521,30524,30526
Gastrectomy, sleeve 31575
Gastric band reservoir, adjustment of 31590
Gastric band, adjustable, placement of 31569
Gastric band, adjustment of 31587
Gastric by-pass for obesity
hypothermia 13500,13503
lavage in the treatment of ingested poison 14200
reconstruction with oesophagectomy 30535
stricture, endoscopy with balloon dilatation 30475
tumour, removal of 30520
ulcer, perforated, suture 30375
Gastric bypass by Roux-en-Y 31572
Gastric bypass, by Biliopancreatic diversion, with or without duodenal switch 31581
Gastro-camera investigation 30473
Gastro-oesophageal balloon intubation 13506
reflux, operations for 43951,43954,43957
Gastroduodenal stricture, balloon dilatation 30475
Gastroduodenostomy 30515
reconstruction of 30517
Gastroenterostomy 30515
reconstruction of 30517
Gastrointestinal blood loss estimation
tract, dilatation of stricture of upper 41819,41820
Gastroplasty 31578
Gastroschisis, operations for 43864,43867
Gastroscopy 30473,30476,30478
insertion of nasogastric/nasoenteral tube 31456,31458
Gastrostomy button, non-endoscopic insertion/replacement 30483,30636
gastrosomy 30375
percutaneous endoscopic 30481,30482
percutaneous tube, jejunal extension 31460
Genioplasty 45761
Gilliam's operation 35683,35684
Gland, adrenal, excision of 36500
Bartholin's, marsupialisation of 35516,35517
lacrimal, excision of palpebral lobe 42593
lymph, biopsy of 30074,30075
lymph, drill biopsy of 30078
lymph, pelvic, excision of 35551
lymph, pelvic, excision of, with hysterectomy 35664
parotid, superficial lobectomy/tumour removal 30253
parotid, total extirpation of 30247,30250
salivary, duct, dilatation or diathermy of 30262
salivary, duct, marsupialisation 30265,30266
salivary, duct, meatotomy 30265,30266
salivary, duct, removal of calculus 30265,30266
salivary, operations on 30262,30265,30266 30269
sublingual, extirpation of 30259
submandibular, extirpation of 30256
Glaucoma, filtering and allied operations for 42746,42749
iridectomy and sclerectomy for 42746
iridectomy or iridotomy 42764
Molteno valve, insertion of 42752
Molteno valve, removal of 42755
Glenoid fossa, reconstruction of 45788
Glioma, craniotomy for removal of 39709
Globe of eye, evisceration of 42512,42515
Glomus tumour, transmastoid removal of 41623
tumour, transtympanic, removal of 41620
Glossectomy, with partial pharyngectomy 41785
Gonadal dysgenesis, vaginoplasty for 37851
Goniotomy 42758
Graciloplasty procedures 32200,32203,32206 32209,32210
Grafenberg's (or Graf) ring, introduction of 35503
ring, removal under GA 35506
Graft, axillo-femoral, infected, excision of 34172
bypass, for occlusive arterial disease 32700,32703,32708 32710-32712,32715,32718,32721,32724,32730,32733 32736,32739,32742,32745,32748,32751,32754,32757 32760,32763
composite (chondro-cutaneous/mucosal) 45656
conjunctival over cornea 42638
corneal 42653,42656
dermis, dermo-fat or fascia 45018
femoro-femoral, infected, excision of 34172
free fascia for facial nerve paralysis 45575,45578
free, split skin 45400,45403,45406 45409,45412,45415,45418,45439,45442,45445,45448 45451,45460-45462,45464-45466,45468,45469,45471 45472,45474,45475,45477,45478,45480,45481 45483-45494
inlay, using a mould 45445
micro-arterial or micro-venous 45503

nerve 39315,39318
skin, to orbit 42524
Grafting, bypass, occlusive arterial disease
for symblepharon 45629
patch, to artery or vein 33545,33548
Granuloma, cautery of 42677
removal from eye, surgical excision 42689
umbilical, excision under GA 43948
Gravid uterus, evacuation of contents by curettage 35643
Great vessel, intrathoracic operation on, other 38456
vessel, ligation or exploration, other 34103
Greater trochanter, transplant of ileopsoas tendon 50121
Groin, lymph, excision of 30329,30330
Grommet, free, in canal, removal of
in situ in drum, removal of 41500
insertion of 41632
Gunderson flap operation 42638
Gynaecological examination under GA 35500
Gynatresia, vaginal reconstruction for 35565

H

Haemangioma, cauterisation of (restriction) 45027
excision of 45030,45033,45035 45036
of neck, deep-seated, excision of 45036
Haemapheresis 13750,13755
Haematoma, aspiration of 30216
breast, exploration and drainage 31551
incision and drainage, without GA 30219
large, incision and drainage, with GA 30223
pelvic, drainage of 30387
Haemochromatosis 13757
Haemodialysis, in hospital 13100,13103
central vein, tunnelled cuffed catheter 34538
removal of tunnelled cuffed catheter 34539
Haemofiltration, continuous (ICU) 13885,13888
in hospital 13100,13103
Haemoperfusion, in hospital 13100,13103
Haemorrhage, antepartum, treatment of 16509
arrest of
- following circumcision, with GA 30663
- following tonsillectomy, with GA 41796,41797
extremity, reoperation for control of 33848
intracranial, burr-hole craniotomy for 39600
nasal, arrest of 41656,41677
nasal, cryotherapy for treatment of 41680
post-op, control under GA, independent 30058
post-operative, following gynaecological surgery 35759
post-operative, laparotomy for 30385
postpartum, treatment of 16567
subdural, tap for 39009
Haemorrhoidectomy 32138,32139
Haemorrhoids, injection into
removal of 32138,32139
rubber band ligation of 32135
sclerotherapy for 32132
Hair transplants, congenital/traumatic alopecia 45560
Hallux rigidus/valgus, correction of 49821,49824,49827 49830,49833,49836-49839,49842
Halo, application 47711,47714
femoral traction, application of 47720,47723
thoracic traction, application of 47717
Hammer toe, correction of 49848
Hand, amputation or disarticulation of 44325,44328
arthrotomy 46327,46330
bone grafting for pseudarthrosis 46405
congenital abnormalities, amputation of phalanges 50396
congenital abnormalities, splitting of phalanges 50396
decompression fasciotomy 47981
digits, flexor/extensor contracture, correction 46492
duplication of digits, amputation of phalanges 50396
duplication of digits, splitting of phalanges 50396
extensor tendon of, repair of 46420,46423
extensor tendon of, tenolysis of 46450
flexor tendon of, repair of 46423,46426,46429 46432,46435
flexor tendon of, tenolysis of 46453
ganglion, excision of 46494
middle palmar/thenar/hypothenar spaces, drainage 46519
osteectomy/osteotomy 46396,46399
paronychia/pulp space infection, incision for 46525
tendon sheath, operation for tendovaginitis 46363
tendon transfer for restoration of function 46417
Hartmann's operation 32030
Heart arrhythmia, ablation of 38287,38290,38293
arrhythmia, surgery for 38287,38290,38293 38390,38393,38512,38515,38518
catheterisation of 38200,38203,38206
electrical stimulation of 13400
intrathoracic operation on, not otherwise covered 38456
mitral annulus, reconstruction after decalcification 38485
subvalvular structures, reconstruction, re-implantation 38490
surgery for congenital heart disease 38700,38703,38706 38709,38712,38715,38718,38721,38724,38727,38730 38733,38736,38739,38742,38745,38748,38751,38754 38757,38760,38763,38766
surgery, open, not otherwise covered 38653
valve replacement 38488,38489
valve, repair 38480,38481
Heller's operation 30532,30533
Hemiarthroplasty, hand 46309,46312,46315 46318,46321
knee 49517
Hemicircumcision, for hypospadias 37354
Hemicolectomy 32000,32003,32006
Hemiepiphysis, staple arrest of 48509
Hemifacial microsomia, construction condyle and ramus 45791
Hemilaryngectomy, vertical, with tracheostomy 41837
Hemispherectomy, for intractible epilepsy 40706
Hemithyroidectomy 30306
Hemivulvectomy 35536
Hepatic duct, common, resection for carcinoma 30463,30464
artery catheterisation for SIRT 35406,35408
duct, common, repair of 30472
ducts, Roux-en-Y bypass 30466,30467
metastases, selective internal radiation therapy for 35404,35406,35408
Hepatocellular carcinoma
destruction by radiofrequency ablation 50950,50952
Hernia, antireflux operations for 30527,30529,30530 43838,43841
diaphragmatic, neonatal, repair of 43837,43840
diaphragmatic, repair of 30600,30601,43838
femoral or inguinal, repair of 30609,30614,43841
inguinal, repair, age less than 3 months 44108,44111,44114
spigelian, repair of 30403,30405
strangulated, incarcerated or obstructed, repair of 30615,43835
umbilical, epigastric, or linea alba, repair of 30620,30621
ventral or incisional, repair of 30403,30405
ventral, following closure exomphalos, repair of 43939
Hernia, epigastric or Linea Alba Hernia 43805
Herniated muscle, fascia, deep, repair of 30238
Hiatus hernia, antireflux operations for 30527,30529,30530
hernia, repair of 30601
para-oesophageal, repair of 31468
Hickman catheter, insertion of, for chemotherapy 34527,34528
catheter, removal of 34530
High dose rate brachytherapy 37227
Hindquarter, amputation or disarticulation of 44373
Hinselmann colposcope, examination uterine cervix 35614
Hip, amputation or disarticulation at 44370
arthrectomy 49309,49312

arthrodesis 49306
arthroplasty 49309,49312,49315 49318,49319,49321,49324,49327,49330,49333,49336 49339,49342,49345,49346
arthroplasty, revision 49346
arthroscopy 49360,49363,49366
arthrotomy 49303
congenital dislocation, open reduction 50351
contracture of, medial/anterior release 50375,50378,50381 50384
dislocation, acetabulum fracture, treatment 47495,47498
dislocation, congenital, treatment of 50349,50352
dislocation, congenital, treatment of including paediatric 50650,50654,50658
dislocation, treatment of 47048,47051
iliopsoas tendon transfer to greater trochanter 50387
prosthesis, operation on 49315
replacement procedures 49318,49319,49321 49324,49327,49330,49333,49336,49339,49342,49345
spica, application of 47540,50564
spica, application, congenital dislocation 50353,50564
transfer of abdominal musculature to greater trochanter 50387
transfer of adductors to ischium 50387
treatment of including paediatric 50650,50654,50658
Hirschsprung's disease, colostomy/enterostomy for 30375
disease, neonatal, laparotomy for 43819
disease, paediatric, operations for 43990,43993,43996 43999
Home, dialysis 13104
Hormone implantation, by cannula 14206
implantation, direct, incision and suture 14203
Humerus, bone graft to 48212,48215
fracture, treatment of 50552,50556,50560 50564,50568,50572
fracture, treatment of 47411,47414,47417 47420,47423,47426,47429,47432,47435,47438,47441 47444,47447,47450,47451,47453,47456,47459
operation for osteomyelitis 43506,43515
osteectomy/osteotomy 48412,48415
Hummelsheim type muscle transplant, squint 42848
Hydatid cyst, liver, total excision of 30437,30438
cyst, liver, removal of contents of 30434,30436
cyst, lungs, enucleation of 38424
Hydradenitis, excision for 31245
Hydrocele, infantile, repair of 30614
removal of 30631
tapping of 30628
Hydrocephalus, operations for 40000,40003,40006 40009
Hydrocortisone, injections into keloid with GA 30210
Hydrodilatation of bladder with cystoscopy 36827
Hydromyelia, operations for 40339,40342
Hydrotubation of Fallopian tubes 35703,35709
Hymenectomy 35509
Hyperbaric oxygen therapy 13020,13025,13030
Hyperemesis gravidarum, treatment of 16505
Hyperextension deformity of toe, release, lengthening 50345
Hyperhidrosis, axillary, excision for 30180,30183
Hyperparathyroidism, operations for 30315,30317,30318 30320
Hyperplasia, papillary, of palate, removal of 45831,45833,45835
Hypertelorism, correction, intra/sub-cranial 45767,45770
Hypertension, portal, treatment of 30602,30603,30605 30606
Hypertrophied tissue, removal of 45801,45803,45805 45807
Hypospadias, examination under GA 37815,37816,37819 37822,37825,37828
granuloplasty, meatal advancement 37818,37819
meatotomy and hemi-circumcision 37354
penis erection test with examination 37815
repair of 37821,37822,37824 37825,37827,37828,37830,37833
urethral fistula repair 37833
Hypothenar spaces of hand, drainage of 46519
Hypothermia, gastric 13500,13503
deep hypothermic circulatory arrest 22075
total body 22065
Hysterectomy 35653,35657,35658 35661,35664,35667,35670,35673
laparoscopically assisted 35750,35753,35754 35756
with ovarian transposition, malignancy 35729
Hysteroscopic resection of myoma or uterine septum 35623,35634
resection of uterine septem 35634
Hysteroscopy 35626,35627,35630 35633-35636
Hysterotomy 35649

I

Ileal atresia, neonatal, laparotomy for 43816
Ileo-femoral by-pass grafting 32712,32718
endarterectomy 33521
Ileorectal anastomosis 32012
Ileostomy 30639,32009,32012 32015,32018,32021
closure of, with rectal resection 32060,32063,32066
closure of, without resection of bowel 30562
refashioning of 30563
reservoir, continent type, creation of 32069
with proctocolectomy 32015
with total colectomy 32009
Iliac endarterectomy 33518
vein, thrombectomy 33810,33811
vessel, ligation or exploration not otherwise covered 34103
Iliopsoas tendon transfer to greater trochanter 50387
Implanon, removal of 30062
Implant, cochlear, insertion of 41617
epidural, for pain management, removal of 39136
foreign, insertion for contour reconstruction 45051
insertion or removal from eye socket 42518
Implantable Cardioverter Defibrillator 38371,38384,38387
implantable bone conduction hearing system 41603,41604
Implantation, fallopian tubes into uterus 35694,35697
hormone or living tissue 14203,14206
Impotence, injection for investigation/treatment 37415
Incidental appendicectomy 30574
Incisional hernia, repair of 30403
Incomplete confinement 16518
Incontinence, anal, Parks' intersphincteric procedure 32126
bladder stress, suprapubic operation 37044
male urinary, injection for treatment of 37339
stress, sling operation for 35599
Indirect flap 45227,45230,45233 45236,45239
Induction, management, second trimester labour 16525
Indwelling oesophageal tube, gastrostomy for fixation 30375
Infantile hydrocele, repair of 30614
Infection, acute intercurrent, complicating pregnancy 16508
Inferior vena cava, thrombectomy 33810,33811
vena caval filter, insertion of 35330
Inflammation of middle ear, operation for 41626
Infliximab 14245
Infliximab 14245
Infusion chemotherapy 13915,13918,13921 13924,13927,13930,13933,13936
chemotherapy, cannulation for 34521,34524
device, automated, spinal, insertion of 39125-39128
intra-arterial, sympatholytic agent 14209
Ingrowing eyelashes, operation for 45626
nail of finger or thumb, resection of 46528,46531

nail of toe, resection of 47915,47916
Inguinal abscess, incision of 30223
hernia, repair of 30609,30614
hernia, repair, age less than 3 months 44108,44111,44114
Injection, alcohol, etc, around nerve or in muscle
alcohol, cortisone, phenol into trigeminal nerve 39100
alcohol, retrobulbar 42824
hormones, for habitual miscarriage 16504
into angioma (restriction applies) 45027
into prostate 37218
into spinal joints or nerves 39013
sclerosant fluid into pilonidal sinus 30679
Injections, multiple, for skin lesions 30207
Inlay graft, using a mould 45445
Innocent bone tumour, excision of 30241
Innominate artery, endarterectomy of 33506
insertion of, for drainage of middle ear 41632
Insufflation Fallopian tubes, for patency (Rubin test) 35706
Intensive care management/procedures 13815,13818,13830 13839,13842,13847,13848,13851,13854,13857,13870 13873,13876,13881,13882,13885,13888
Intercostal drain, insertion of 38806,38809
Internal auditory meatus, exploration of 41599
drainage of empyema, without rib resection 38806,38809
Interosseous muscle space of hand, fasciotomy of 47981
Interphalangeal joint, arthrodesis of 46300
joint, arthrotomy of 46327,46330
joint, dislocation, treatment of 47036,47039
joint, hemiarthroplasty 46309,46312,46315 46318,46321
joint, interposition arthroplasty of 46306
joint, joint capsule release of 46381
joint, ligamentous repair 46333
joint, synovectomy/capsulectomy/debridement 46336
joint, total replacement arthroplasty of 46309,46312,46315 46318,46321
joint, volar plate arthroplasty 46307
Interscapulothoracic amputation or disarticulation 44334
Interventional endovascular procedures 35300,35303,35306 35307,35309,35312,35315,35317,35319-35321,35324 35327,35330
Intervertebral disc/s, laminectomy for removal of 40300
disc, lumbar, total artificial replacement 48691-48693
disc/s, microsurgical discectomy of 40301
Intestinal conduit or reservoir, endoscopic examination 36860
duct, patent vitello, excision of 43945
malrotation, neonatal, laparotomy for 43801,43804
obstruction, surgical relief of 30387
plication, Noble type, with enterolysis 30375
remnant, abdominal wall vitello, excision of 43942
resection, large 32000,32003
resection, small 30565,30566
sling procedure prior to radiotherapy 32183
urinary conduit, revision 36609
urinary reservoir, continent, formation 36606
Intra-abdominal artery/vein, cannulation, chemotherapy 34521
malignancy, radical or debulking operation 30392
Intra-anal abscess, drainage of 32174,32175
Intra-aortic balloon, counterpulsation, management 13847,13848
balloon pump, insertion of 38362,38609
balloon pump, removal of 38612,38613
Intra-arterial cannulisation for blood collection 13842
infusion chemotherapy 13927,13930,13933 13936
infusion, of sympatholytic agent 14209
Intra-atrial baffle, insertion of 38745
Intra-epithelial neoplasia, laser therapy for 35539,35542,35545
Intra-ocular excision of dermoid of eye 42574
foreign body, removal of 42563,42569
procedures, resuturing of wound after 42857
Intra-operative ultrasound, biliary tract 30439
staging of intra-abdominal tumours 30441
Intra-oral tumour, radical excision of 30275
Intra-orbital abscess, drainage of 42572
Intracerebral tumour, craniotomy and removal of 39709
Intracranial abscess, excision of 39903
aneurysm, clipping or reinforcement of sac 39800
aneurysm, endovascular coiling 35412
aneurysm, ligation of cervical vessel/s 39812
arteriovenous malformation, excision of 39803
cyst, drainage of via burr-hole 39703
electrode placement 40709,40712
haemorrhage, burr-hole craniotomy for 39600,39603
infection, drainage of via burr-hole 39900
neurectomy, for trigeminal neuralgia 39106
pressure monitoring device, insertion of 39015
pressure monitoring, catheter/subarachnoid bolt 13830
stereotactic procedures 40800,40803
tumour, biopsy and/or decompression 39706
tumour, burr-hole biopsy for 39703,39706
tumour, craniotomy and removal of 39709,39712
Intradiscal injection of chymopapain 40336
Intradural lesion, laminectomy for, not otherwise covered 40312
Intrahepatic bypass 30466,30467
Intramedullary tumour, laminectomy and radical excision 40318
Intranasal operation on antrum/removal offoreign body 41716
operation on frontal sinus or ethmoid sinuses 41737
operation on sphenoidal sinus 41752
Intrascleral ball or cartilage, insertion of 42515
Intrathecal infusion device, revision of 39133
steroid injection 18232
Intrathoracic operation on heart, lungs, etc, other 38456
vessels, anastomosis/repair 38727,38730
Intrauterine contraceptive device, introduction of 35503
contraceptive device, removal of under GA 35506
device, introduction of, for idiopathic menorrhagia 35502
growth retardation, attendance for 16508
Intravascular injections
pressure monitoring 13876
Intravenous infusion chemotherapy 13915,13918,13921 13924
perfusion of a sympatholytic agent 14209
regional anaesthesia of limb 18213
Intraventricular baffle, insertion of 38754
Intubation, small bowel 30487,30488
Intussusception, reduction of 30375
management fluid/gas reduction for 14212
paediatric, operations for 43933,43936
Invitro fertilisation 13200,13203,13206 13209,13212,13215,13218,13221
processing of bone marrow 13760
Ionisation, cervix 35608
Iridectomy 42764
and sclerectomy, for glaucoma (Lagrange's op) 42746
following intraocular procedures 42857
Iridencleisis 42746
Iridocyclectomy 42767
Iridotomy 42764
laser 42785,42786
Iris and ciliary body, excision of tumour of 42767
excision of tumour of 42764
tumour, laser photocoagulation of 42806
Ischaemic limb, debridement of deep tissue 35100
limb, debridement of superficial tissue 35103
ventricular septal rupture, repair of 38509
Ischio-rectal abscess, drainage of 32174,32175
abscess, incision with drainage 30223

J

Jacket, plaster, application of, to spine 47708

Jaw, dislocation, treatment of 47000
aspiration biopsy of cyst/s 45799
operation on, for acute osteomyelitis 43503
operation on, for chronic osteomyelitis 43512,45815
reconstruction operation 45596,45597,45599 45602,45605,45608,45611
Jejunal atresia, bowel resection and anastomosis 43810
extension, percutaneous gastrostomy tube 31460
Jejunostomy, operative feeding 31462
Joint, application of external fixator, not for fracture 50130
arthrodesis of 50109
arthroplasty of, not otherwise covered 50127
arthroscopy of 50100
arthrotomy of 50103
cicatricial flexion contracture of, correction 50112
deformity, correction of 50300
dislocation, treatment of 47024,47027,47030 47033,47036,47039,47042,47045
finger/hand, debridement of 46336
greater trochanter, transplantation of 50121
manipulation of 50115
sacro-iliac, arthrodesis 49300
sacro-iliac, disruption of 47513
stabilisation, repair capsule/ligament 50106
subtalar, arthrodesis of 50118
synovectomy of, not otherwise covered 50104
Juvenile cataract, removal of 42716

K

Keloid, excision of
extensive, multiple injections of hydrocortisone 30210
Keratectomy, partial, for corneal scars 42647
phototherapeutic 42810
Keratocanthoma, removal of31255-31258,31260-31263,31265-31268 31270-31273,31275-31278,31280-31283,31285-31288 31290-31293,31295
Keratoplasty 42653,42656
Keratosis, obturans, surgical removal 41509
Kidney, dialysis, in hospital 13100,13103
donor, continuous perfusion of 22055
exploration of 36537
ruptured, exposure and exploration of 36576
solitary, pyeloplasty by open exposure 36567
transplant 36503,36506,36509
Kirschner wire, insertion of 47921
Knee, amputation at or below 44367
arthrodesis of 49512,49545
arthroplasty of 49518,49519,49521 49524,49527,49530,49533,49534
arthroscopy of 49557-49564,49566
arthrotomy of 49500
collateral or cruciate ligament repair 49503,49506
congenital deformity, post-op manipulation, plaster 50348
contracture of, posterior release 50363,50366,50369 50372
cruciate ligament reconstruction 49536,49539,49542
dislocation, treatment of 47054
fracture, treatment of 47588,47591
hamstring tendon transfer 50357,50360
hemiarthroplasty of 49517
ligament or tendon transfer 49503,49506
meniscectomy of 49503,49506
mobilisation, for post-traumatic stiffness 49569
orthopaedic treatment of 49503,49506
patello-femoral stabilisation 49503,49506,49564
patello-femoral stabilisation, revision of 49548
prosthesis, removal of 49515
reconstruction/repair 49536,49539
rectus femoris tendon transfer 50357
replacement procedures 49518,49519,49521 49524,49527,49530,49533,49534
revision of orthopaedic procedures 49551,49554
synovectomy of 49509
Kyphosis, treatment of 48606,48613
treatment of including paediatric 50600,50604,50608 50612,50616,50620,50624,50628,50632

L

Labour, second trimester, management of 16525
Labyrinth, destruction of 41572
Labyrinthotomy 41572
Laceration, ear/eyelid/nose/lip, full thickness, repair 30052
repair and suturing of 30026,30029,30032 30035,30038,30041,30042,30045,30048,30049
Lacrimal canalicular system, establishment patency 42599,42602
canaliculus, immediate repair of 42605
drainage by insertion of glass tube 42608
gland, excision of palpebral lobe 42593
passages, obstruction, probing for 42610,42611,42614 42615
sac, excision of 42596
Lagrange's operation (iridectomy and sclerectomy) 42746
Laminectomy and insertion of epidural implant 39139
followed by posterior fusion 40324,40327
for cordotomy or myelotomy 39124
for extradural tumour or abscess 40309
for hydromelia 40342
for intradural lesion 40312
for recurrent disc lesion and/or spinal stenosis 40303
for removal of intervertebral disc/s 40300
for spinal stenosis 40303,40306
with bone graft and posterior fusion 48654,48657
with excision of arteriovenous malformation 40318
with excision of intra-medullary tumour 40318
Laparascopic division of adhesions 31450,31452,35637
splenectomy 31470
Laparoscopy and hysteroscopy under GA 35636
complicated operative 35638,35641
diagnostic 30390
division of adhesions 30393,35637
involving procedures via laparoscope 35637,35638
laparoscopically assisted hysterectomy 35750,35753,35754 35756
on abdominal viscera 30375
sterilisation via 35687,35688
with biopsy 30391
with drainage of pus 31454
with transection/resection Fallopian tubes 35687,35688
Laparostomy 30397,30399
Laparotomy and division of adhesions 30376,30378,30379 30623,30626
exploratory 30373
for control of post-operative haemorrhage 30385,33845
for drainage 30394
for grading of lymphoma 30384
for gross intra-peritoneal sepsis 30396
for intussusception, paediatric 43933,43936
for neonatal conditions 43801,43804,43807 43810,43813,43816,43819,43822,43825,43828,43831
for staging of gynaecological malignancy 35726
for thrombosis 33845
for trauma, involving 3 or more organs 30388
involving gynaecology (exc. hysterectomy) 35712,35713,35716 35717
Laparoscopy, diagnostic 30627
on abdominal viscera 30375,30387
with division of extensive adhesions 30379
with insertion of portacath 30400
Large intestine, resection of 32000,32003

intestine, subtotal colectomy 32004,32005
Laryngeal web, division of 41868
Laryngectomy 41834
supraglottic 41840
Laryngofissure, external operation on 41876
Laryngopharyngectomy 41843
- or primary restoration of alimentary continuity after 41843
- with tracheostomy and plastic reconstruction 30294
Laryngoplasty 41876,41879
Laryngoscopy 41846,41849,41852
fibreoptic, with examination of larynx 41764
Larynx, direct examination of 41846
direct examination of, with biopsy 41849
direct examination of, with removal of tumour 41852
external operation on 41876
fibreoptic examination of 41764
fractured, operation for 41873
Laser: ablation of prostate, endoscopic 37207,37208
angioplasty, peripheral 35315
capsulotomy 42788,42789
destruction of bladder tumour with cystoscopy 36840,36845
destruction of stone with urethroscopy 37318
diathermy/visual laser for lesion of prostate 37224
division of suture, eye 42794
excision, tumours of face/neck 30190
incision of palate 41787
iridotomy 42785,42786
photocoagulation of iris tumour 42806
photocoagulation of neoplastic skin lesions 30195
photocoagulation of vascular lesions 14100,14106,14109 14112,14115,14118,14124
photoiridosyneresis 42808
photomydriasis 42807
removal of cancer of skin/mucous membrane 30196
removal of palmar/plantar warts 30187
resurfacing, carbon dioxide, face or neck 45025,45026
therapy for intraepithelial neoplasia 35539,35542,35545
therapy for malignancy of gastrointestinal tract 30479
trabeculoplasty 42782,42783
treatment, eye 42782,42783,42785 42786,42788,42789,42791,42792,42794,42801,42802 42805,42806
vitreolysis/corticolysis 42791,42792
Lateral pharyngeal bands, removal of 41804
pharyngotomy 41779
rhinotomy with removal of tumour 41728
Lavage and proof puncture of maxillary antrum 41698,41701
colonic, total, intra-operative 32186
gastric, in the treatment of ingested poison 14200
maxillary antrum 41704
Le Fort osteotomies 45753,45754
operation for genital prolapse 35578
Leg, amputation 44367,44370
hamstring tendon transfer 50357,50360
rectus femoris tendon transfer 50357
Lens, artificial, insertion of 42701,42703
artificial, removal and replacement 42707,42710
artificial, removal or repositioning 42704
extraction 42698
extraction and insertion of artificial lens 42702
intraocular, repositioning of 42713
Lensectomy 42731
Lesion, craniocervical junction, transoral approach for 40315
intradural, laminectomy for, not otherwise covered 40312
Lesions, skin, multiple injections for 30207
Leveen shunt, insertion of 30408
Lid, ophthalmic, suturing of 42584
scleral graft to 42860
Ligament, finger joint, repair of 46333
of foot, repair of 49812
or tendon transfer 47966
ruptured medial palpebral, repair of 42854
transplantation 47966
Ligation, great vessel 34103
purse string, cervix 16511
rubber band, of haemorrhoids or rectal prolapse 32135
transantral, of maxillary artery 41707
Ligature of cervix, purse string, removal of 16512
Limb, fasciotomy of 30226
ischaemic, debridement of tissue 35100,35103
lengthening procedures 50303,50306
lower, congenital deficiency, treatment of 50411,50414,50417
or chest, decompression escharotomy 45054
perfusion of 22055,34533
Limbic tumour, removal or excision of 42692,42695
Linea alba hernia, repair of, under 10 years
alba hernia, repair of, over 10 years 30620,30621
Lingual tonsil, removal of 41804
Lip, cleft, operations for 45677,45680,45683 45686,45689,45692,45695,45698,45701,45704
full thickness laceration, repair 30052
full thickness wedge excision 45665
reconstruction 45671,45674
Lipectomy, radical abdominoplasty 30177
subumbilical excision 30174
wedge excision 30165,30168,30171
Lipomeningocoele, tethered cord, release of 40112
Liposuction, for post-traumatic pseudolipoma 45584,45585
abdominal contouring post diabetic injections 31346
for reduction of a buffalo hump 45586
free tissue transfer, complete revision of 45497
free tissue transfer, first stage revision of 45498
free tissue transfer, second stage revision 45499
Lippe's loop, introduction of 35503
loop, removal of under GA 35506
Lisfranc's amputation 44364
Litholapaxy, with or without cystoscopy 36863
Lithotripsy, extracorporeal shock wave (ESWL) 36546
Little's Area, cautery of 41674
Liver abscess, open abdominal drainage of 30431,30433
biopsy 30409,30411,30412
cyst/s, laparoscopic marsupialisation 30416,30417
hydatid cyst, removal of contents of 30434,30436
hydatid cyst, total excision of 30437,30438
lobectomy of, for trauma 30428,30430
lobectomy of, other than for trauma 30418,30421
repair of laceration/s, for trauma 30422,30425
ruptured, repair 30375
segmental resection of 30414,30415,30427
tumours destruction by radiofrequency ablation 50950,50952
tumours, destruction of by cryotherapy 30419
Living tissue, implantation of 14203,14206
Lobar emphysema, neonatal, thoracotomy & lung resection 43861
Lobectomy, liver, for trauma 30428,30430
liver, other than for trauma 30418,30421
lung 38438,38441
partial, for epilepsy 40703
superficial, of parotid gland 30253
Local anaesthetic, injection of
flap repair 45200,45203,45206
flap revision 45239,45240
Lop ear or similar deformity, correction of 45659
Lord's procedure, massive dilatation of anus 32153
Lumbar cerebrospinal fluid drain, insertion of 40018
decompression of spinal cord 40351
discectomy, percutaneous 48636
puncture 39000
shunt diversion, insertion of 40006
shunt, revision or removal of 40009
sympathectomy 35000,35009
Lunate bone, osteectomy or osteotomy of 48406

Lung compliance, estimation of
hydatid cysts, enucleation of 38424
intrathoracic operation, not otherwise covered 38456
needle biopsy of 38812
resection, congenital cystadenomatoid malformation 43861
resection, congenital lobar emphysema 43861
wedge resection of 38440
Lymph glands, axilla, excision of 30332,30335,30336
glands, biopsy of 30074,30075,30078
glands, groin, excision of 30329,30330
glands, pelvic, radical excision of 35551
node biopsies, retroperitoneal 35723
node dissection, retroperitoneal 37607,37610
node of neck, biopsy of 31420
nodes of axilla, excision of 30335,30336
nodes of neck, dissection of 31423,31426,31429 31432,31435,31438
sentinel node biopsy for breast cancer 30299,30300,30302 30303
Lymphadenectomy, atypical mycobacterial infection 44130
granulomatous disease 44130
pelvic 35551,36502
Lymphangiectasis, limbs, major excision 45048
Lymphangioma, excision of 45030,45033,45035 45036
Lymphoedema, major excision of 45048
Lymphoid patches, removal of 45801,45803,45805 45807,45809

M

Macrocheilia, operation for 45675
Macrodactyly, surgical reduction of enlarged elements 46510
Macroglossia, operation for 45675
Macrostomia, operation for 45676
Malignant lesion, removal of 31300,31305,31310 31315,31320,31325,31330,31335
Malignant upper aerodigestive tract tumour 31400,31403,31406
Mallet finger, closed pin fixation of 46438
finger, open repair of text test 46441
finger, with intra-articular fracture, open reduction 46442
Mammaplasty, augmentation 45524,45527,45528
reduction 45520,45522
Mammary prosthesis, removal of 45548,45551,45552
prosthesis, replacement of 45552-45554
Manchester operation for genital prolapse 35577
Mandible, condylectomy 45611
dislocations, treatment of 47000
hemi-mandibular reconstruction with bone graft 45608
operation on, for acute osteomyelitis 43503
operation on, for chronic osteomyelitis 43512,45815
or maxilla, fractures, treatment of 47753,47756,47762 47765,47768,47771,47774,47777,47780,47783,47786 47789
osteectomy or osteotomy of 45720,45723,45726 45729,45731,45732,45735,45738,45741,45744,45747 45752
resection of 45599,45602,45605
segmental resection of, for tumours 45605
Mandibular, frenulum, repair of, under GA 30281
or palatal exostosis, excision of 45825
Manipulation of fibrous tissue surrounding breast prosthesis
of joints 50115
of spine 48600,48603
of ureteric calculus, endoscopic 36857
Manometry, biliary 30493
Marshall-Marchetti operation for urethropexy 35599,37044
Marsupialisation of Bartholin's cyst or gland 35516,35517
salivary gland 30265,30266
Mastectomy, total
subcutaneous 31524
Mastitis, granulomatous, exploration and drainage 31551
Mastoid cavity, obliteration of 41548,41564
portion, decompression of facial nerve 41569
Mastoidectomy, cortical 41545
intact wall technique, with myringoplasty 41551,41554
radical or modified radical 41557,41560,41563 41564
revision of, with myringoplasty 41566
with insertion of cochlear implant 41617
with transmastoid removal of glomus tumour 41623
Maxilla, operation on, for acute osteomyelitis 43503
operation on, for chronic osteomyelitis 43512,45815
or mandible, fractures, treatment of 47753,47756,47762 47765,47768,47771,47774,47777,47780,47783,47786 47789
osteectomy or osteotomy 45720,45723,45726 45729,45731,45732,45735,45738,45741,45744,45747 45752
resection of, segmental, for tumour/cyst 45605
resection of, sub-total 45602
resection of, total 45596,45597
Maxillary antrum, lavage of 41704
antrum, proof puncture and lavage of 41698,41701
artery, transantral ligation of 41707
frenulum, repair of 30281
sinus lift procedure 45849
sinus, drainage of, through tooth socket 41719
sinus, operations on 41710,41713,41716 41719,41722
tuberosity, reduction of 45829
Meatoplasty, with correction of auditory canal stenosis 41521
with removal of cartilage and/or bone 41512,41515
Meatotomy and hemi-circumcision, hypospadias 37354
ureteric, with cystoscopy 30265,30266,36830
urethral 37321
Meatus, external auditory, removal of exostoses in 41518
external auditory, removal of keratosis obturans 41509
internal auditory, exploration of 41599
pinhole urinary, dilatation of 37300
Meckel's diverticulum, removal of 30375
Meconium ileus, laparotomy for 43813,43816
Medial palpebral ligament, ruptured, repair of 42854
Median bar, endoscopic resection of 36854
sternotomy for post-operative bleeding 38656
Mediastinum, cervical exploration of 38448
exploration of, for hyperparathyroidism 30318,30320
intrathoracic operation on, not otherwise covered 38456
Meibomian cyst, extirpation of 42575
Melanoma, removal of 31300,31305,31310 31315,31320,31325,31330,31335
excision of, oral & maxillofacial region 45801,45803,45805 45807,45809
Melasma, full face chemical peel 45019,45020
Meloplasty, for correction of facial asymmetry 45587,45588
Membranes, retained, evacuation of 16564
Meningeal haemorrhage, operations for 39600,39603
Meningocele, excision and closure of 40100
Meniscectomy, knee 49503,49506
temporo-mandibular 45755
Mesenteric artery, inferior, operation on 32736
vessels, by-pass grafting to 32730,32733
Meso caval shunt for portal hypertension 30603
Metacarpal bones, amputation of 44325
bones, bone grafting, pseudarthrosis 46402,46405
bones, fracture, treatment of 47336,47339,47342 47345
bones, operation for osteomyelitis 46462
bones, osteotomy/osteectomy 46396,46399
Metacarpophalangeal joint, arthrodesis 46300
joint, arthroplasty 46306,46307,46309

46312,46315,46318,46321
joint, arthrotomy 46327,46330
joint, dislocation, treatment of 47042,47045
joint, hemiarthroplasty 46309,46312,46315 46318,46321
joint, ligamentous repair of 46333
joint, volar plate arthroplasty 46307
Metacarpus, operation on, for chronic osteomyelitis 43512
Metastatic carcinoma, craniotomy for removal of 39709
Metatarsal bones, osteotomy or osteectomy of 48400,48403
fracture, treatment of 47633,47636,47639 47642,47645,47648,47651,47654,47657
Metatarso-phalangeal joint, synovectomy of 49860,49863
joint, total replacement of 49857
Metatarsus, amputation or disarticulation of 44358
operation on, for acute osteomyelitis 43500
Micro-arterial graft 45503
Microdochotomy of breast, benign or malignant condition 31554
Microlaryngoscopy 41855
- with arytenoidectomy 41867
- with division of laryngeal web 41868
- with removal of juvenile papillomata 41858
- with removal of papillomata by laser surgery 41861
- with removal of tumour 41864
Microsomia, construction of condyle and ramus 45791
Microvascular anastomosis using microsurgical techniques 45502
for supercharging of pedicled flaps 45561
repair using microsurgical techniques 45500,45501,45504
Microvenous graft 45503
Middle ear, clearance of 41635,41638
ear, exploration of 41629
ear, insertion of tube for drainage of 41632
ear, operation for abscess or inflammation of 41626
palmar spaces of hand, drainage of 46519
Midtarsal amputation of foot 44364
Miles' operation 32039
Minitracheostomy insertion 41884
Minnesota tube, insertion of 13506
Miscarriage, habitual, treatment of 16504
incomplete, curettage for 35639,35640
threatened, ligation of cervix 16511
threatened, treatment of 16505
Mitral annulus, reconstruction after decalcification 38485
valve, open valvotomy of 38487
Mitrofanoff continent valve, formation of 37045
Moh's procedure 31000-31002
Mole, desiccation by diathermy
retained, evacuation of 16564
Molluscum contagiosum, removal in operating theatre 30189
Mucous membrane, biopsy of 30071
membrane, cancer, treatment 30196,30197,30202 30203,30205
membrane, graft 42641
membrane, repair of recent wound 30026,30029,30032 30035,30038,30041,30042,30045,30048,30049
Multiple delivery, administration of anaesthetic
Multiple, injections for varicose veins 32500,32501
pregnancy, interventional techniques 16633,16636
Muscle, activity sampling (electromyography)
biopsy of 30074,30075
distal, devascularisation of 32200
excision of 30226,30229
excision of, with melanoma 31340
extra-ocular, ruptured, repair of 42854
flap repair 45000,45009,45012
flap, delay of 45015
removal of foreign body from 30067,30068
ruptured, repair of 30232,30235
transfer for facial nerve paralysis 45578
transplant (Hummelsheim type), for squint 42848
Myelomeningocele, excision and closure of 40103
Myelotomy, laminectomy for 39124
Mylohyloid ridge, reduction of 45827
Myocardial electrode, permanent, insertion, thoracotomy 38470
biopsy, by cardiac catherterisation 38275
Myocutaneous flap, delay of 45015
flap repair 45003,45006
Myoma, hysteroscopic resection 35623
Myomectomy, hypertrophic obstructive cardiomyopathy 38650
uterine, abdominal 35649
uterine, laparoscopic 35638
Myotomy, cricopharyngeal 41770,41776
hypertrophic obstructive cardiomyopathy 38650
ocular muscles 42833,42839,42851
oesophagogastric (Heller's operation) 30532,30533
Myringoplasty 41527,41530
- and mastoidectomy 41551,41560
- and ossicular chain reconstruction 41542
- and revision of mastoidectomy 41566
- with mastoidectomy and ossicular chain recon 41554,41563
Myringotomy 41626

N

Naevus, excision of
excision of, in oral & maxillofacial region 45801,45803,45805 45807,45809
Nail bed, exploration and repair of deformity 46489
bed, reconstruction of laceration 46486
digital, of finger or thumb, removal of 46513,46516
digital, of toe, removal of 47904,47906
ingrowing, of finger or thumb, resection 46528,46531
ingrowing, of toe, excision/resection 47915,47916,47918
ingrown, of toe, operation under GA, paediatric 44136
plate injury/deformity, radical excision 46534
plate or rod, removal of 47930
Nasal adhesions, division of 41683
bones, fracture, treatment of 47735,47738,47741
cavity and/or post nasal space, examination of 41653
cavity, packing for arrest of haemorrhage 41677
haemorrhage, arrest of 41656,41677
haemorrhage, cryotherapy in the treatment of 41680
polyp or polypi, removal of 41662,41665,41668
septum button, insertion of 41907
septum, reconstruction of 41672
septum, septoplasty or submucous resection 41671
space, post, direct examination of 41761
turbinates, cryotherapy 41695
Nasendoscopy 41764
Naso-lacrimal tube, replacement of 42610,42611,42614 42615
Nasopharyngeal angiofibroma, transpalatal removal 41767
Nasopharynx, fibreoptic examination of 41764
Neck, deep-seated haemangioma, excision of 45036
excision of infected by-pass graft 34157
scar, revision of (restriction applies) 45506,45512
Necrosectomy, pancreatic 30577
Necrotic material, debridement of 35100,35103
Needle biopsy, aspiration
biopsy of prostate 37218
biopsy of vertebra 30093
Needling of cataract 42734
needling of encysted bleb 42744
Neonatal alimentary obstruction, laparotomy for 43825
surgery 43801,43804,43807 43810,43813,43816,43819,43822
neonatal, repair of 30387
Neoplasia, intraepithelial, laser therapy 35539,35542,35545
Neoplastic lesions, cutaneous, treatment of 30195
Nephrectomy 36516,36519,36522 36525-36529

radical, for nephroblastoma, paediatric 43984
Nephro-ureterectomy, complete, with bladder repair 36531
for tumour 36532
for tumour, complicated 36533
Nephroblastoma, operations for 43981,43984
Nephrolithotomy 36540,36543
Nephroscopy 36627,36630,36633
36636,36639,36642,36645,36648
Nephrostomy 36552
drainage tube, exchange of, imaging guided 36649
percutaneous, using interventional imaging 36624
Nerve block, regional or field 18213,18216,18219
18222,18225-18228,18230,18232-18234,18236,18238
18240,18242,18244,18246,18248,18250,18252,18254
18256,18258,18260,18262,18264,18266,18268,18270
18272,18274,18276,18278,18280,18282,18284,18286
18288,18290,18292,18294,18296,18298
cranial, intracranial decompression 39112
cutaneous, nerve graft to 39318
cutaneous, repair of 39300,39303
exploration of 39330
facio-hypoglossal or facio-accessory, anastomosis of 39503
graft to nerve trunk 39315
intracranial, for trigeminal neuralgia 39106
peripheral, removal of tumour from 39324,39327
sacral, stimulation for faecal incontinence 32213-32218
section, retrolabyrinthine, vestibular/cochlear 41596
section, translabyrinthine, vestibular 41593
stimulation for pain 39130,39131,39133-39139
transposition of 39321
trigeminal, primary branch, injection with alcohol etc 39100
trunk, internal (interfasicular), neurolysis of 39312
trunk, microsurgical repair 39306,39309
trunk, nerve graft to 39315
vestibular, section of, via posterior fossa 39500
Neurectomy, foot, for plantar digital neuritis 49866
intracranial, for trigeminal neuralgia 39106
peripheral nerve 39324,39327
transantral vidian, with antrostomy 41713
Neuroblastoma, operations for 43981,43984,43987
Neuroendocrine tumour, retroperitoneal, removal of 30321,30323
Neuroendoscopy 40903
Neurolysis, by open operation 39330
of nerve trunk 39312
Neuroma, acoustic, removal of 41575,41576,41578
41579
Neurostimulator receiver, spinal, subcutaneous
placement 39134
Neurotomy, of peripheral nerves 39327
percutaneous, for facet joint denervation 39118
percutaneous, of spinal nerves 39115
Neurovascular island flap, for pulp innervation 46504
island flap, with vascular pedicle 45563
Nipple, accessory, excision of 31566
inverted, surgical eversion of 31563
reconstruction of 45545,45546
Noble type intestinal plication with enterolysis 30375
Node, lymph, biopsy of 30074,30075
scalene, biopsy 30096
Nodes, lymph, pelvic, excision of 35551
Non-gravid uterus, suction curettage of 35639,35640
Nose, cauterisation or packing, for haemorrhage 41677
composite graft to 45656
cryotherapy to, for haemorrhage 41680
dermoid of, congenital, excision of 41729
foreign body in, removal of, other than simple 41659
fracture, treatment of 47735,47738,47741
full thickness repair of laceration (restriction) 30052
operations, other 41659,41662,41665
41668,41671,41672,41674,41677,41680,41683,41686
41689,41692,41695
plastic operations 45632,45635,45638
45639,45641,45644-45647,45650,45652,45653

O

Ocular muscle, torn, repair of 42854
transillumuination 42821
Odontoid screw fixation 40316
Oesophageal atresia, neonatal, operations for 43843,43846,43849
43852,43855,43858
atresia/corrosive stricture, replacement for 43903
perforation, repair of, by thoracotomy 30560
prosthesis, insertion of 30490
stricture, endoscopic dilatation of 41819,41820
transection for portal hypertension 30606
tube, indwelling, gastrostomy for fixation 30375
Oesophagectomy 30535,30536,30538
30539,30541,30542,30544,30545,30547,30548,30550
30551,30553,30554,30556,30557
cervical 30294
Oesophagogastric myotomy 30532,30533
Oesophagoscopy 30473,30475,30476
30478
with dilatation of stricture 41819,41820
with rigid oesophagoscope 41816,41822,41825
Oesophagostomy, cervical 30293,30294
cervical, neonatal oesophageal atresia 43858
closure or plastic repair of 30293
Oesophagus, resection of stricture, paediatric 43906
balloon dilatation of 41832
dilatation of 41819,41820,41822
41825,41828,41831
intrathoracic operation on, not otherwise covered 38456
local excision for tumour 30559
removal of foreign body in 41825
Olecranon, excision of bursa of 30110,30111
fracture, treatment of 47396,47399,47402
fracture, treatment of paediatric 50540
Omentectomy, infra-colic 35726
with debulking operation 35720
Oophorectomy, laparoscopic 35638
with laparotomy, not with hysterectomy 35712,35713,35716
35717
with vaginal hysterectomy 35673
Open heart surgery, not otherwise covered 38653
Operative arteriography or venography 35200
cholangiography or pancreatography 30439
feeding jejunostomy 31462
laparoscopy, complicated 35641
Ophthalmological examination under GA 42503
Optic fundi, examination of
nerve meninges, incision of 42548
Orbit, anophthalmic, insertion of cartilage or implant 42518
anophthalmic, placement of motility integrating peg 42518
eye, decompression of 42545
eye, exenteration of 42536
eye, exploration of 42530,42533
eye, removal tumour/foreign body 42539,42542,42543
eye, skin graft to 42524
Orbital cavity, bone or cartilage graft to 45593
cavity, reconstruction of 45590
dermoid, congenital, excision of 42574
dystopia, correction of 45776,45779
implant, enucleation of eye 42506,42509
implant, evisceration of eye and insertion of 42515
Orbitotomy 42530,42533
Orchidectomy 30638,30641
Orchidopexy for undescended testis 37803,37804,37806
37807,37809,37810
Oro-antral fistula, plastic closure of 41722
pin or wire, insertion of 47921

Oro-nasal fistula, plastic closure of 45714
Orthopaedic pin or wire, insertion of 47921
ring fixator, adjustment of 50309
Osseo-integration procedures 45794,45797,45847
for implantable bone conduction hearing system 41603,41604
Ossicular chain reconstruction 41539,41542
Osteectomy of accessory bone 48400
carpus 48406,48409
clavicle 48406,48409
femur 48424,48427
fibula 48406,48409
humerus 48412,48415
mandible or maxilla 45720,45723,45726
45729,45731,45732,45735,45738,45741,45744,45747
45752
metatarsal 48400,48403
pelvic bone 48424
pelvis 48427
phalanx 48400,48403
radius 48406
rib 48406
scapula (other than acromion) 48406
sesamoid bone 48400
tarsus 48406
tibia 48418,48421
ulna 48406
Osteomyelitis, acute or chronic, operations for 43500,43503,43506
43509,43512,43515,43518,43521,43524
carpus, operation for 46462
metacarpal, operation for 46462
operations for, in oral and maxillofacial region 45815,45817
phalanx, operation for 46459,46462
skull, craniectomy for 39906
Osteoplasty of knee 49503,49506
Osteotomy of accessory bone 48400
carpus 48406,48409
clavicle 48406,48409
femur 48424,48427
fibula 48406,48409
foot 49833,49836-49838
humerus 48412,48415
mandible or maxilla 45720,45723,45726
45729,45731,45732,45735,45738,45741,45744,45747
45752
metatarsal 48400,48403
midfacial 45753,45754
pelvic bone 48424
pelvis 48427
phalanx 48400,48403
radius 48406,48409
rib 48406,48409
scapula (other than acromion) 48406,48409
sesamoid bone 48400
tarsus 48406,48409
tibia 48418,48421
ulna 48406,48409
Otitis media, acute, operation for 41626
Oval window surgery 41615
Ovarian biopsy by laparoscopy 35637
cyst aspiration 35518
cyst, excision of, with hysterectomy 35673
cyst, excision of, with laparotomy 35712,35713,35716
35717
cyst, puncture of, via laparoscope 35637
cystectomy, laparoscopic 35638
transposition with hysterectomy for malignancy 35729
tumour, radical or debulking operation for 35720
ovaries, operation for 30387
rectum, abdominal rectopexy 32117
rectum, perineal repair of 32120
rectum, rubber band ligation of 32135
rectum, sclerotherapy for 32132
urethra 35570,35573
urethra, excision of 37369
vaginal, repair of 35568-35573,35577,35578
35595-35597
Ovaries, prolapse, operation for 30387
Oxycephaly, cranial vault reconstruction for 45785
Oxygen consumption, estimation of
therapy, hyperbaric 13020,13025,13030

P

Pacemaker electrode, permanent, insertion, sub-xyphoid 38473
gracilis neosphincter 32210
permanent, insertion or replacement 38353
Pacemaking electrode, temporary transvenous, insertion 38256
Pain management, implanted drug delivery system 39125-39128,39130,39131
39133
spinal and peripheral nerve stimulation 39130,39131,39133-39139
Palatal exostosis, excision of 45825
Palate, cleft, repair of 45707,45710,45713
papillary hyperplasia removal of 45831,45833,45835
Palmar warts, removal of 30185-30187
Palpebral ligament, medial, ruptured, repair of 42854
lobe of lacrimal gland, excision of 42593
Pancreas, drainage of 30375
excision of 30583
Pancreatectomy 30583,30593,30594
Pancreatic abscess, laparotomy and external drainage of 30575
cyst, anastomosis to Roux loop of jejunum 30587
cyst, anastomosis to stomach or duodenum 30586
juice, collection of 30488
necrosectomy 30577
Pancreatico-duodenectomy (Whipple's operation) 30584
Pancreatico-jejunostomy 30589,30590
Pancreato-cholangiography, endoscopic 30484
Pancreatography, operative 30439
Panendoscopy 30473,30476,30478
Panhysterectomy 35664
Pannus, treatment of, with cautery of conjunctiva 42677
Papilloma, bladder, transurethral resection 36840,36845
larynx, removal of 41852
removal in oral & maxillofacial region 45801,45803,45805
45807,45809
Papillomata, juvenile, removal with microlaryngoscopy 41858
removal of by laser surgery 41861
Para-oesophageal, hiatus hernia, repair of 31468
Paracentesis abdominis 30406
anterior or posterior chamber or both 42740
in relation to eye 42734
of tympanum 41626
thoracic cavity 38803
Paralysis, facial nerve, plastic operations for 45575,45578
Parapharyngeal tumour, excision of 31409,31412
Paraphimosis, reduction of under GA 30666
Parathyroid operation for hyperparathyroidism 30315
Parental nutrition
central vein, tunnelled cuffed catheter 34538
removal of tunnelled cuffed catheter 34539
Paretic states, eyebrows, elevation of 42872
Parks' intersphincteric operation 32126
Paronychia of foot, incision for 47912
of hand, incision for 46525
Parotid duct, diathermy or dilatation 30262
duct, meatotomy or marsupialisation 30265,30266
duct, removal of calculus 30265,30266
duct, repair of, 30246
fistula, repair of 30269
gland, superficial lobectomy/removal of tumour 30253
gland, total extirpation of 30247,30250
tumour, excision of 30251

Parovarian cyst, removal of 35712,35713,35716 35717
Patch angioplasty for vein stenosis 34815
grafting to artery or vein 33545,33548
Patella, bursa, excision of 30110,30111
congenital dislocation, reconstruction of quadriceps 50420
dislocation, treatment of 47057,47060
fracture, treatment of 47579,47582,47585
Patellar bursa, excision of 30110,30111
Patellectomy 49503,49506
Patello-femoral stabilisation 49503,49506,49564
stabilisation, revision of 49548
Patent diseased coronary bypass vein graft, dissection 38637
ductus arteriosus, division/ligation 38700,38703
Patent ductus arteriosus, transcatheter closure 38273
urachus, excision of 37800
Patent Urachus 37801
Pectus carinatum, repair or radical correction 38457
excavatum, repair or radical correction 38457,38458
Pedicle, tubed, or indirect flap 45230
- formation of 45227
- preparation of site and attachment to site 45233
- spreading of pedicle 45236
Pelvi-ureteric junction, plastic procedures to 36564
cystoscopy of 36825
Pelvic abscess, drainage via rectum or vagina 30223
abscess, laparotomy for drainage of 30394
bone, operation on, for osteomyelitis 43509,43518
bone, osteectomy or osteotomy of 48424,48427
floor repair, laparoscopic or abdominal 35595
haematoma, drainage of 30387
lymph glands, excision of 35551,35664,35670
ring, fracture, treatment of 47474,47477,47480 47483,47486,47489
Pelvic lymphadenectomy 36502
Pelvis, bone graft/shelf procedure, acetabular dysplasia 50393
fracture, treatment of 47474,47477,47480 47483,47486,47489,47492,47495,47498,47501,47504 47507,47510
osteotomy or osteectomy of 48424,48427
Penile warts, cystoscopy for treatment of 36815
Penis, amputation of 37402,37405
artificial erection device, insertion 37426,37429
artificial erection device, revision or removal of 37432
circumcision of 30653,30656,30659 30660
correction of chordee 37417,37418
frenuloplasty 37435
injection for impotence 37415
lengthening by translocation of corpora 37423
paraphimosis, reduction of under GA 30666
partial amputation of 37402
repair of avulsion 37411
repair of laceration of cavernous tissue, or fracture 37408
surgery for penile drainage causing impotence 37420
Peptic ulcer, bleeding, control of 30505,30506,30508 30509
ulcer, perforated, suture of 30375
Per anal release, rectal stricture 32114
Percutaneous aspiration biopsy of deep organ 30094
biliary dilatation 30495
biliary drainage 30440,30451,30495
biliary stenting 30492
cordotomy 39121
drainage of deep abscess, imaging guided 30224
endoscopic gastrostomy 30481,30482
epidural electrode, insertion 39130
epidural electrodes, management of 39131
epidural implant, removal 39136
gastrostomy tube, jejunal extension 31460
liver biopsy 30409
lumbar discectomy 48636
needle biopsy of lung 38812
neurotomy for facet joint denervation 39118
neurotomy of peripheral nerves 39323
neurotomy of spinal nerves 39115
retrieval of foreign body 35360-35363
retrieval of inferior vena caval filter 35331
transhepatic cholangiogram, imaging guided 30440
ureteric stent exchange 36608
Perforated duodenal ulcer, suture of 30375
gastric ulcer, suture of 30375
peptic ulcer, suture of 30375
Perforating wound of eyeball, repair of 42551,42554,42557
Perfusion of donor kidney, continuous 22055
of limb or organ 22055
retrograde, cerebral (if performed) 22075
retrograde, intravenous, sympatholytic agent 14209
whole body 22060
Perianal abscess, drainage of 32174,32175
abscess, incision with drainage 30223
excision of rectal tumour 32103,32104,32106
thrombosis, incision of 32147
Pericardectomy 38447,38449
Pericardium, drainage of, sub-xyphoid 38452
drainage of, transthoracic 38450
Perineal anoplasty, ano-rectal malformation 43960
biopsy of prostate 37212
graciloplasty 32203,32209
graciloplasty, insert. stimulator & electrode 32209
prostatectomy 37200
recto-sigmoidectomy for rectal prolapse 32112
repair of rectocele 32131
repair, rectal prolapse 32120
Perineorrhaphy 35571
Perinephric abscess, drainage of 36537
area, exploration of 36537
Periorbital correction of Treacher Collins Syndrome 45773
dermoid, congenital, excision of 42573
Peripheral arterial atherectomy 35312
arterial catheterisation 35321
cannulation for cardiopulmonary bypass 38603
laser angioplasty 35315
nerve, neurectomy/neurotomy/tumour 39324,39327
peripheral nerve stimulation for pain 39131,39133-39137
venous catheterisation 35317,35319,35320
Peritomy, conjunctival 42632
Peritoneal adhesions, division, with laparotomy 30376,30378,30379
biopsies, multiple, with infracolic omentectomy 35726
catheter, insertion and fixation of 13109
catheter, removal of 13110
dialysis 13112
Peritoneo venous (Leveen) shunt, insertion of 30408
Peritonitis, laparotomy for 30394
Peritonsillar abscess, incision of 41807
Periurethral injection for urinary incontinence 37339
Perthes, hips or knees, application of cast under GA 50390
Petro-clival and clival tumour, removal of 39653,39654,39656
Peyronie's plaque, operation for 37417
Phalanges, amputation/splitting, congenital abnormalities 50396
Phalanx, bone grafting of, for pseudarthrosis 46402,46405
distal, for osteomyelitis 46459
finger or thumb, fractures, treatment of 47300,47303,47306 47309,47312,47315,47318,47321,47324,47327,47330 47333
middle or proximal, for osteomyelitis 46462
operation for acute osteomyelitis 43500
operation for chronic osteomyelitis 43512
osteectomy or osteotomy of 46399,48400,48403
toe, fracture, treatment of 47663,47666,47672

47678
Pharyngeal adhesions, division of 41758
bands or lingual tonsils, removal of 41804
cysts, removal of 41813
flap for velo-pharyngeal incompetence 45716
pouch, endoscopic resection (Dohlman's op) 41773
pouch, removal of 41770
Pharyngectomy, partial 41782,41785
Pharyngoplasty 45716
Pharyngotomy (lateral) 41779
Pharynx, cauterisation or diathermy 41674
removal of foreign body from 30061
Photocoagulation, laser, vascular lesions 14100,14106,14109 14112,14115,14118,14124
of xenon arc 42782,42783
Photoiridosyneresis, laser 42808
Photomydriasis, laser 42807
Phototherapeutic, keratectomy 42810
Pigeon chest, correction of 38457
Pilonidal cyst or sinus, excision of 30675,30676
sinus, injection of sclerosant fluid 30679
Pin, orthopaedic, insertion of 47921
wire or screw, buried, removal of 47924,47927
Pinealoma, craniotomy for removal of 39712
Pinguecula, removal of 42689
Pinhole urinary meatus, dilatation of 37300
Pirogoff's amputation of foot 44361
Pitanguy abdominoplasty 30177
Pituitary tumour, removal of 39715
Placement of catheters 38220,38222,38243
Placenta, retained, evacuation of 16564
Placentography, preparation for 36800
Plantar fasciotomy, radical 49854
warts, removal of 30186,30187
Plaster jacket, application of, to spine 47708
Plastic procedures to pelvi-ureteric junction 36564
reconstruction for bicornuate uterus 35680
reconstruction of lacrimal canaliculus 42602
repair, direct flap 45209,45212,45215 45218,45221,45224
repair, of cervical oesophagostomy 30293
repair, single stage, local flap 45200,45203,45206
repair, to enlarge vaginal orifice 35569
Plate, rod or nail, removal of 47930
Pleura, percutaneous biopsy of 30090
Pleural effusion 38803
Pleurectomy with thoracotomy 38424
pleurodesis 38436
pleurodesis 38424
Plexus, brachial, exploration of 39333
Plication, intestinal, with enterolysis, Noble type 30375
Pneumonectomy 38438,38441
Poison, ingested, gastric-lavage in the treatment of 14200
Polycythemia 13757
Polyhydramnios, attendance, not routine antenatal 16502
Polyp, anal, excision of 32142,32145
aural, removal of 41506,41509
cervix, removal of 35611
larynx, removal of 41852
nasal, removal of 41662,41665,41668
rectal, removal with sigmoidoscopy 32078,32081
uterus, removal of 35639,35640
Polypectomy, with hysteroscopy 35633
Popliteal artery, exploration of, for popliteal entrapment 34145
vessel, ligation or exploration, other 34103
Porta hepatitis, radical resection for carcinoma 30461
Portacath, laparatomy with insertion of 30400
Portal hypertension, operations for 30602,30603,30605 30606
Porto caval shunt for portal hypertension 30602
Portoenterostomy for biliary atresia 43978
Posterior chamber, removal of silicone oil 42815
juxtasceral Depot injection 42741
sclerotomy 42734
spinal fusion 40321,40324,40327
vaginal compartment repair 35571,35573
Postero-lateral bone graft to spine 48648,48651
Postnasal space, examination under GA 41653
space, direct examination with/without biopsy 41761
Postnatal care 16564,16567,16570 16571,16573
Postoperative haemorrhage 30058
- control under GA, independent 30058
- laparotomy for control of 30385
- tonsils/adenoids, arrest, under GA 41796,41797
following gynaecological surgery, under GA 35759
Postpartum haemorrhage, treatment of 16567
Pre-auricular sinus, excision of 30104,30105
Pre-auricular, excision of 30105
Preeclampsia, treatment of 16509
Pregnancy, attendance for complication by 16508
- diabetes or anaemia 16502
- intrauterine growth retardation 16508
- threatened premature labour 16502,16508
multiple, attendance other than routine antenatal 16502
Premalignant skin lesions, treatment of 30192
Premature labour, attendances not routine antenatal 16502,16508
Prepuce, breakdown of adhesions of 30649
operations on 30653,30656,30659 30660,30663,30666
Tumour, benign of soft tissue removal 30611
Presacral and sacrococcygeal tumour, excision of 32036
sympathectomy 35012
Pressure monitoring, intracranial 13830
monitoring, intravascular 13876
Priapism, decompression of 37393
shunt operation for 37396
Primary repair of cutaneous nerve 39300
repair of extensor tendon of hand or wrist 46420
repair of flexor tendon of hand or wrist 46426,46432
repair of nerve trunk 39306
restoration of alimentary continuity 41843
Proctectomy, perineal 32047
Proctocolectomy with ileostomy 32015,32018,32021
Products of conception, retained, evacuation of 16564
Progesterone implant 14203,14206
Proof puncture of maxillary antrum 41698,41701
Prostate, biopsy of 37212,37215,37218 37219
diathermy or visual laser destruction of 37224
endoscopic laser ablation 37207,37208
high energy transurethral microwave thermotherapy 37230,37233
total excision of 37209-37211
transurethral microwave thermotherapy 37230,37233
Prostate, impantation of gold fiducial markers 37217
Prostatectomy, endoscopic 37203,37206
open 37200
radical 37210,37211
Prostatic abscess, endoscopic drainage of 37221
abscess, open drainage of 37212
coil, insertion of 37223
Prosthesis, breast, manipulation fibrous tissue surrounding
breast, removal and/or replacement 45548,45551-45555
knee, removal of 49515
oesophageal, insertion of 30490
shoulder, removal of 48927
Pseudarthrosis, bone grafting of metatarsal for 46402,46405
bone grafting of phalanx for 46402,46405
Pterygium, removal of 42686
Ptosis of eyelid, correction of 45623-45625

breast, correction of (unilateral) 45556,45557
Pulmonary artery, banding of 38715,38718
artery catheterisation 13818
decortication with thoracotomy 38421
Pulp space infection of foot, incision for 47912
space infection of hand, incision for 46525
Pulse generator, subcutaneous placement 39134
Pump or resevoir, loading of 14218
Punch biopsy of synovial membrane 30087
Punctum, occlusion of 42620,42622
snip operation 42617
Purse string ligation, cervix 16511
string ligature of cervix, removal 16512
Puva therapy 14050,14053
Pyelography retrograde, preparation for 36824
Pyelolithotomy 36540,36543
Pyeloplasty, by open exposure 36564,36567,36570
Pyeloscopy, retrograde 36652,36654,36656
Pyelostomy, open 36552
Pyloromyotomy for pyloric stenosis 43930
Pyloroplasty 30375
reconstruction of 30517
Pylorus, dilation of, with vagotomy 30502
Pyonephrosis, drainage of 36537

Q

Quadriceps, patella, reconstruction, congenital dislocation 50420
Quadricepsplasty, for knee mobilisation 49569
Quinsy, incision of 41807

R

Radial vessel, ligation or exploration, other 34106
Radiation dosimetry 15518,15521,15524 15527,15530,15533,15536
field setting 15500,15503,15506 15509,15512,15513,15515
oncology treatment 15211,15214,15215 15218,15221,15224,15227,15230,15233,15236,15239 15242,15245,15248,15251,15254,15257,15260,15263 15266,15269,15272
proctitis, anorectal application of formalin 32212
Radiofrequency ablation
destruction/non-resectable liver cancer 50950,50952
endometrial 35616
Radioisotope, therapeutic dose, administration of 16003,16006,16009 16012
Radiosurgery, stereotactic 15600
Radiotherapy, deep or orthovoltage 15100,15103,15106 15109,15112,15115
planning 15500,15503,15506 15509,15512,15513,15515,15518,15521,15524,15527 15530,15533,15536
radioactive sources, sealed 15303,15304,15307 15308,15311,15312,15315,15316,15319,15320,15323 15324,15327,15328,15331,15332,15335,15336,15338 15339,15342,15345,15348,15351,15354,15357
radioactive sources, unsealed 16003,16006,16009 16012,16015,16018
superficial 15000,15003,15006 15009,15012
Radioulnar joint, dislocation, treatment of 47024,47027
joint, distal, reconstruction/stabilisation 46345
joint, distal, synovectomy 46342
Radius, bone graft to 48218,48221,48224 48227
fracture, treatment of 47360,47363,47366 47369,47372,47375,47378,47381,47384-47387,47390 47393,47396,47399,47402,47405,47408
fracture, treatment of paediatric 50500,50504,50508 50512,50516,50520,50524,50528,50532,50536,50540 50544,50548
operation on, for acute osteomyelitis 43503
operation on, for chronic osteomyelitis 43512
osteectomy or osteotomy of 48406,48409
Ranula, removal of 30282,30283
Rectal biopsy, full thickness 32096
fistula, closure of 37038,37336
polyp, removal of with sigmoidoscopy 32078,32081
prolapse, abdominal rectopexy of 32117
prolapse, Delorme procedure for 32111
prolapse, paediatric, injection under GA 44105
prolapse, perineal recto-sigmoidectomy for 32112
prolapse, perineal repair of 32120
prolapse, rubber band ligation of 32135
prolapse, sclerotherapy for 32132
stricture, dilatation of 32115
stricture, per anal release of 32114
tumour, excision of 32099,32102-32104,32106 32108
Rectal prolapse, submucosal or perirectal injection 44104
Rectocele, perineal repair of 32131
vaginal compartment repair of 35571
Rectopexy, abdominal, of rectal prolapse 32117
Rectosigmoidectomy (Hartmann's operation) 32030
perineal, for rectal prolapse 32112
Rectovaginal fistula, repair of 35596
Rectum and anus, abdomino-perineal resection of 32039,32042,32045 32046,44101
anterior resection of 32024-32026,32028
examination under GA, paediatric 44101,44102
perineal resection of 32047
suction biopsy of 30071
Recurrent hernia, repair of 30403
Reduction mammaplasty (unilateral) 45520
with surgical repositioning of nipple 45520
without surgical repositioning of nipple 45522
Reduction ureteroplasty 36618
Reflux, gastro-oesophageal, correction 43951,43954,43957
vesico-ureteric, correction 36588
Renal artery, aberrant, operation for 36537
biopsy (closed) 36561
cyst, excision of 36558
dialysis in hospital 13100,13103
pelvis, brush biopsy of, with cystoscopy 36821
transplant 36503,36506,36509
repair of abdominal aortic aneurysm 33116,33119
Resevoir, implanted associated with gastric band or pump, loading of 14218
Resuturing of wound following intraocular procedures 42857
Retina, cryotherapy of 42818
detached, diathermy or cryotherapy for 42773
detached, removal of encircling silicone band 42812
detached, resection or buckling operation for 42776
detached, revision operation for 42779
light coagulation for 42782,42783
photocoagulation of 42809
pre-detachment of, cryotherapy for 42818
Retrobulbar abscess, operation for 42572
injection of alcohol 42824
Retrolabyrinthine vestibular nerve section 41596
Retroperitoneal abscess, drainage of 30402
lymph node biopsies 35723
lymph node dissection 37607,37610
neuroendocrine tumour, removal of 30321,30323
Retropharyngeal abscess, incision with drainage 30223
Retropubic prostatectomy 37200
Retroversion, operation for 35683,35684
Rhinophyma, carbon dioxide laser ablation/excision 45652
shaving of 45653

Rhinoplasty procedures 45632,45635,45638 45639,45641,45644
secondary revision of 45650
Rhinotomy, lateral, with removal of tumour 41728
Rhizolysis, spinal 40330
Rib, cervical, removal of 34139
first, resection of portion 34136
fracture, treatment of 47471
operation for acute osteomyelitis 43503
operation for chronic osteomyelitis 43512
osteectomy or osteotomy of 48406,48409
resection, with radical operation for empyema 38415
Ring fixator, adjustment of 50309
Rod, plate or nail, removal of 47930
rods, re-exploration for adjustment /removal 48615
Rosen incision, myringoplasty 41527
Rotational atherectomy, of the coronary artery 38309,38312,38315 38318
Rotator cuff of shoulder, repair of 48906,48909
Round window repair or cochleotomy 41614
Roux-en-Y biliary bypass 30460,30466,30467
Rovsing's operation 36537
Rubin test for patency of Fallopian tubes 35706
Ruptured medial palpebral ligament, repair of 42854
membranes, threatened premature labour 16508
muscle, repair of 30232,30235
thoracic aorta, operative management of 38572
urethra, repair of 37306,37309
viscus, simple repair of 30375

S

Sacral nerve lead(s) 36663
Sacral sinus, excision of 30675,30676
colpopexy 35597
nerve stimulation for faecal incontinence 32213-32218
sympathectomy 35012
Sacro-iliac joint, arthrodesis of 49300
joint disruption, treatment of 47513
Sacrococcygeal and presacral tumour, excision of 32036
teratoma, neonatal, excision of 43876,43879
sacrospinous colpopexy 35568
Salivary gland, major, transposition of duct 41910
gland, operations on 30262,30265,30266 30269
Salpingectomy, laparoscopic 35638
with laparotomy, not with hysterectomy 35712,35713,35716 35717
with vaginal hysterectomy 35673
Salpingo-oophorectomy not with hysterectomy 35712,35713,35716 35717
Salpingolysis 35694,35697
Salpingostomy 35694,35697
laparoscopic 35638
Saphenous vein anastomosis 34809
Scalene node biopsy 30096
Scalenotomy 34133
Scalp vein catheterisation in a neonate 13300
Scaphoid, bone graft to 48230,48233,48236
Scapula, fracture, treatment of 47468
(other than acromion), osteectomy/osteotomy 48406,48409
operation for chronic osteomyelitis 43512
Scar, abrasive therapy to 45021,45024
face or neck, revision of (restriction applies) 45506,45512
in oral and maxillofacial region 45801,45803,45805 45807
other than face or neck, revision of (restriction) 45515,45518
other, removal of 31200,31205,31210 31215,31220,31225,31230,31235,31240
Scars, corneal, removal of, by partial keratectomy 42647
Sclera, removal of imbedded foreign body 42644
removal of superficial foreign body 30061
transplantation of 42662,42665
Scleral blood vessels, laser coagulations of graft to lid 42860
Sclerectomy and iridectomy for glaucoma 42746
Sclerosant fluid, injection of into pilonidal sinus 30679
injection of starburst vessels, head/neck 30213,30214
injection of telangiectases, head/neck 30213,30214
Scoliosis, treatment of 48606,48612,48613 48615,48618,48621,48624,48627,48630,48632
anterior correction of (Dwyer procedure) 48621,48624
application of halo 47714
bone graft to 50644
congenital, vertebral resection and fusion for 48632,50640
re-exploration for 48615,50616
requiring anterior decompression of spinal cord 48630,50636
revision of failed surgery 48618,50620
spinal fusion for 48606,48612,48613
spinal fusion for, with segmental instrumentation 48612,48613,48627
spinal fusion with use of Harrington rod 48681
treatment of including paediatric 50600,50604,50608 50612,50616,50620,50624,50628,50632,50636,50640 50644
Screw, pin or wire, buried, removal of 47924,47927
Scrotal contents, exploration of 37604
Scrotum, excision of abscess of 30223
partial excision of 37438
Second trimester labour, management of 16525
Secondary, repair of extensor tendon of hand or wrist 46423
repair of flexor tendon of hand or wrist 46429
Segmentectomy 38438
Selective coronary angiography 38215,38218,38220 38222,38225,38228,38231,38234,38237,38240,38241 38243,38246
internal radiation therapy 35404,35406,35408
Semen, collection of 13290,13292
Semimembranosus bursa, excision of 30114
Seminal vesicle/ampulla of vas, total excision of 37209
Sengstaken-Blakemore tube, insertion of 13506
Sentinel lymph node biopsy for breast cancer 30299,30300,30302 30303
Septal defect, atrial, closure of 38742
defect, ventricular, closure of 38751
perforation, closure of 41671
Septectomy, cardiac 38739,38748
Septoplasty of nasal septum 41671
Septostomy, or balloon valvuloplasty 38270
Septum button, nasal, insertion of 41907
nasal, cauterisation/diathermy 41674
nasal, reconstruction of 41672
nasal, septoplasty or submucous resection 41671
vaginal, excision of, for correction of double vagina 35566
Sequestrectomy 43512,43515,43518 43521,43524
Seroma, breast, exploration, drainage, operating theatre 31551
Sesamoid bone, osteotomy or osteectomy of 48400
Seton, readjustment of, in anal fistula 32166
Shirodkar suture 16511
Shoulder, amputation or disarticulation at 44331
arthrectomy or arthrodesis 48939,48942
arthroscopic surgery 48948,48951,48954 48957,48960
arthroscopy 48945
arthrotomy 48912
dislocation, treatment of 47009,47012,47015
hemi-arthroplasty of 48915
open reduction for congenital dislocation 50408
orthopaedic treatment of 48900,48903
prosthesis, removal of 48927
removal of calcium deposit from cuff 48900

rotator cuff, repair of 48906,48909
spica, application of 47540
Stabilisation procedure for recurrent anterior or posterior dislocation 48930
stabilisation, for multidirection instability 48933
synovectomy of 48936
total replacement of 48918,48921,48924
Shunt, aorto-pulmonary or cavo-pulmonary 38733,38736
arteriovenous, external, insertion/removal 34500,34506
cranial or cisternal, insertion of 40003
cranial or cisternal, revision or removal of 40009
lumbar, insertion of 40006
lumbar, revision or removal of 40009
Sigmoidoscopic examination 32072,32075
- with diathermy or resection of polyp/s 32078,32081
Sigmoidoscopy, fibreoptic, flexible 32084,32087
Silicone band, encircling, removal from detached retina 42812
breast prosthesis, removal of 45555
Sinoscopy 41764
Sinus, diathermy of
ethmoidal, external operation on 41749
excision of 30099,30102,30103
frontal, catheterisation of 41740
frontal, radical obliteration of 41746
frontal, trephine of 41743
injection of sclerosant fluid under anaesthesia 30679
intranasal operation on 41737
maxillary, drainage of, through tooth socket 41719
pilonidal, excision of 30675,30676
pre-auricular, excision of 30104
sphenoidal, intranasal operation on 41752
urogenital, vaginal reconstruction for 35565
SIR-Spheres administration 35404,35406,35408
Skin, biopsy of 30071
cancer, treatment of 30196,30197,30202 30203,30205
full face chemical peel 45019,45020
graft to orbit 42524
lesions, multiple injections for 30207
lesions, treatment of 30192,30195
malignant lesion, removal of 31300,31305,31310 31315,31320,31325,31330,31335
repair of recent wound of 30026,30029,30032 30035,30038,30041,30042,30045,30048,30049
subcutaneous tissue, extensive excision 31245
tags, anal, excision of 32142,32145
Skull base surgery for tumour removal 39640,39642,39646 39650,39653,39654,39656,39658,39660,39662
base tumour, removal, infra-temporal 41581
calipers, insertion of 47705
fracture, attendance for treatment of 47703
fractured, operations for 39606,39609,39612 39615
osteomyelitis, acute, operation for 43503
osteomyelitis, chronic, operation for 43521
osteomyelitis, craniectomy for 39906
treatment of fracture, not requiring operation 47703
tumour, excision of 39700
Sling operation for stress incontinence 35599
procedure, intestinal, prior to radiotherapy 32183
Slough, debridement of 35100,35103
Small bone, exostosis, excision of 47933
bowel intubation 30487,30488
bowel strictureplasty 30564
bowel, endoscopic examination of 32095
intestine, resection of 30565,30566
Smith's fracture of radius, treatment of 47369,47372,47375
Smith-Petersen nail, removal of 47924,47927
Socket, eye, contracted, reconstruction of 42527
Spasticity management
implanted drug delivery system 14227,14230,14233 14236,14239,14242
Spermatic cord, exploration of, inguinal approach 30643,30644
Spermatocele, excision of 37601
Sphenoidal sinus, intranasal operation on 41752
Sphincter, anal, direct repair of 32129
anal, stretching of 32153
bladder, endoscopic incision/resection 36854
of Oddi, transduodenal operation on 30458
urethral, reconstruction 37375
urinary, artificial, insertion 37381,37384,37387
urinary, artificial, revision or removal 37390
Sphincterotomy, anal, independent procedure 43999
endoscopic 30485,36854
Spinal and pudendal nerve motor latency, measurement
catheter, insertion of for infusion device 39125,39128
cord, cervical decompression 40331-40335
fusion to cervical, thoracic or lumbar regions 48660,48663,48666 48669,48672,48675
fusion, application of halo for scoliosis 47714
fusion, posterior 40321,40324,40327
fusion, posterior interbody, with laminectomy 48654,48657
nerves, injection into 39013
nerves, percutaneous neurotomy 39115
neurostimulator receiver, subcutaneous placement 39134
rhizolysis 40330
shunt for hydrocephalus 40006
spinal stimulation, for pain 39131,39133-39139
stenosis, laminectomy for 40303,40306
thoracic decompression 40345,40348
thoraco-lumbar/high lumbar decompression 40351
using segmental instrumentation 48613
Spine, application of plaster jacket to 47708
application of a localiser cast to 50600
bone graft to 48642,48645,48648 48651
fracture, treatment of 47681,47684,47687 47690,47693,47696,47699,47702
internal fixation of 48678,48681,48684 48687,48690
manipulation of 48600,48603
operation on, for acute osteomyelitis 43509
operation on, for chronic osteomyelitis 43518
Spleen, ruptured, repair of 30375
Splenectomy 30597,30599,30619
laparoscopic 31470
Spleno renal shunt, selective, for portal hypertension 30605
Splenorrhaphy 30596
Split skin free grafts, granulating areas 45400,45403
skin free grafts to one defect 45439,45442,45445 45448
Squamous cell carcinoma, removal of 31255-31258,31260-31263,31265-3126 31270-31273,31275-31278,31280-31283,31285-31288 31290-31293,31295
Squint, muscle transplant (Hummelsheim type) 42848
operation for 42833,42836,42839 42842
readjustment of adjustable sutures 42845
recurrent, operation for 42851
Staging laparotomy for gynaecological malignancy 35726
Stapedectomy 41608
Stapes mobilisation 41611
Staple arrest of hemi-epiphysis 48509
Starburst vessels, head/neck, diathermy or injection 30213,30214
Stenosing tendovaginitis, hand/wrist, open operation 46363
Stenosis, arteriovenous fistula/access device, correction of 34518
auditory canal, correction of 41521
spinal, laminectomy for 40303,40306
tracheal, dilatation of, with bronchoscopy 41904
venous, operations for 34812,34815
Stent, external, application restore valve competency 34824,34827,34830

34833
insertion, transluminal 35306,35307,35309
insertion, transluminal, rotational atherectomy 38312,38318
ureteric, passage through nephrostomy tube 36604
Stereotactic procedures 40800,40801,40803
Sterilisation (female) 35687,35688
in conjunction with Caesarean section 35691
Sternal wire/s, removal of 38460
Sternocleidomastoid muscle, bipolar release, torticollis 50402
Sternotomy for removal of thymus or mediastinal tumour 38446
involving division of adhesions 38643,38647
median, for post-operative bleeding 38656
wound, debridement of 38462,38464
Sternum and mediastinum, reoperation for infection 38468,38469
biopsy of 30081,30084,30087
fracture, treatment of 47466,47467
operation for acute osteomyelitis 43503
operation for chronic osteomyelitis 43512
reoperation for dehiscence or infection 38466
Stomach lavage
lavage in the treatment of ingested poison 14200
Stone/s, biliary/renal tract, extraction of
removal of, by urethroscopy 36540,36543
Strabismus, operation for 42833,42836,42839
Stress incontinence, abdomino-vaginal operation 35602,35605
Marshall-Marchetti, urethropexy 35599,37044
sling operation 35599,37042
Stamey or similar type needle colposuspension 37043
suprapubic procedure for 37044
Stricture, anal, anoplasty for 32123
oesophagus, dilatation of 41819
rectal, dilatation of 32115
rectum, plastic operation to 30387
tracheal, dilatation of, with bronchoscopy 41904
urethral, dilatation of 37303
Strictureplasty, small bowel 30564
Strontium 89, administration of 16015
Stump, amputation, reamputation of 44376
cervix-residual, removal of, abdominal approach 35612
cervix-residual, removal of, vaginal approach 35613
Styloid process of temporal bone, removal of 30244
Sub-valvular structures, heart, reconstruction, re-implant 38490
Subclavian artery, endarterectomy 33506
to femoral bypass grafting 32715
vessel, ligation/exploration, other 34103
Subcutaneous fasciotomy, Dupuytren's contracture 46366
fistula in ano, excision of 32156
foreign body, removal not otherwise covered 30064
tenotomy 47960
tissue, repair of recent wound of 30026,30029,30032 30035,30038,30041,30042,30045,30048,30049
Subdural haemorrhage, tap for 39009
Sublingual gland, duct, removal of calculus 30265,30266
gland, extirpation of 30259
gland, meatotomy or marsupialisation 30265,30266
Submandibular abscess, incision of 30223
ducts, relocation of 30255
gland, extirpation of 30256
Submaxillary gland, repair of cutaneous fistula 30269
Submucous resection of nasal septum 41671
resection of turbinates 41692
Subperiosteal abscess 43500,43503,43506 43509,43512,43515,43518,43521,43524
Subphrenic abscess, laparotomy for drainage of 30394
Subtalar arthrodesis 50118
Subtemporal decompression 40015
Subungual haematoma, incision of 30219
Suction biopsy of rectum 30071
curettage of uterus 35639,35640,35643
Supraglottic laryngectomy with tracheostomy 41840
Suprapubic cystostomy or cystotomy 37008
prostatectomy 37200
stab cystotomy 37011
Surgical reduction of enlarged elements, macrodactyly 46510
Suspension of uterus 35683,35684
Suture, laser division of, eye, following trabeculoplasty 42794
shirodkar 16511
traumatic wounds 30026,30029,30032 30035,30038,30041,30042,30045,30048,30049
Sutures, adjustable, readjustment of, for squint 42845
dressing and removal of, requiring GA 30055
Swann-Ganz catheterisation 13818
Sweat, collection of specimen of, by iontophoresis
gland bearing area, excision of 30180,30183
Sycosis barbae/nuchae, excision of 31245
Symblepharon, grafting for 45629
Syme's amputation of foot 44361
Sympathectomy, chemical
surgical 35000,35003,35006 35009,35012
Symphysis pubis, fracture, treatment of 47474,47477,47480 47483,47486,47489
Synacthen stimulation testing 30097
Synechiae, division of 42761
Synovectomy, of ankle 50312
of elbow 49109
of finger joints 46336
of hand tendons 46336,46342
of joint, not otherwise covered 50104
of metatarso-phalangeal joint 49860,49863
of shoulder 48936
of tendons of digit 46348,46351,46354 46357,46360
total, of knee 49509
total, of wrist 49224
Synovial cavity, aspiration of
membrane, punch biopsy of 30087

T

Talipes equinovarus, cast/manipulation/splint 49878
equinovarus, procedures for 50315,50318,50321 50324,50327,50330
Talus fracture, treatment of 47606,47609,47612 47615,47618
vertical, congenital, reconstruction 50336
Tantalum markers, surgical insertion of 42805
Tarsometatarsal joint, fracture, treatment of 47621,47624
joint, Lisfranc's amputation of 44364
Tarsorrhaphy 42584
Tarsus, dislocation, treatment of 47063,47066
fracture, treatment of 47627,47630
operation on, for acute osteomyelitis 43503
operation on, for chronic osteomyelitis 43512
osteectomy or osteotomy of 48406,48409
Tear duct, probing of 42610,42611,42614 42615
third degree, repair of 16573
Teflon injection, into vocal cord 41870
injection, peri-urethral 37339
Telangiectases, head/neck, diathermy or injection of 30213,30214
Temporal artery, biopsy of 34109
bone, reconstruction of 45788
bone, removal of styloid process of 30244
bone, resection for removal of tumour 41584,41587
Temporomandibular joint, arthroplasty 45758
arthrodesis 45877
arthroscopy of 45855,45857
arthrotomy 45859

joint, external fixation, application of 45879
joint, irrigation of 45865
joint, manipulation of 45851
joint, open surgical exploration of 45861,45863,45865 45867,45869,45871,45873
meniscectomy 45755
stabilisation of 45875
synovectomy of 45867
Tendon 49718,49721,49724 49727
- Achilles, repair of 49718,49721,49724 49727
- artificial prosthesis, insertion of for grafting 46414
- foot, adductor hallucis, transfer of 49827,49830
- foot, repair of 49800,49803,49806 49809,49812
- foreign body in, removal 30067,30068
- hand/digit, synovectomy of 46336,46339,46342 46345,46348,46351,46354,46357,46360
- hand/wrist, repair of 46420,46423,46426 46429,46432,46435
- lengthening of 47957,47960,47963
- major, of ankle, repair of 49718,49721,49724 49727
- or ligament transfer 47966
- prosthesis, artificial, insertion for grafting 46414
- reconstruction of, by tendon graft 46408
- repair of 47954,49718
- sheath, open operation for tenovaginitis 46363,47972
- tenotomy 47960,47963
- transfer of, to restore elbow function 50405
- transfer of, to restore hand function 46417
- transplantation of 47966
Tenolysis, hand 46450,46453
Tenoplasty 47963
Tenosynovectomy 47969
Tenosynovitis, open operation, tendon sheath hand/wrist 46363
Tenotomy 47960,47963,49806 49809
percutaneous, of finger 46456
Tenovaginitis, open operation for 46363,47972
Teratoma, mediastinal, thoracotomy and excision 43912
sacrococcygeal, neonatal, excision of 43876,43879
Testicular implant 45051
Testis, exploration of 37604,37810,37813
impalpable, exploration of groin 37812
undescended, orchidopexy for 37803,37806,37809 37810
Testopexy 37803
Tethered cord, release of 40112
Thenar spaces of hand, drainage of 46519
Therapeutic haemapheresis 13750
Therapeutic venesection 13757
Thigh, amputation through 44367
hamstring tendon transfer 50357,50360
rectus femoris tendon transfer 50357
Third degree tear, repair of 16573
ventriculostomy 40012
Thompson arthroplasty of hip 49315
Thoracic aneurysm, replacement by graft 33103
aorta, operative management of rupture/dissection 38572
aorta, repair or replacement procedures 38550,38553,38556 38559,38562,38565,38568,38571
cavity, aspiration of 38800,38803
decompression of spinal cord 40345,40348
outlet compression, removal operation 34139
sympathectomy 35003,35006
Thoraco-lumbar decompression of spinal cord 40351
Thoracoplasty 38427,38430
Thoracoscopy 38436
Thoracotomy 38418,38421,38424
and excision of cyst/teratoma 43912
for congenital cystadenomatoid malformation 43861
for congenital lobar emphysema 43861
for oesophageal atresia, neonatal 43852
for removal of thymus or mediastinal tumour 38446
involving division of adhesions 38643,38647
or median sternotomy for post-operative bleeding 38656
Threatened abortion, treatment of 16505
miscarriage, purse string ligation of cervix 16511
miscarriage, treatment of 16505
premature labour, treatment of 16502,16508
Three snip operation 42617
Thrombectomy of arteriovenous access device 34515
of artery or vein 33803,33806,33812
Thrombosis, peri-anal, incision of 32147
reoperation on extremity for 33848
Thrombus, removal of 33803,33806,33812
Thumb, digital nail, removal of 46513,46516
flexor tendon sheath, open operation 46522
fractures, treatment of 47300,47303,47306 47309,47312,47315,47318,47321,47324,47327,47330 47333
ingrowing nail, resection 46528,46531
Thymectomy 38456
Thymoma, malignant, removal from mediastinum 38456
Thymus, removal of by thoracotomy or sternotomy 38446
Thyroglossal cyst and/or fistula, removal of 30313,30314,30326
Thyroglossal, removal of
Thyroglossal, radical removal of 30326
Thyroidectomy 30296,30297,30299 30300,30302,30303,30306,30308-30310
Tibia, bone graft to 48206,48209
congenital deficiency, treatment of 50417,50423
congenital pseudarthritis, resection, fixation 50354
epiphyseodesis 48503,48506
fracture, treatment of 47543,47546,47549 47552,47555,47558,47561,47564-47567,47570,47573
fracture, treatment of paediatric 50580,50584,50588
operation on, for acute osteomyelitis 43503
operation on, for chronic osteomyelitis 43512
osteectomy or osteotomy of 48418,48421
Tibial vessel, ligation/exploration not otherwise covered 34106
Tic douloureux, injection for 39100
Tissue, expansion for breast reconstruction 45539,45542
expander, insertion of 45566
expander, removal of 45568
expansion, intra-operative 45572
free transfer of 45563-45565
living, implantation of 14203,14206
subcutaneous, repair of recent wound of 30026,30029,30032 30035,30038,30041,30042,30045,30048,30049
Toe, amputation or disarticulation of 44338,44342,44346 44350,44354,44358
dislocation, treatment of 47069,47072
fractures, treatment by reduction 47663,47666,47672 47678
hammer or claw, correction of 49848,49851
hyperextension deformity, release, lengthening 50345
phalanx of, operation for acute osteomyelitis 43500
Toenail, ingrowing, excision or resection for 47915,47916,47918
ingrown, operation with GA, paediatric 44136
removal of 47904,47906
Tongue, partial or complete excision of 30272,41779,41782 41785
tie, repair of 30278,30281
Tonsils, lingual, removal of 41804
or tonsils and adenoids 41796,41797
- removal of, twelve years or over 41792,41793
- removal of, under twelve years 41788,41789
Topectomy, for epilepsy 40703

Torkildsen's operation 40000
Torticollis, bipolar release sternocleidomastoid muscle 50402
operation for 44133
Trabeculectomy for glaucoma 42746,42783
Trabeculoplasty, laser, of eye 42782
Trachea, dilatation of stricture and stent insertion 41905
removal of foreign body from 41886
Tracheal excision, repair, with cardiopulmonary bypass 38455
excision, repair, without cardiopulmonary bypass 38453
stricture, dilatation of with bronchoscopy 41904
Trachelorrhaphy 35617,35618
Tracheo-oesophageal fistula, division and repair 43900
formation of, including enoscopic procedures 41885
Tracheomalacia, aortopexy for 43909
Tracheoplasty or laryngoplasty with tracheostomy 41879
Tracheostomy
by open exposure of the trachea 41881
closure of 30102,30103
percutaneous technique, sequential dilation, partial splitting method 41880
using Minitrach or similar device 41884
with laryngoplasty or tracheoplasty 41879
with supraglottic laryngectomy 41840
with vertical hemi-laryngectomy 41837
Transanal
transanal endoscopic microsurgery 32103,32104,32106
Transantral ethmoidectomy with radical antrostomy 41713
ligation of maxillary artery 41707
vidian neurectomy 41713
Transfusion 13703,13706
collection of blood for 13709
paediatric/neonatal 13306,13309
Transillumination, ocular 42821
Translabyrinthine vestibular nerve section 41593
Transluminal balloon angioplasty 35300,35303
rotational atherectomy with stent insertion 38312,38318
rotational atherectomy without stent insertion 38309,38315
stent insertion 35306,35309
Transmastoid decompression of endolymphatic sac 41590
removal of glomus tumour 41623
Transmetacarpal amputation of hand 44325
Transmetatarsal amputation of foot 44364
Transorbital ligation of ethmoidal arteries 41725
Transplantation, cornea 42653,42656
ureter 36585,36588,36591 36594,36597,36600,36603
Transposition of digit 46507
of nerve 39321
Transpupilliary thermotherapy 42811
Transthoracic drainage of pericardium 38450
Transtympanic removal of glomus tumour 41620
Transurethral injection for urinary incontinence 37339
Transvenous electrode/s, permanent, insertion of 38350,38356
pacemaking electrode, temporary, insertion of 38256
Treacher Collins Syndrome, peri-orbital correction of 45773
Trephine of frontal sinus 41743
Trichiasis, treatment of 42587
Trichoepitheliomas, face/neck, removal by laser excision 30190
Trigeminal gangliotomy, radiofrequency/balloon/glycerol 39109
nerve, injection with alcohol, cortisone etc 39100
neuralgia, intracranial neurectomy 39106
Trigger finger, correction of 46363
Tubed pedicle or indirect flap 45230
- formation of 45227
- preparation of site and attachment to site 45233
- spreading of pedicle 45236
Tuboplasty 35694,35697
tubuerous, tubular or constricted breast, treatment by 45559
Tumour, adrenal gland, excision of 30324
benign, of soft tissue, removal 31350
bladder, diathermy/resection with cystoscopy 36840,36845
bladder, laser destruction with cystoscopy 36840
bone, benign, requiring allograft, resection of 50230
bone, innocent, excision of 30241
bone, malignant, operations for 50200,50201,50203 50206,50209,50212,50215,50218,50221,50224,50227 50230,50233,50236,50239
broad ligament, removal of 35712,35713,35716 35717
cardiac, excision of 38670,38673,38677 38680
carotid body, resection of 34148,34151,34154
cerebello-pontine angle, removal of 41575,41576,41578 41579
deep, peripheral nerve, removal of 39327
endocrine, exploration of 30578,30580,30581
extradural, laminectomy for 40309
face/neck, laser excision 30190
gastric, removal of 30520
glomus, removal of 41620,41623
gynaecological, radical or debulking operation 35720
intra-oral, radical excision of 30275
intra-temporal fossa, removal of 41578
intracerebral, craniotomy and removal of 39709
intracranial, biopsy/decompression, osteoplastic flap 39706
intracranial, burr-hole biopsy or drainage 39703
intracranial, craniotomy and removal of 39709,39712
intramedullary, laminectomy for 40318
involving ciliary body an/or iris, excision of 42767
iris, excision of 42764
larynx, removal of 41852
limbic, removal of 42692
lipoma, liposuction or surgical removal of 31345
malignant of soft tissue, removal of 31355
malignant upper aerodigestive tract 31400,31403,31406
malignant, bone, operations for 50200,50201,50203 50206,50209,50212,50215,50218,50221,50224,50227 50230,50233,50236,50239
malignant, skin, removal of 31300,31305,31310 31315,31320,31325,31330,31335
mandible, segmental resection for 45605
mediastinal, removal by thoracotomy or sternotomy 38446
microlaryngoscopy with removal of 41864
neuroendocrine, removal of 30321,30323
other, removal of (restriction applies) 31200,31205,31210 31215,31220,31225,31230,31235,31240
ovarian, radical or debulking operation for 35720
parapharyngeal, excision of, cervical approach 31409,31412
parathyroid, removal of 30306
parotid gland, removal of 30253
parotid, excision of 30251
peripheral nerve, removal from 39324,39327
pituitary, hypophysectomy or removal of 39715
rectal, excision of 32099,32102,32108
removal of, by laminectomy 40309,40318
removal of, by lateral rhinotomy 41728
removal of, by neurectomy, neurotomy 39327
removal of, by temporal bone resection 41584,41587
removal of, by urethrectomy 37330
removal of, in oral and maxillofacial region 45801,45803,45805 45807,45809,45811,45813
sacrococcygeal and presacral, excision of 32036
skin, malignant, removal of 31300,31305,31310 31315,31320,31325,31330,31335
skin, micrographic serial excision 31000-31002
skull base, removal of 39640,39642,39646 39650,39653,39654,39656,39658,39660,39662
skull, excision of 39700
spinal, laminectomy for 40318
thyroid, removal of 30310
vagina, simple, removal of 35557

vocal cord, removal from 41852
Tunnelled cuffed catheter
central vein, for haemodialysis or parenteral nutrition 34538
removal 34539
Turbinates, cauterisation or diathermy of 41674
dislocation, treatment of 41686
submucous resection of 41692
Turbinectomy 41689
Turricephaly, cranial vault reconstruction for 45785
Tympani, paracentesis of 41626
Tympanic membrane, micro-inspection of 41650
membrane, micro-inspection with ear toilet 41647
Tympanum, perforation, cauterisation or diathermy 41641

U

Ulcer, corneal, epithelial debridement for 42650
duodenal, perforated, suture of 30375
gastric, perforated, suture of 30375
other, removal of 31200,31205,31210 31215,31220,31225,31230,31235,31240
peptic, bleeding, control of 30505,30506,30508 30509
peptic, perforated, suture of 30375
Ulna, bone graft to 48218,48221,48224 48227
fracture, treatment of 47360,47363,47366 47369,47372,47375,47378,47381,47384-47387,47390 47393,47396,47399,47402,47405,47408
fracture, treatment of paediatric 50500,50504,50508 50512,50516,50520,50524,50528,50532,50536,50540
operation on, for acute osteomyelitis 43503
operation on, for chronic osteomyelitis 43512
osteectomy or osteotomy of 48406,48409
Ulnar vessel, ligation/exploration not otherwise covered 34106
Ultrasound, intraoperative, biliary tract 30439
staging of intra-abdominal tumours 30441
Umbilical artery catheterisation 13303
granuloma, excision under GA 43948
hernia, repair of 30620,30621
vein catheterisation in a neonate 13300
Undescended testis, orchidopexy for 37803,37804,37806 37807,37809,37810
Unstable lie, attendances other than routine antenatal 16502
Urachus, patent, excision of 37800
Ureter, brush biopsy of, with cystoscopy 36821
divided, repair of 36573
exploration of 36612
retrocaval, correction of, by open exposure 36564,36567
transplantation of 36597
- into bladder 36588,36591
- into intestine 36594
- into isolated intestinal segment 36600,36603
- into skin 36585
Ureterectomy 36579
Ureteric calculus, endoscopic extraction/manipulation 36857
catheterisation with cystoscopy 36818,36824
dilatation 36821
meatotomy 36830
reflux, correction of 36588
stent, insertion of 36605,36607,36821
stent, removal/replacement of 36825
stent, through nephrostomy tube 36604
Ureterolithotomy 36549
complicated by previous surgery 37444
Ureterolysis 36615
Ureteroplasty 36618
Ureteroscopy 36803,36806,36809
Ureterostomy, cutaneous, closure of 36621
revision of 36609
Urethra, cauterisation of 35523
diathermy of 37318
diverticulum, excision of 37372
endoscopic examination with cystoscopy 36812
laser therapy, intraepithelial neoplasia 35539,35542,35545
prolapsed, excision of 37369
ruptured, repair of 37306,37309
Urethral abscess, drainage of 30223,37816,37828
caruncle, cauterisation of 35523
caruncle, excision of 35526,35527
dilatation with cystoscopy 36812
diverticulum, excision of 37372
fistula, closure of 37333,37336,37833
prosthesis, with cystoscopy 36811
reconstruction, hypospadias/epispadias 37815,37816,37827 37828,37830
sounds, passage of, as an independent procedure 37300
sphincter, reconstruction of 37375
stricture, dilatation of 37303
stricture, optical urethrotomy for 37327
stricture, plastic repair of 37342,37343,37345 37348,37351
tumour, removal of by urethrectomy 37330
valves, destruction of 37854
warts, cystoscopy for the treatment of 36815
Urethral sling, division or removal of 37340,37341
Urethrectomy 37330
Urethrocoele, repair of 35570
repair of 35570,35573
Urethropexy (Marshall-Marchetti operation) 35599,37044
Urethroplasty 37342,37343,37345 37348,37351
Urethroscopy, as an independent procedure 37315
with biopsy/diathermy/foreign body/stone 37318
with cystoscopy 36812
with cystoscopy and injection for incontinence 37339
with laser destruction of stone 37318
Urethrostomy 37324
Urethrotomy, external or internal 37324
optical, for urethral stricture 37327
Urinary conduit or reservoir, endoscopic examination 36860
conduit, revision of 36609
reservoir, formation of 36606
sphincter, artificial 37381,37384
- insertion of pressure regulating balloon, pump 37387
- revision or removal of 37390
Urogenital sinus, vaginal reconstruction for 35565
Uterine adenomyoma, excision of 35649
adhesiolysis, with hysteroscopy 35633
adhesions, laparoscopic division 35638
adnexae, removal, with abdominal hysterectomy 35653
artery embolisation 35410
myomectomy 35649
septum, hysteroscopic resection 35623
tubes, insufflation of, for patency (Rubin test) 35706
Utero-sacral ligaments, laparoscopic division 35638
Uterus, acute inversion, vaginal correction 16570
bicornuate, plastic reconstruction for 35680
curettage of 35639,35640
debulking prior to vaginal hysterectomy 35658
gravid, evacuation of contents 35643
implantation of Fallopian tubes into 35694,35697
suspension or fixation of 35683,35684
UVB therapy 14050,14053
Uvula, excision of 41810
Uvulectomy and partial palatectomy 41787
Uvulopalatopharyngoplasty 41786
Uvulotomy 41810

V

Vagina, artificial formation of 35565
dilatation of, as an independent procedure 35554
laser therapy, intraepithelial neoplasia 35539,35542,35545
partial or complete removal of 35560
removal of simple tumour of 35557
Vaginal correction of acute inversion of uterus 16570
compartment repair, anterior 35570
compartment repair, anterior/posterior 35573
compartment repair, posterior 35571
fistula, repair or closure of 35596,37029,37333
hysterectomy 35657,35673
orifice, plastic repair to enlarge 35569
reconstruction, congenital absence/gynatresia 35565
septum, excision for correction of double vagina 35566
upper prolapse, sacrospinous colpopexy for 35568
upper vault prolapse, pelvic floor repair 35595
upper vault prolapse, sacral colpopexy 35597
warts, removal under GA or nerve block 35507,35508
Vaginectomy, radical, for malignancy 35561,35562,35564
Vaginoplasty for congenital adrenal hyperplasia 37851
Vagotomy 30496,30497,30499 30500,30502,30503
Vallecular cysts, removal of 41813
Valve annuloplasty, heart 38475,38477,38478
leaflet/s, aortic, decalcification of 38483
mitral, open valvotomy of 38487
repair, heart 38480,38481
replacement, heart 38488,38489
Valvotomy for pulmonary stenosis 38456
open, of mitral valve 38487
Valvuloplasty, balloon or septostomy 38270
Varicocele, surgical correction of 30634,30635
Varicose veins, injection of sclerosing fluid
veins, multiple injections 32500,32501
veins, operations for 32500,32501,32504 32507,32508,32511,32514,32517
Vas deferens, operations on 37616,37619,37622 37623
Vasectomy 37622,37623
Vasoepididymostomy (unilateral) 37616,37619
Vasotomy 37622,37623
Vasovasotomy 37616,37619
Vein, anastomosis, microsurgical 45502
bypass for venous stenosis or occlusion 34812
cannulation of, in a neonate 13300
central, catheterisation 13318,13319,13815
central, catheterisation, subcutaneous tunnel 34527,34528
femoral bypass, saphenous vein anastomosis 34809
graft for priapism 37396
great, ligation or exploration not otherwise covered 34103
harvesting, leg/arm, for bypass, not same limb 32760
harvesting, leg/arm, for patch graft, not same incision 33551
intra-abdominal, cannulation, infusion chemotherapy 34521
ligation or exploration not otherwise covered 34106
major, repair of wound of 33815,33818,33821 33824,33827,33830,33833,33836,33839
patch grafting to 33545,33548
saphenous, cross leg by-pass graft 34806
scalp, catheterisation of 13300
stenosis, patch angioplasty for 34815
thrombectomy of 33810-33812
transplant to restore valvular function 34821
umbilical, catheterisation of 13300
varicose, multiple injections 32500,32501
varicose, operations for 32500
Veins, major, access as part of re-operation 35202
Velopharyngeal incompetence, flap or pharyngoplasty 45716
Vena cava, inferior, operations on 34800,34803
caval filter, insertion of 35330
Venesection
therapeutic 13757
Venography, operative 35200
Venous anastomosis, not otherwise covered 32766,32769
catheterisation, peripheral 35317,35319,35320
stenosis or occlusion, vein bypass for 34812
valve, plication or repair to restore competency 34818
Ventilation, mechanical, intensive care 13857,13881,13882
Ventral hernia following closure exomphalos, repair of 43939
hernia, repair of 30403
Ventricular aneurysm, plication of 38506
aneurysm, resection 38507,38508
assist device, insertion of 38615,38618
assist device, removal of, independent 38621,38624
augmentation 38766
chamber, operation for arrhythmia 38518
myomectomy 38763
puncture 39006
reservoir or external drain, insertion of 39015
septal defect, closure of 38751
septal rupture, ischaemic, repair of 38509
septectomy 38748
Ventricular septal defect, transcatheter closure 38274
Ventriculo-cisternostomy 40000
Ventriculostomy, third 40012
Vermilionectomy 45668,45669
Version, external cephalic 16501
Vertebra, needle biopsy of 30093
Vertebral bodies, fracture, treatment of 47681,47684,47687 47690,47693,47696,47699,47702
bodies, total or sub-total, excision of 48639
diseases of, excision & spinal fusion for 48640
resection and fusion for congenital scoliosis 48632
Vesical fistula, cutaneous, operation for 37023
Vesico-intestinal fistula, closure of 37038
Vesicostomy, cutaneous, establishment of 37026
Vesicovaginal fistula, closure of 37029
Vestibular nerve section, retrolabyrinthine 41596
nerve section, translabyrinthine 41593
nerve section, via posterior fossa 39500
Vestibuloplasty, unilaterla or bilateral 45837
Vidian neurectomy, transantral, with antrostomy 41713
Villus, chorionic, sampling 16603
Viscera, abdominal, operation involving laparotomy 30387
pelvic, operation involving laparotomy 30387
Viscus, ruptured, simple repair of 30375
Vitello intestinal duct, patent, excision of 43945
intestinal remnant, abdominal wall, excision of 43942
Vitrectomy 42719,42725
Vitreolysis of lens material 42791,42792
Vocal cord, biopsy of 41849
cord, removal of nodule or tumour 41852
cord, teflon injection into 41870
Volvulus, reduction of 30375
Vulva, biopsy of, with colposcopy 35615
laser therapy for intraepithelial neoplasia 35539,35542,35545
wide local excision of suspected malignancy 35536
Vulval warts, removal under GA or nerve block 35507,35508
Vulvectomy, hemi 35536
radical for malignancy 35548
Vulvoplasty, for localised gigantism 35534
Vulvoplasty, for repair of female genital mutilation or anomalies of the uro-gyn 35533

W

Warts, anal, removal under GA or nerve block 32177,32180
palmar or plantar, removal of 30186,30187
penile or urethral, cystoscopy for treatment of 36815
removal in operating theatre 30189
vulval/vaginal, removal, GA or nerve block 35507,35508
Wedge excision for axillary hyperhidrosis 30180
excision of lip, eyelid or ear, full thickness 45665

Wertheim's operation 35664
Whipple's operation (pancreatico-duodenectomy) 30584
Wire, orthopaedic, insertion of 47921
pin or screw, buried, removal of 47924,47927
Wolfe graft 45451
Wound, debridement under GA or major block 30023
dressing of, requiring GA 30055
resuturing following intraocular procedures 42857
traumatic, suture of 30026,30029,30032
30035,30038,30041,30042,30045,30048,30049
Wrist, arthrodesis of 49200,49203
arthroplasty of 49209
arthroscopic surgery 49221,49224,49227
arthroscopy of 49218
arthrotomy of 49212
fracture, treatment of 47369,47372,47375
osteoplasty 49224
proximal carpectomy 49206
reconstruction of 49215
revision arthroplasty 49210,49211
tendon sheath, open operation 46363
tendon, repair of 46420,46423,46426
46429,46432,46435
Wry neck, operation for 44133

X

Xenon arc photo-coagulation 42782,42783

Z

Z-plasty, in association with Dupuytren's Contracture 46384
Zygo-apophyseal joint, injection into 39013
Zygoma, osteotomy or osteectomy of 45720,45723,45726
45729,45731,45732,45735,45738,45741,45744,45747
45752
Zygomatic arch, reconstruction of 45788
bone, fracture, treatment of 45981,47762,47765
47768,47771

ORAL AND MAXILLOFACIAL SERVICES
CATEGORY 4

SUMMARY OF CHANGES FROM 1/1/2016

The 1/1/2016 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

There are no changes to this Category for 1 January 2016.

OM.1.1. BENEFITS FOR MEDICAL SERVICES PERFORMED BY APPROVED DENTAL PRACTITIONERS

Under the provisions of the *Health Insurance Act 1973* (the Act), Medicare benefits are payable where an eligible person incurs medical expenses in respect of certain professional services rendered by a approved dental practitioner approved before 1 November 2004.

Category 4 is restricted to those dental practitioners who were approved by the Minister prior to 1 November 2004 for the provision of oral and maxillofacial surgery services and relevant attendances.

Approved dental practitioners may also request certain diagnostic imaging services – refer to Category 5 – Diagnostic Imaging Services for more information.

OM.1.2. CHANGES TO THE SCHEME EFFECTIVE FROM 1 NOVEMBER 2004

From 1 November 2004, access to Category 4 is restricted to those dental practitioners who were approved by the Minister prior to 1 November 2004. No new approvals will be granted after that date.

Background

Since 2000, practitioners performing oral and maxillofacial surgery in Australia are required to have both dental and medical qualifications in order to sit for their FRACDS(OMS) exam. This effectively means that since then, any practitioner who has obtained an FRACDS(OMS) or equivalent can access Category 3 of the MBS because they are medically qualified. The Government, in consultation with the Australian and New Zealand Association of Oral and Maxillofacial Surgeons, the Australian Dental Association, the Royal Australian College of Surgeons, the Royal Australian College of Dental Surgeons and the Australian Medical Association, has agreed that access by new practitioners to Category 4 will be withdrawn from 1 November 2004. Practitioners who were approved prior to that date will continue to have access to Category 4. The long-term proposal is that once all practitioners who currently access Category 4 have left the workforce, Category 4 will be removed from the Medicare Benefits Schedule.

Details of the services attracting Medicare benefits are set out in the Medicare Benefits Schedule.

OM.2.1. DEFINITION OF ORAL AND MAXILLOFACIAL SURGERY

Oral and Maxillofacial Surgery is defined as the surgical specialty which deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the oral and maxillofacial region.

OM.2.2. SERVICES THAT CAN BE PROVIDED

Dental practitioners holding the FRACDS (OMS) or equivalent who were approved by the Minister prior to 1 November 2004 may perform prescribed oral and maxillofacial services listed in this category. All dental practitioners approved for the purposes of subsection 3(1) of the Act are also recognised to perform those items of oral and maxillofacial surgery listed in Group C2 of the booklet "Medicare Benefits for Treatment of Cleft Lip and Cleft Palate Conditions".

It is emphasised that -

- the sole purpose of granting approval to dental practitioners is to enable payment of Medicare benefits;
- the services set out in Groups 01 to 011 of the Medicare Benefits Schedule book, and in the Cleft Lip and Cleft Palate Schedule are the only ones for which Medicare benefits are payable when the services are performed by an eligible dental practitioner.

OM.3.1. PRINCIPLES OF INTERPRETATION

Each professional service listed in the Schedule is a complete medical service in itself. Where a service is rendered partly by one practitioner and partly by another, only the one amount of benefit is payable.

OM.3.2. MULTIPLE OPERATION RULE

The Schedule fees for two or more operations performed on a patient on the one occasion are calculated by the following rule:-

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

NOTE:

1. Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents

2. Where two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.

3. The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees and benefits specified in the Schedule apply. For these purposes the term "operation" includes all services in Groups O3 to O9.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

OM.3.3. AFTER CARE (POST-OPERATIVE TREATMENT)

The fee specified for each of the operations listed in the Schedule contains a component for the consequential after-care customarily provided unless otherwise indicated. After-care is deemed to include all post-operative treatment rendered by practitioners and need not necessarily be limited to treatment given by the approved dental practitioner or to treatment given by any one practitioner. This does not preclude, however, the payment of benefit for professional services for the treatment by a dental practitioner of an intercurrent condition or an unusual complication arising from the operation.

Some minor operations are merely stages in the treatment of a particular condition. Professional services by dental practitioners subsequent to such operations should not be regarded as after-care but rather as continuation of the treatment of the original condition and should attract benefit. Item 52057 is a service to which this policy applies.

OM.3.4. ADMINISTRATION OF ANAESTHETICS BY MEDICAL PRACTITIONERS

When a medical practitioner administers an anaesthetic in connection with a procedure prescribed for the payment of Medicare benefits (and the procedure has been performed by an approved dental practitioner), Medicare benefits are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.

The Schedule fee for anaesthesia is established using the RVG schedule at Category 3 - Group T10.

Before the payment of benefits for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of additional details are required on the anaesthetist's account:

- The anaesthetist's account must show the name/s of the medical practitioner/s who performed the associated operation/s. Also, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and the total time of the anaesthesia;
- The assistant anaesthetist's account must show the name/s of the medical practitioners who performed the associated operation/s, as well as the name of the principle anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthesia.

OM.4.1. CONSULTATIONS - (ITEMS 51700 AND 51703)

The consultation item numbers (51700 and 51703) are to be used by approved dental practitioners in the practice of oral and maxillofacial surgery.

The referral must be from a registered dental practitioner or a medical practitioner.

OM.4.2. ASSISTANCE AT OPERATIONS - (ITEMS 51800 AND 51803)

Items covering operations which are eligible for benefits for assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery or surgical assistance have been identified by the inclusion of the word "Assist" in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

The assistance must be rendered by a practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to an approved dental practitioner no additional benefits are payable. The assistance benefit is the same irrespective of the number of practitioners providing assistance.

Benefits payable under item 51800

Medicare benefits are payable under Item 51800 for assistance rendered at the following procedures:

51900, 51904, 52010, 52018, 52039, 52048, 52051, 52062, 52063, 52066, 52078, 52090, 52092, 52095, 52105, 52108, 52111, 52130, 52138, 52141, 52144, 52147, 52182, 52300, 52303, 52312, 52315, 52321, 52324, 52336, 52339, 52424, 52440, 52452, 52480, 52482, 52600, 52603, 52609, 52612, 52615, 52624, 52626, 52627, 52800, 52803, 52806, 52809, 52818, 52824, 52828, 52830, 53006, 53009, 53016, 53215, 53220, 53225, 53226, 53236, 53239, 53242, 53406, 53409, 53412, 53413, 53415, 53416, 53453, 53460.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under item 51300.

Benefits payable under Item 51803
Medicare benefits are payable under Item 51803 for assistance rendered at the following procedures:
51906, 52054, 52094, 52114, 52117, 52120, 52122, 52123, 52126, 52129, 52131, 52148, 52158, 52184, 52186, 52306, 52330, 52333, 52337, 52342, 52345, 52348, 52351, 52354, 52357, 52360, 52363, 52366, 52369, 52372, 52375, 52378, 52379, 52380, 52382, 52430, 52442, 52444, 52446, 52456, 52484, 52618, 52621, 52812, 52815, 52821, 52832, 53015, 53017, 53019, 53209, 53212, 53218, 53221, 53224, 53227, 53230, 53233, 53414, 53418, 53419, 53422, 53423, 53424, 53425, 53427, 53429, 53455.

or at a combination of procedures (including those identified as payable under item 51800 above) for which the aggregate fee exceeds the amount specified in the item.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under Item 51303.

Assistance at multiple operations
Where assistance is provided at two or more operations performed on a patient on the one occasion the multi operation formula is applied to all the operations to determine the surgical fee payable to each approved dental practitioner. The multi-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Items 51800/51300 or 51803/51303).

The derived fee applicable to Item 51803/51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery.

OM.4.3. REPAIR OF WOUND - (ITEM 51900)

Item 51900 covers debridement of "deep and extensively contaminated" wound. Benefits are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

OM.4.4. LIPECTOMY, WEDGE EXCISION - TWO OR MORE EXCISIONS - (ITEM 51906)

Multiple lipectomies attract benefits under Item 51906 once only, i.e. the multiple operation rule does not apply.

Medicare benefits are not payable in respect of liposuction.

OM.4.5. UPPER AERODIGESTIVE TRACT ENDOSCOPIC PROCEDURE - (ITEM 52035)

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

Cleaning, disinfection and sterilisation procedures
Endoscopic procedures should be performed in facilities where endoscope and accessory reprocessing protocols follow procedures outlined in:-

(i) 'Infection and Endoscopy' (3rd edition), Gastroenterological Society of Australia;
(ii) 'Infection control in the health care setting - Guidelines for the prevention of transmission of infectious diseases', National Health and Medical Research Council; and
(iii) Australian Standard AS 4187-1994 (and Amendments), Standards Association of Australia.

Anaesthetic and resuscitation equipment
Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post operative and resuscitation facilities should conform to the standards outlined in 'Sedation for Endoscopy', Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons. These

guidelines will be taken into account in determining appropriate practice in the context of the Professional Services Review process.

OM.4.6. TUMOUR, CYST, ULCER OR SCAR - (ITEMS 52036 TO 52054)

It is recognised that odontogenic keratocysts, although not neoplastic, often require the surgical management of benign tumours.

OM.4.7. ASPIRATION OF HAEMATOMA - (ITEM 52056)

Aspiration of haematoma is indicated in clinical situations where incision may leave an unsightly scar or where access is difficult for conventional drainage.

OM.4.8. OSTEOTOMY OF JAW - (ITEMS 52342 TO 52375)

The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site.

Bone grafts taken from a separate site, e.g. iliac crest, would attract additional benefit under Item 52318 or 52319 for the harvesting, plus item 52130 or 52131 for the grafting.

Where the site of grafting under item 52131 requires closure by single stage local flap, item 52300 may be claimed where clinically appropriate. Clinically appropriate in this instance means that the flap is required to close defects because the defect cannot be closed directly.

A local skin flap is an area of skin or subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by pedicle and is moved to the defect by rotation, advancement or transposition, or a combination of these manoeuvres.

Benefits are only payable where the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This latter procedure will also attract benefit if closed by graft or flap repair but not been closed by direct suture.

By definition, direct wound closure (e.g. by suture) does not constitute skin flap. Similarly, angled, curved or trapdoor incisions which are used for exposure and which are sutured back into the same position relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of the wound prior to suturing is considered a normal part of wound closure and is not considered to skin flap repair.

For the purposes of these items, a reference to maxilla includes the zygoma.

OM.4.9. GENIOPLASTY - (ITEM 52378)

Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

OM.4.10. FRACTURE OF MANDIBLE OR MAXILLA - (ITEMS 53400 TO 53439)

There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones.

Hence a bilateral fracture of the mandible would be assessed as:

- Item 53409 x 1½;
- two maxillae and one side of the mandible as Item 53406 x 1½ + 53409 x ¼.

Splinting in Item 53406 or 53409 refers to cap splints, arch bars, silver (cast metal) or acrylic splints.

OM.4.11. SKIN SENSITIVITY TESTING - (ITEM 53600)

The allergens are local anaesthetics and the contents of anaesthetic capsules, acrylic and other polymers and metals.

OM.4.12. DESTRUCTION OF NERVE BRANCH BY NEUROLYTIC AGENT - (ITEM 53706)

Item 53706 includes the use of botulinum toxin as a neurolytic agent.

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.

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

Higher rates of benefits are also provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons).

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.

GROUP O1 - CONSULTATIONS

APPROVED DENTAL PRACTITIONER, REFERRED CONSULTATION - SURGERY, HOSPITAL OR RESIDENTIAL AGED CARE FACILITY

51700	Professional attendance (other than a second or subsequent attendance in a single course of treatment) by an approved dental practitioner, at consulting rooms, hospital or residential aged care facility where the patient is referred to him or her *(See para OM4.1 of explanatory notes to this Category)* **Fee:** $85.55	**Benefit:** 75% = $64.20	85% = $72.75
51703	Professional attendance by an approved dental practitioner, each attendance subsequent to the first in a single course of treatment at consulting rooms, hospital or residential aged care facility where the patient is referred to him or her *(See para OM4.1 of explanatory notes to this Category)* **Fee:** $43.00	**Benefit:** 75% = $32.25	85% = $36.55

	GROUP O2 - ASSISTANCE AT OPERATION
51800	Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation identified by the word "Assist." for which the fee does not exceed $558.30 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed $558.30 *(See para OM4.2 of explanatory notes to this Category)* **Fee:** $86.30 **Benefit:** 75% = $64.75 85% = $73.40
51803	Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation identified by the word "Assist." for which the fee exceeds $558.30 or at a series or combination of operations identified by the word "Assist." where the aggregate fee exceeds $558.30 *(See para OM4.2 of explanatory notes to this Category)* **Derived Fee:** one fifth of the established fee for the operation or combination of operations

GROUP O3 - GENERAL SURGERY

51900	WOUND OF SOFT TISSUE, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.) *(See para OM4.3 of explanatory notes to this Category)* **Fee:** $326.05	**Benefit:** 75% = $244.55	85% = $277.15
51902	WOUNDS, DRESSING OF, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.) **Fee:** $73.90	**Benefit:** 75% = $55.45	85% = $62.85
51904	LIPECTOMY - wedge excision of skin or fat - 1 EXCISION (Anaes.) (Assist.) **Fee:** $454.85	**Benefit:** 75% = $341.15	85% = $386.65
51906	LIPECTOMY - wedge excision of skin or fat - 2 OR MORE EXCISIONS (Anaes.) (Assist.) *(See para OM4.4 of explanatory notes to this Category)* **Fee:** $691.75	**Benefit:** 75% = $518.85	85% = $612.25
52000	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.) **Fee:** $82.50	**Benefit:** 75% = $61.90	85% = $70.15
52003	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) **Fee:** $117.55	**Benefit:** 75% = $88.20	85% = $99.95
52006	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.) **Fee:** $117.55	**Benefit:** 75% = $88.20	85% = $99.95
52009	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) **Fee:** $185.60	**Benefit:** 75% = $139.20	85% = $157.80
52010	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.) **Fee:** $254.00	**Benefit:** 75% = $190.50	85% = $215.90
52012	SUPERFICIAL FOREIGN BODY, removal of, as an independent procedure (Anaes.) **Fee:** $23.50	**Benefit:** 75% = $17.65	85% = $20.00
52015	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and suture, as an independent procedure (Anaes.) **Fee:** $109.90	**Benefit:** 75% = $82.45	85% = $93.45
52018	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.) **Fee:** $276.80	**Benefit:** 75% = $207.60	85% = $235.30
52021	ASPIRATION BIOPSY of 1 or MORE JAW CYSTS as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (Anaes.) **Fee:** $29.45	**Benefit:** 75% = $22.10	85% = $25.05
52024	BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure (Anaes.) **Fee:** $52.20	**Benefit:** 75% = $39.15	85% = $44.40
52025	LYMPH NODE OF NECK, biopsy of (Anaes.) **Fee:** $183.90	**Benefit:** 75% = $137.95	85% = $156.35
52027	BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure and not being a service to which item 52025 applies (Anaes.) **Fee:** $149.75	**Benefit:** 75% = $112.35	85% = $127.30
52030	SINUS, excision of, involving superficial tissue only (Anaes.) **Fee:** $90.00	**Benefit:** 75% = $67.50	85% = $76.50
52033	SINUS, excision of, involving muscle and deep tissue (Anaes.) **Fee:** $183.90	**Benefit:** 75% = $137.95	85% = $156.35

52034	PREMALIGNANT LESIONS of the oral mucous, treatment by cryotherapy, diathermy or carbon dioxide laser **Fee:** $43.00	**Benefit:** 75% = $32.25	85% = $36.55
52035	ENDOSCOPIC LASER THERAPY for neoplasia and benign vascular lesions of the oral cavity (Anaes.) *(See para OM4.5 of explanatory notes to this Category)* **Fee:** $476.10	**Benefit:** 75% = $357.10	85% = $404.70
52036	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 52039 applies (Anaes.) *(See para OM4.6 of explanatory notes to this Category)* **Fee:** $126.90	**Benefit:** 75% = $95.20	85% = $107.90
52039	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.) *(See para OM4.6 of explanatory notes to this Category)* **Fee:** $326.05	**Benefit:** 75% = $244.55	85% = $277.15
52042	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.) *(See para OM4.6 of explanatory notes to this Category)* **Fee:** $172.50	**Benefit:** 75% = $129.40	85% = $146.65
52045	TUMOUR, CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), removal of, not being a service to which another item in Groups O3 to O9 applies, involving muscle, bone, or other deep tissue (Anaes.) *(See para OM4.6 of explanatory notes to this Category)* **Fee:** $246.50	**Benefit:** 75% = $184.90	85% = $209.55
52048	TUMOUR OR DEEP CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), removal of, requiring wide excision, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) *(See para OM4.6 of explanatory notes to this Category)* **Fee:** $371.50	**Benefit:** 75% = $278.65	85% = $315.80
52051	TUMOUR, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.) *(See para OM4.6 of explanatory notes to this Category)* **Fee:** $502.25	**Benefit:** 75% = $376.70	85% = $426.95
52054	TUMOUR, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.) *(See para OM4.6 of explanatory notes to this Category)* **Fee:** $587.60	**Benefit:** 75% = $440.70	85% = $508.10
52055	HAEMATOMA, SMALL ABSCESS OR CELLULITIS, not requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding after care) **Fee:** $27.35	**Benefit:** 75% = $20.55	85% = $23.25
52056	HAEMATOMA, aspiration of (Anaes.) *(See para OM4.7 of explanatory notes to this Category)* **Fee:** $27.35	**Benefit:** 75% = $20.55	85% = $23.25
52057	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.) *(See para OM3.3 of explanatory notes to this Category)* **Fee:** $162.95	**Benefit:** 75% = $122.25	85% = $138.55
52058	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS, using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $237.60	**Benefit:** 75% = $178.20	85% = $202.00

52059	ABSCESS, DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $267.65 **Benefit:** 75% = $200.75 85% = $227.55
52060	MUSCLE, excision of (Anaes.) **Fee:** $189.40 **Benefit:** 75% = $142.05 85% = $161.00
52061	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.) **Fee:** $223.60 **Benefit:** 75% = $167.70 85% = $190.10
52062	MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) **Fee:** $295.70 **Benefit:** 75% = $221.80 85% = $251.35
52063	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) **Fee:** $356.35 **Benefit:** 75% = $267.30 85% = $302.90
52064	BONE CYST, injection into or aspiration of (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
52066	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.) **Fee:** $445.40 **Benefit:** 75% = $334.05 85% = $378.60
52069	SUBLINGUAL GLAND, extirpation of (Anaes.) **Fee:** $198.50 **Benefit:** 75% = $148.90 85% = $168.75
52072	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) **Fee:** $58.80 **Benefit:** 75% = $44.10 85% = $50.00
52073	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.) **Fee:** $149.75 **Benefit:** 75% = $112.35 85% = $127.30
52075	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.) **Fee:** $149.75 **Benefit:** 75% = $112.35 85% = $127.30
52078	TONGUE, partial excision of (Anaes.) (Assist.) **Fee:** $295.70 **Benefit:** 75% = $221.80 85% = $251.35
52081	TONGUE TIE, division or excision of frenulum (Anaes.) **Fee:** $46.50 **Benefit:** 75% = $34.90 85% = $39.55
52084	TONGUE TIE, MANDIBULAR FRENULUM OR MAXILLARY FRENULUM, division or excision of frenulum, in a person aged not less than 2 years (Anaes.) **Fee:** $119.50 **Benefit:** 75% = $89.65 85% = $101.60
52087	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) **Fee:** $204.70 **Benefit:** 75% = $153.55 85% = $174.00
52090	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.) **Fee:** $356.35 **Benefit:** 75% = $267.30 85% = $302.90
52092	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.) **Fee:** $464.50 **Benefit:** 75% = $348.40 85% = $394.85
52094	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 52092 (Anaes.) (Assist.) **Fee:** $587.55 **Benefit:** 75% = $440.70 85% = $508.05
52095	BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.) **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70
52096	ORTHOPAEDIC PIN OR WIRE, insertion of, into maxilla or mandible or zygoma, as an independent procedure (Anaes.) **Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95
52097	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital (Anaes.) **Fee:** $160.05 **Benefit:** 75% = $120.05 85% = $136.05

52098	EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.) **Fee:** $188.20 **Benefit:** 75% = $141.15 85% = $160.00
52099	BURIED WIRE, PIN or SCREW, 1 or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, not being a service associated with a service to which item 52102 or 52105 applies (Anaes.) **Fee:** $141.25 **Benefit:** 75% = $105.95 85% = $120.10
52102	BURIED WIRE, PIN or SCREW, 1 or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, where undertaken in the operating theatre of a hospital, per bone (Anaes.) **Fee:** $141.25 **Benefit:** 75% = $105.95 85% = $120.10
52105	PLATE, 1 or more of, and associated screw and wire which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, not being a service associated with a service to which item 52099 or 52102 applies (Anaes.) (Assist.) **Fee:** $263.60 **Benefit:** 75% = $197.70 85% = $224.10
52106	ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $108.90 **Benefit:** 75% = $81.70 85% = $92.60
52108	LIP, full thickness wedge excision of, with repair by direct sutures (Anaes.) (Assist.) **Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15
52111	VERMILIONECTOMY (Anaes.) (Assist.) **Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15
52114	MANDIBLE or MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) **Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $508.10
52117	MANDIBLE, including lower border, or MAXILLA, sub-total resection of (Anaes.) (Assist.) **Fee:** $699.45 **Benefit:** 75% = $524.60 85% = $619.95
52120	MANDIBLE, hemimandiblectomy of, including condylectomy where performed (Anaes.) (Assist.) **Fee:** $827.30 **Benefit:** 75% = $620.50 85% = $747.80
52122	MANDIBLE, hemi-mandibular reconstruction of, OR MAXILLA, reconstruction of, with BONE GRAFT, PLATE, TRAY OR ALLOPLAST, not being a service associated with a service to which item 52123 applies (Anaes.) (Assist.) **Fee:** $827.30 **Benefit:** 75% = $620.50 85% = $747.80
52123	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.) **Fee:** $936.55 **Benefit:** 75% = $702.45 85% = $857.05
52126	MAXILLA, total resection of (Anaes.) (Assist.) **Fee:** $900.45 **Benefit:** 75% = $675.35 85% = $820.95
52129	MAXILLA, total resection of both maxillae (Anaes.) (Assist.) **Fee:** $1,205.40 **Benefit:** 75% = $904.05 85% = $1,125.90
52130	BONE GRAFT, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) **Fee:** $442.45 **Benefit:** 75% = $331.85 85% = $376.10
52131	BONE GRAFT WITH INTERNAL FIXATION, not being a service to which an item in the range (a) 51900 to 52186; or (b) 52303 to 53460 applies (Anaes.) (Assist.) **Fee:** $611.90 **Benefit:** 75% = $458.95 85% = $532.40
52132	TRACHEOSTOMY (Anaes.) **Fee:** $248.95 **Benefit:** 75% = $186.75 85% = $211.65
52133	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.) **Fee:** $91.05 **Benefit:** 75% = $68.30 85% = $77.40

52135	POST-OPERATIVE or POST-NASAL HAEMORRHAGE, or both, control of, where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $144.35	**Benefit:** 75% = $108.30	85% = $122.70
52138	MAXILLARY ARTERY, ligation of (Anaes.) (Assist.) **Fee:** $448.55	**Benefit:** 75% = $336.45	85% = $381.30
52141	FACIAL, MANDIBULAR or LINGUAL ARTERY or VEIN or ARTERY and VEIN, ligation of, not being a service to which item 52138 applies (Anaes.) (Assist.) **Fee:** $443.70	**Benefit:** 75% = $332.80	85% = $377.15
52144	FOREIGN BODY, deep, removal of using interventional imaging techniques (Anaes.) (Assist.) **Fee:** $413.55	**Benefit:** 75% = $310.20	85% = $351.55
52147	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) **Fee:** $390.25	**Benefit:** 75% = $292.70	85% = $331.75
52148	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) **Fee:** $689.80	**Benefit:** 75% = $517.35	85% = $610.30
52158	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) **Fee:** $1,110.65	**Benefit:** 75% = $833.00	85% = $1,031.15
	MALIGNANT DISEASE		
52180	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.) **Fee:** $188.20	**Benefit:** 75% = $141.15	85% = $160.00
52182	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.) (Assist.) **Fee:** $414.25	**Benefit:** 75% = $310.70	85% = $352.15
52184	BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) **Fee:** $611.90	**Benefit:** 75% = $458.95	85% = $532.40
52186	BONE TUMOUR, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) **Fee:** $753.25	**Benefit:** 75% = $564.95	85% = $673.75

	GROUP O4 - PLASTIC & RECONSTRUCTIVE
52300	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, with skin or mucosa (Anaes.) (Assist.) **Fee:** $284.35 **Benefit:** 75% = $213.30 85% = $241.70
52303	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, with buccal pad of fat (Anaes.) (Assist.) **Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15
52306	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.) **Fee:** $602.45 **Benefit:** 75% = $451.85 85% = $522.95
52309	FREE GRAFTING (mucosa or split skin) of a granulating area (Anaes.) **Fee:** $204.70 **Benefit:** 75% = $153.55 85% = $174.00
52312	FREE GRAFTING (mucosa, split skin or connective tissue) to 1 defect, including elective dissection (Anaes.) (Assist.) **Fee:** $284.35 **Benefit:** 75% = $213.30 85% = $241.70
52315	FREE GRAFTING, FULL THICKNESS, to 1 defect (mucosa or skin) (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70
52318	BONE GRAFT, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies - Autogenous - small quantity (Anaes.) **Fee:** $141.25 **Benefit:** 75% = $105.95 85% = $120.10
52319	BONE GRAFT, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies - Autogenous - large quantity (Anaes.) **Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20
52321	FOREIGN IMPLANT (NON-BIOLOGICAL), insertion of, for CONTOUR RECONSTRUCTION of pathological deformity, not being a service associated with a service to which item 52624 applies (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70
52324	DIRECT FLAP REPAIR, using tongue, first stage (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70
52327	DIRECT FLAP REPAIR, using tongue, second stage (Anaes.) **Fee:** $235.05 **Benefit:** 75% = $176.30 85% = $199.80
52330	PALATAL DEFECT (oro-nasal fistula), plastic closure of, including services to which item 52300, 52303, 52306 or 52324 applies (Anaes.) (Assist.) **Fee:** $781.95 **Benefit:** 75% = $586.50 85% = $702.45
52333	CLEFT PALATE, primary repair (Anaes.) (Assist.) **Fee:** $781.95 **Benefit:** 75% = $586.50 85% = $702.45
52336	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) (Assist.) **Fee:** $488.75 **Benefit:** 75% = $366.60 85% = $415.45
52337	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.) **Fee:** $1,069.10 **Benefit:** 75% = $801.85 85% = $989.60
52339	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) **Fee:** $556.60 **Benefit:** 75% = $417.45 85% = $477.10
52342	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para OM4.8 of explanatory notes to this Category)* **Fee:** $966.80 **Benefit:** 75% = $725.10
52345	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para OM4.8 of explanatory notes to this Category)* **Fee:** $1,090.35 **Benefit:** 75% = $817.80

52348	MANDIBLE or MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para OM4.8 of explanatory notes to this Category)* **Fee:** $1,232.05 **Benefit:** 75% = $924.05
52351	MANDIBLE or MAXILLA, bilateral osteotomy of osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para OM4.8 of explanatory notes to this Category)* **Fee:** $1,383.65 **Benefit:** 75% = $1,037.75
52354	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para OM4.8 of explanatory notes to this Category)* **Fee:** $1,402.70 **Benefit:** 75% = $1,052.05
52357	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para OM4.8 of explanatory notes to this Category)* **Fee:** $1,579.20 **Benefit:** 75% = $1,184.40
52360	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para OM4.8 of explanatory notes to this Category)* **Fee:** $1,611.05 **Benefit:** 75% = $1,208.30
52363	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para OM4.8 of explanatory notes to this Category)* **Fee:** $1,812.40 **Benefit:** 75% = $1,359.30
52366	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para OM4.8 of explanatory notes to this Category)* **Fee:** $1,772.30 **Benefit:** 75% = $1,329.25
52369	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) *(See para OM4.8 of explanatory notes to this Category)* **Fee:** $1,992.70 **Benefit:** 75% = $1,494.55
52372	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para OM4.8 of explanatory notes to this Category)* **Fee:** $1,933.55 **Benefit:** 75% = $1,450.20
52375	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (H) (Anaes.) (Assist.) *(See para OM4.8 of explanatory notes to this Category)* **Fee:** $2,165.75 **Benefit:** 75% = $1,624.35
52378	GENIOPLASTY including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para OM4.9 of explanatory notes to this Category)* **Fee:** $748.65 **Benefit:** 75% = $561.50 85% = $669.15
52379	FACE, contour reconstruction of 1 region, using autogenous bone or cartilage graft (Anaes.) (Assist.) **Fee:** $1,279.45 **Benefit:** 75% = $959.60 85% = $1,199.95
52380	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) **Fee:** $2,178.60 **Benefit:** 75% = $1,633.95 85% = $2,099.10

52382	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) **Fee:** $2,611.60 **Benefit:** 75% = $1,958.70 85% = $2,532.10
52420	MANDIBLE, fixation by intermaxillary wiring, excluding wiring for obesity **Fee:** $241.15 **Benefit:** 75% = $180.90 85% = $205.00
52424	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) (Anaes.) (Assist.) **Fee:** $473.65 **Benefit:** 75% = $355.25 85% = $402.65
52430	MICROVASCULAR REPAIR OF, using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.) **Fee:** $1,090.35 **Benefit:** 75% = $817.80 85% = $1,010.85
52440	CLEFT LIP, unilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $541.35 **Benefit:** 75% = $406.05 85% = $461.85
52442	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $676.80 **Benefit:** 75% = $507.60 85% = $597.30
52444	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $751.85 **Benefit:** 75% = $563.90 85% = $672.35
52446	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $887.50 **Benefit:** 75% = $665.65 85% = $808.00
52450	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) **Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65
52452	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) **Fee:** $488.75 **Benefit:** 75% = $366.60 85% = $415.45
52456	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) **Fee:** $827.30 **Benefit:** 75% = $620.50 85% = $747.80
52458	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) **Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65
52460	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) **Fee:** $781.95 **Benefit:** 75% = $586.50 85% = $702.45
52480	COMPOSITE GRAFT (Chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Anaes.) (Assist.) **Fee:** $502.25 **Benefit:** 75% = $376.70 85% = $426.95
52482	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) **Fee:** $483.25 **Benefit:** 75% = $362.45 85% = $410.80
52484	MACROSTOMIA, operation for (Anaes.) (Assist.) **Fee:** $575.30 **Benefit:** 75% = $431.50 85% = $495.80

	GROUP O5 - PREPROSTHETIC		
52600	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) **Fee:** $338.35	**Benefit:** 75% = $253.80	85% = $287.60
52603	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) **Fee:** $323.40	**Benefit:** 75% = $242.55	85% = $274.90
52606	MAXILLARY TUBEROSITY, reduction of (Anaes.) **Fee:** $246.70	**Benefit:** 75% = $185.05	85% = $209.70
52609	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.) **Fee:** $323.40	**Benefit:** 75% = $242.55	85% = $274.90
52612	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.) **Fee:** $406.05	**Benefit:** 75% = $304.55	85% = $345.15
52615	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.) **Fee:** $503.85	**Benefit:** 75% = $377.90	85% = $428.30
52618	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) **Fee:** $586.50	**Benefit:** 75% = $439.90	85% = $507.00
52621	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.) **Fee:** $586.50	**Benefit:** 75% = $439.90	85% = $507.00
52624	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) **Fee:** $473.65	**Benefit:** 75% = $355.25	85% = $402.65
52626	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.) **Fee:** $290.50	**Benefit:** 75% = $217.90	85% = $246.95
52627	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, extra oral implantation of titanium fixture (Anaes.) (Assist.) **Fee:** $503.85	**Benefit:** 75% = $377.90	85% = $428.30
52630	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, fixation of transcutaneous abutment (Anaes.) **Fee:** $186.50	**Benefit:** 75% = $139.90	85% = $158.55
52633	OSSEO-INTEGRATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $503.85	**Benefit:** 75% = $377.90	85% = $428.30
52636	OSSEO-INTEGRATION PROCEDURE - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $186.50	**Benefit:** 75% = $139.90	85% = $158.55

	GROUP O6 - NEUROSURGICAL
52800	NEUROLYSIS BY OPEN OPERATION, without transposition, not being a service associated with a service to which item 52803 applies (Anaes.) (Assist.) **Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30
52803	NERVE TRUNK, internal (interfascicular), NEUROLYSIS of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $398.55 **Benefit:** 75% = $298.95 85% = $338.80
52806	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from superficial peripheral nerve (Anaes.) (Assist.) **Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30
52809	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from deep peripheral nerve (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70
52812	NERVE TRUNK, PRIMARY repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $676.80 **Benefit:** 75% = $507.60 85% = $597.30
52815	NERVE TRUNK, SECONDARY repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $714.35 **Benefit:** 75% = $535.80 85% = $634.85
52818	NERVE, TRANSPOSITION OF (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70
52821	NERVE GRAFT TO NERVE TRUNK, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,030.20 **Benefit:** 75% = $772.65 85% = $950.70
52824	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.) **Fee:** $443.70 **Benefit:** 75% = $332.80 85% = $377.15
52826	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.) **Fee:** $237.60 **Benefit:** 75% = $178.20 85% = $202.00
52828	CUTANEOUS NERVE, primary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $353.35 **Benefit:** 75% = $265.05 85% = $300.35
52830	CUTANEOUS NERVE, secondary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $466.10 **Benefit:** 75% = $349.60 85% = $396.20
52832	CUTANEOUS NERVE, nerve graft to, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $639.20 **Benefit:** 75% = $479.40 85% = $559.70

GROUP O7 - EAR, NOSE & THROAT

53000	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.) **Fee:** $32.55	**Benefit:** 75% = $24.45	85% = $27.70
53003	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.) **Fee:** $91.90	**Benefit:** 75% = $68.95	85% = $78.15
53004	MAXILLARY ANTRUM, LAVAGE OF - each attendance at which the procedure is performed, including any associated consultation (Anaes.) **Fee:** $35.60	**Benefit:** 75% = $26.70	85% = $30.30
53006	ANTROSTOMY (RADICAL) (Anaes.) (Assist.) **Fee:** $521.25	**Benefit:** 75% = $390.95	85% = $443.10
53009	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) **Fee:** $295.70	**Benefit:** 75% = $221.80	85% = $251.35
53012	ANTRUM, drainage of, through tooth socket (Anaes.) **Fee:** $117.55	**Benefit:** 75% = $88.20	85% = $99.95
53015	ORO-ANTRAL FISTULA, plastic closure of (Anaes.) (Assist.) **Fee:** $587.60	**Benefit:** 75% = $440.70	85% = $508.10
53016	NASAL SEPTUM, septoplasty, submucous resection or closure of septal perforation (Anaes.) (Assist.) **Fee:** $483.25	**Benefit:** 75% = $362.45	85% = $410.80
53017	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.) **Fee:** $602.85	**Benefit:** 75% = $452.15	85% = $523.35
53019	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.) **Fee:** $580.90	**Benefit:** 75% = $435.70	85% = $501.40
53052	POST-NASAL SPACE, direct examination of, with or without biopsy (Anaes.) **Fee:** $122.85	**Benefit:** 75% = $92.15	85% = $104.45
53054	NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX one or more of these procedures (Anaes.) **Fee:** $122.85	**Benefit:** 75% = $92.15	85% = $104.45
53056	EXAMINATION OF NASAL CAVITY or POST-NASAL SPACE, or NASAL CAVITY AND POST-NASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $71.95	**Benefit:** 75% = $54.00	85% = $61.20
53058	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) **Fee:** $122.85	**Benefit:** 75% = $92.15	85% = $104.45
53060	CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES FOR OBSTRUCTION OR HAEMORRHAGE SECONDARY TO SURGERY (OR TRAUMA) - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.) **Fee:** $100.50	**Benefit:** 75% = $75.40	85% = $85.45
53062	POST SURGICAL NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) **Fee:** $90.00	**Benefit:** 75% = $67.50	85% = $76.50
53064	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes.) **Fee:** $162.95	**Benefit:** 75% = $122.25	85% = $138.55
53068	TURBINECTOMY or TURBINECTOMIES, partial or total, unilateral (Anaes.) **Fee:** $136.50	**Benefit:** 75% = $102.40	85% = $116.05

53070	TURBINATES, submucous resection of, unilateral (Anaes.) **Fee:** $178.05	**Benefit:** 75% = $133.55	85% = $151.35

GROUP O8 - TEMPOROMANDIBULAR JOINT

53200	MANDIBLE, treatment of a dislocation of, not requiring open reduction (Anaes.) **Fee:** $70.65	**Benefit:** 75% = $53.00	85% = $60.10
53203	MANDIBLE, treatment of a dislocation of, requiring open reduction (Anaes.) **Fee:** $118.70	**Benefit:** 75% = $89.05	85% = $100.90
53206	TEMPOROMANDIBULAR JOINT, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.) **Fee:** $142.95	**Benefit:** 75% = $107.25	85% = $121.55
53209	GLENOID FOSSA, ZYGOMATIC ARCH and TEMPORAL BONE, reconstruction of (Obwegeser technique) (Anaes.) (Assist.) **Fee:** $1,649.10	**Benefit:** 75% = $1,236.85	85% = $1,569.60
53212	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.) **Fee:** $890.85	**Benefit:** 75% = $668.15	85% = $811.35
53215	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.) **Fee:** $408.70	**Benefit:** 75% = $306.55	85% = $347.40
53218	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedures (Anaes.) (Assist.) **Fee:** $653.80	**Benefit:** 75% = $490.35	85% = $574.30
53220	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $329.60	**Benefit:** 75% = $247.20	85% = $280.20
53221	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $872.30	**Benefit:** 75% = $654.25	85% = $792.80
53224	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $967.00	**Benefit:** 75% = $725.25	85% = $887.50
53225	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) **Fee:** $290.50	**Benefit:** 75% = $217.90	85% = $246.95
53226	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $312.30	**Benefit:** 75% = $234.25	85% = $265.50
53227	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,188.20	**Benefit:** 75% = $891.15	85% = $1,108.70
53230	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,338.45	**Benefit:** 75% = $1,003.85	85% = $1,258.95
53233	TEMPOROMANDIBULAR JOINT, surgery of, involving procedures to which items 53224, 53226, 53227 and 53230 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,504.05	**Benefit:** 75% = $1,128.05	85% = $1,424.55
53236	TEMPOROMANDIBULAR JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $470.70	**Benefit:** 75% = $353.05	85% = $400.10
53239	TEMPOROMANDIBULAR JOINT, arthrodesis of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $470.70	**Benefit:** 75% = $353.05	85% = $400.10

53242	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) **Fee:** $312.30 **Benefit:** 75% = $234.25 85% = $265.50

GROUP O9 - TREATMENT OF FRACTURES

53400	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $129.20	**Benefit:** 75% = $96.90	85% = $109.85
53403	MANDIBLE, treatment of fracture of, not requiring splinting *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $157.85	**Benefit:** 75% = $118.40	85% = $134.20
53406	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $406.65	**Benefit:** 75% = $305.00	85% = $345.70
53409	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $406.65	**Benefit:** 75% = $305.00	85% = $345.70
53410	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $85.65	**Benefit:** 75% = $64.25	85% = $72.85
53411	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $238.80	**Benefit:** 75% = $179.10	85% = $203.00
53412	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $392.10	**Benefit:** 75% = $294.10	85% = $333.30
53413	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $480.35	**Benefit:** 75% = $360.30	85% = $408.30
53414	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $551.85	**Benefit:** 75% = $413.90	85% = $472.35
53415	MAXILLA, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $435.65	**Benefit:** 75% = $326.75	85% = $370.35
53416	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $435.65	**Benefit:** 75% = $326.75	85% = $370.35
53418	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $566.35	**Benefit:** 75% = $424.80	85% = $486.85
53419	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $566.35	**Benefit:** 75% = $424.80	85% = $486.85
53422	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $718.75	**Benefit:** 75% = $539.10	85% = $639.25
53423	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $718.75	**Benefit:** 75% = $539.10	85% = $639.25

53424	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $616.65	**Benefit:** 75% = $462.50	85% = $537.15
53425	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $616.65	**Benefit:** 75% = $462.50	85% = $537.15
53427	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $842.25	**Benefit:** 75% = $631.70	85% = $762.75
53429	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $842.25	**Benefit:** 75% = $631.70	85% = $762.75
53439	MANDIBLE, treatment of a closed fracture of, involving a joint surface (Anaes.) *(See para OM4.10 of explanatory notes to this Category)* **Fee:** $238.80	**Benefit:** 75% = $179.10	85% = $203.00
53453	ORBITAL CAVITY, reconstruction of a wall or floor with or without foreign implant (Anaes.) (Assist.) **Fee:** $483.25	**Benefit:** 75% = $362.45	85% = $410.80
53455	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.) **Fee:** $567.65	**Benefit:** 75% = $425.75	85% = $488.15
53458	NASAL BONES, treatment of fracture of, not being a service to which item 53459 or 53460 applies **Fee:** $43.05	**Benefit:** 75% = $32.30	85% = $36.60
53459	NASAL BONES, treatment of fracture of, by reduction (Anaes.) **Fee:** $235.50	**Benefit:** 75% = $176.65	85% = $200.20
53460	NASAL BONES, treatment of fractures of, by open reduction involving osteotomies (Anaes.) (Assist.) **Fee:** $480.35	**Benefit:** 75% = $360.30	85% = $408.30

	GROUP O10 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
53600	SKIN SENSITIVITY TESTING for allergens to anaesthetics and materials used in OMS surgery, USING 1 TO 20 ALLERGENS *(See para OM4.11 of explanatory notes to this Category)* **Fee:** $38.95 **Benefit:** 75% = $29.25 85% = $33.15

GROUP O11 - REGIONAL OR FIELD NERVE BLOCKS

(Note. Where an anaesthetic combines a regional nerve block with a general anaesthetic for an operative procedure, benefits will be paid only under the anaesthetic item relevant to the operation. The items in this Group are to be used in the practice of oral and maxillofacial surgery and are not to be used for dental procedures (eg. restorative dentistry or dental extraction.))

53700	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent **Fee:** $124.85	**Benefit:** 75% = $93.65	85% = $106.15
53702	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent **Fee:** $62.50	**Benefit:** 75% = $46.90	85% = $53.15
53704	FACIAL NERVE, injection of an anaesthetic agent **Fee:** $37.65	**Benefit:** 75% = $28.25	85% = $32.05
53706	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies *(See para OM4.12 of explanatory notes to this Category)* **Fee:** $124.85	**Benefit:** 75% = $93.65	85% = $106.15

INDEX

A

Abcess, incision with drainage, requiring admission 52055
Abscess, deep, percutaneous drainage 52058
Abscess, drainage tube, exchange of 52059
Abscess, large, incision with drainage,requiring admission 52057
Alveolar ridge augmentation 52624
Alveolar ridge augmentation 52626
Alveolar ridge augmentation, cleft grafting of 52337
Antrobuccal fistula operation 53015
Antroscopy of temporomandibular joint 53218
Antroscopy of temporomandibular joint 53215
Antrostomy, radical 53006
Antrum, drainage of, through tooth socket 53012
Antrum, intranasal operation, or removal of foreign body 53009
Antrum, maxillary, proof puncture and lavage of 53000
Antrum, maxillary, proof puncture and lavage of 53003
Antrum, maxillary, removal of foreign body from 53009
Arch bars, to maxilla or mandible, removal of 52106
Artery, facial, mandibular or lingual, ligation of 52141
Artery, maxillary, ligation of 52138
Arthrocentesis, with irrigation of temporomandibular joint 53225
Aspiration biopsy, one or more jaw cysts 52021
Assistance at operation 51800
Assistance at operation 51803
Attendance 51700
Attendance 51703
Axillary sinus, excision of 52033

B

Basal cell carcinoma, complicated, removal 52054
Basal cell carcinoma, complicated, removal 52051
Basal cell carcinoma, uncomplicated, removal 52036
Basal cell carcinoma, uncomplicated, removal 52039
Basal cell carcinoma, uncomplicated, removal 52045
Basal cell carcinoma, uncomplicated, removal 52048
Basal cell carcinoma,uncomplicated, removal 52042
Biopsy, aspiration of jaw cysts 52021
Biopsy, aspiration of jaw cysts, lymph gland, muscle or other deep tissue or org 52027
Biopsy, aspiration of jaw cysts, skin or mucous membrane 52024
Bone, graft, harvesting of, via separate incision 52319
Bone, graft, harvesting of, via separate incision 52318
Bone, graft, to other bones 52130
Bone, graft, with internal fixation 52131
Bone, growth stimulator 52095
Bone, tumour, malignant, operations for 52184
Bone, tumour, malignant, operations for 52182
Bone, tumour, malignant, operations for 52180
Bone, tumour, malignant, operations for 52186
Bone,cyst, injection into or aspiration of 52064

C

Calculus, removal of, salivary gland duct 52075
Caldwell-Luc's operation 53006
Carbuncle, incision with drainage, in operating theatre 52057
Cauterisation, septum/turbinates/pharynx 53060
Cellulitis, incision with drainage, not requiring GA 52055
Cleft lip, operations for 52456
Cleft lip, operations for 52458
Cleft lip, operations for 52452
Cleft lip, operations for 52450
Cleft lip, operations for 52446
Cleft lip, operations for 52442
Cleft lip, operations for 52440
Cleft lip, operations for 52444
Cleft palate, palate, secondary repair, closure of fistula 52336
Cleft palate, palate, secondary repair, lengthening procedure 52339
Cleft palate, primary repair 52333
Composite graft to nose, ear or eyelid 52482
Condylectomy/condylotomy 53224
Contour reconstruction, insertion of foreign implants 52321
Cricothyrostomy 52133
Cutaneous nerve, nerve graft to 52832
Cutaneous nerve, repair of 52828
Cutaneous nerve, repair of 52830
Cyst, jaw, aspiration biopsy of, mandible or maxilla, segmental resection of 52114
Cyst, jaw, not otherwise covered, removal of 52045
Cyst, jaw, not otherwise covered, removal of 52036
Cyst, jaw, not otherwise covered, removal of 52039
Cyst, jaw, not otherwise covered, removal of 52042
Cyst, jaw, not otherwise covered, removal of 52048
Cyst, jaw,aspiration biopsy of 52021

D

Deep tissue or organ, biopsy of 52027
Dermis, dermofat or fascia graft 52424
Dermoid, excision 52039
Dermoid, excision 52045
Dermoid, excision 52042
Dermoid, excision 52036
Diathermy, salivary gland duct 52072
Dilatation,salivary gland duct 52072
Dislocation, mandible, treatment of 53203
Dislocation, mandible, treatment of 53200
Duct, salivary gland, diathermy or dilatation of 52072
Duct, salivary gland, removal of calculus from 52075
Duct, sublingual gland, removal of calculus from 52075

E

Endo-biopsy 52024
Endo-biopsy 52027
Endoscopic, laser therapy of upper aerodigestive tract 52035
Exostosis, mandibular or palatal, excision of 52600
External fixation, orthopaedic, removal 52098
External fixation, orthopaedic, removal 52097

F

Face, contour reconstruction 52379
Facial artery or vein, ligation of 52141
Fibroma, removal of 52036
Fibroma, removal of 52039
Fibroma, removal of 52042
Fibroma, removal of 52045
Fistula, antrobuccal, operation for 53015
Fistula, oro-antral, plastic closure of 53015
Flap repair, direct 52327
Flap repair, direct 52324
Flap repair, single stage local 52300
Flap repair, single stage local 52303
Flap repair, single stage local 52306
Foreign body, antrum, removal of 53009

Foreign body, deep, removal , interventional imaging 52144
Foreign body, implants for contour reconstruction, insertion of 52321
Foreign body, maxillary sinus, removal of 53009
Foreign body, muscle/other deep tissue, removal of 52018
Foreign body, subcutaneous, removal, other 52015
Foreign body, superficial removal, other 52012
Foreign body, tendon, removal of 52144
Foreign body, tendon, removal of 52018
Fracture, mandible or maxilla, treatment of 53413
Fracture, mandible or maxilla, treatment of 53414
Fracture, mandible or maxilla, treatment of 53415
Fracture, mandible or maxilla, treatment of 53416
Fracture, mandible or maxilla, treatment of 53418
Fracture, mandible or maxilla, treatment of 53419
Fracture, mandible or maxilla, treatment of 53422
Fracture, mandible or maxilla, treatment of 53423
Fracture, mandible or maxilla, treatment of 53424
Fracture, mandible or maxilla, treatment of 53425
Fracture, mandible or maxilla, treatment of 53427
Fracture, mandible or maxilla, treatment of 53429
Fracture, mandible or maxilla, treatment of 53439
Fracture, mandible or maxilla, treatment of 53412
Fracture, mandible or maxilla, treatment of 53409
Fracture, mandible or maxilla, treatment of 53410
Fracture, mandible or maxilla, treatment of 53411
Fracture, mandible or maxilla, treatment of 53400
Fracture, mandible or maxilla, treatment of 53403
Fracture, mandible or maxilla, treatment of 53406
Fracture, zygomatic bone, treatment of 53411
Fracture, zygomatic bone, treatment of 53414
Fracture, zygomatic bone, treatment of 53413
Fracture, zygomatic bone, treatment of 53412
Free grafts, full thickness 52315
Free grafts, full thickness grafts, mucosa/split skin/connective tissue 52309
Free grafts, full thickness grafts, mucosa/split skin/connective tissue 52312
Frenulum, mandibular or maxillary, repair of 52084
Furuncle, incision with drainage, in operating theatre 52057

G

Genioplasty 52378
Gland, lymph, biopsy of 52027
Gland, salivary, incision of 52057
Gland, salivary, meatotomy or marsupialisation 52075
Gland, salivary, removal of calculus from duct 52075
Gland, salivary, transportation of duct 52147
Gland, salivary,dilation or diathermy of duct 52072
Gland, sublingual, extirpation of 52069
Gland, submandibular, extirpation of 52066
Gland, submaxillary, extirpation of 52066
Gland, submaxillary, incision of 52057
Gland, submaxillary, incision of 52147
Glenoid fossa, zygomatic arch, temporal bone, reconstruction 53209
Grafts, composite (chondrocutaneous/mucosal) 52480
Grafts, free, full thickness 52315
Grafts, mucosa or split skin 52309
Grafts, mucosa or split skin 52312

H

Haematoma, aspiration of 52056
Haematoma, incision with drainage, not requiring GA 52055
Haematoma, large, incision with drainage, in operating theatre 52057
Haemorrhage, post-nasal and/or post-operative, control of 52135
Hemifacial microsomia, construction condyle and ramus 53212
Hyperplasia, papillary, of palate, removal of 52609
Hyperplasia, papillary, of palate, removal of 52615
Hyperplasia, papillary, of palate, removal of 52612
Hypertrophied tissue, removal of 52036
Hypertrophied tissue, removal of 52042
Hypertrophied tissue, removal of 52039
Hypertrophied tissue, removal of 52045

I

Innocent bone tumour, excision of 52063
Intranasal operation on antrum/foreign body 53009

J

Jaw dislocation, treatment of 53200
Jaw, aspiration biopsy of cyst/s 52021
Jaw, dislocation, treatment of 53203
Jaw, fracture, treatment of 53409
Jaw, fracture, treatment of 53410
Jaw, fracture, treatment of 53411
Jaw, fracture, treatment of 53412
Jaw, fracture, treatment of 53413
Jaw, fracture, treatment of 53414
Jaw, fracture, treatment of 53415
Jaw, fracture, treatment of 53416
Jaw, fracture, treatment of 53418
Jaw, fracture, treatment of 53419
Jaw, fracture, treatment of 53422
Jaw, fracture, treatment of 53406
Jaw, fracture, treatment of 53403
Jaw, fracture, treatment of 53400
Jaw, fracture, treatment of 53423
Jaw, fracture, treatment of 53439
Jaw, fracture, treatment of 53429
Jaw, fracture, treatment of 53427
Jaw, fracture, treatment of 53425
Jaw, fracture, treatment of 53424
Jaw, operation on, for osteomyelitis 52090
Jaw, plastic and reconstructive operation on 52345
Jaw, plastic and reconstructive operation on 52348
Jaw, plastic and reconstructive operation on 52351
Jaw, plastic and reconstructive operation on 52354
Jaw, plastic and reconstructive operation on 52375
Jaw, plastic and reconstructive operation on 52372
Jaw, plastic and reconstructive operation on 52369
Jaw, plastic and reconstructive operation on 52366
Jaw, plastic and reconstructive operation on 52363
Jaw, plastic and reconstructive operation on 52360
Jaw, plastic and reconstructive operation on 52342
Jaw, plastic and reconstructive operation on 52357

K

Keloid, excision of 52036
Keloid, excision of 52039
Keloid, excision of 52042
Keloid, excision of 52045
Kirschner wire, insertion of 52096

L

Lacerations, ear/eyelid/nose/lip, full thickness, repair of 52010
Lacerations, repair and suturing of 52000
Lacerations, repair and suturing of 52003
Lacerations, repair and suturing of 52006
Lacerations, repair and suturing of 52009
Lavage and proof puncture of maxillary antrum 53000
Lavage and proof puncture of maxillary antrum 53003
Le Fort osteotomies 52380

Le Fort osteotomies 52382
Lingual artery or vein, ligation of 52141
Lip, full thickness wedge excision of 52108
Lipectomy, wedge excision 51904
Lipectomy, wedge excision 51906
Lipoma, removal of 52039
Lipoma, removal of 52036
Lipoma, removal of 52042
Lipoma, removal of 52045
Local flap repair, single stage 52303
Local flap repair, single stage 52300
Local flap repair, single stage 52306
Lymph gland, muscle or other deep tissue or organ biopsy of 52027
Lymph node, biopsy of 52025
Lymphoid patches, removal of 52036
Lymphoid patches, removal of 52039
Lymphoid patches, removal of 52042
Lymphoid patches, removal of 52045

M

Macrocheilia, operation for 52482
Macrostomia, operation for 52484
Mandible, dislocation, treatment of 53200
Mandible, dislocation, treatment of 53203
Mandible, fixation by intermaxillary wiring 52420
Mandible, hemi-mandiblectomy of 52120
Mandible, hemi-mandibular reconstruction with bone graft 52122
Mandible, operation on, for osteomyelitis 52090
Mandible, or maxilla, fractures, treatment of 53414
Mandible, or maxilla, fractures, treatment of 53415
Mandible, or maxilla, fractures, treatment of 53416
Mandible, or maxilla, fractures, treatment of 53418
Mandible, or maxilla, fractures, treatment of 53419
Mandible, or maxilla, fractures, treatment of 53422
Mandible, or maxilla, fractures, treatment of 53423
Mandible, or maxilla, fractures, treatment of 53424
Mandible, or maxilla, fractures, treatment of 53425
Mandible, or maxilla, fractures, treatment of 53427
Mandible, or maxilla, fractures, treatment of 53429
Mandible, or maxilla, fractures, treatment of 53413
Mandible, or maxilla, fractures, treatment of 53412
Mandible, or maxilla, fractures, treatment of 53439
Mandible, or maxilla, fractures, treatment of 53410
Mandible, or maxilla, fractures, treatment of 53409
Mandible, or maxilla, fractures, treatment of 53406
Mandible, or maxilla, fractures, treatment of 53403
Mandible, or maxilla, fractures, treatment of 53400
Mandible, or maxilla, fractures, treatment of 53411
Mandible, osteectomy of osteotomy of 53406
Mandible, osteectomy of osteotomy of 53403
Mandible, osteectomy of osteotomy of 53400
Mandible, osteectomy of osteotomy of 53409
Mandible, osteectomy of osteotomy of 53439
Mandible, osteectomy of osteotomy of 53429
Mandible, osteectomy of osteotomy of 53427
Mandible, osteectomy of osteotomy of 53425
Mandible, osteectomy of osteotomy of 53424
Mandible, osteectomy of osteotomy of 53423
Mandible, osteectomy of osteotomy of 53422
Mandible, osteectomy of osteotomy of 53419
Mandible, osteectomy of osteotomy of 53418
Mandible, osteectomy of osteotomy of 53416
Mandible, osteectomy of osteotomy of 53415
Mandible, osteectomy of osteotomy of 53414
Mandible, osteectomy of osteotomy of 53413
Mandible, osteectomy of osteotomy of 53412
Mandible, osteectomy of osteotomy of 53410
Mandible, osteectomy of osteotomy of 53411
Mandible, removal of buried wire, pin or screw 52102
Mandible, removal of buried wire, pin or screw 52099
Mandible, removal of one or more plates 52366
Mandible, removal of one or more plates 52363
Mandible, removal of one or more plates 52360
Mandible, removal of one or more plates 52357
Mandible, removal of one or more plates 52354
Mandible, removal of one or more plates 52351
Mandible, removal of one or more plates 52348
Mandible, removal of one or more plates 52345
Mandible, removal of one or more plates 52342
Mandible, removal of one or more plates 52369
Mandible, removal of one or more plates 52375
Mandible, removal of one or more plates 52372
Mandible, segmental resection of, for tumours or cysts 52114
Mandible, sub-total resection of 52117
Mandible, total resection of 52123
Mandibular artery or vein, exostosis, excision of 52600
Mandibular artery or vein, frenulum, repair of 52084
Manidbular artery or vein, ligation of 52141
Maxilla, operation on, for osteomyelitis 52090
Maxilla, or mandible, fractures, treatment of 53400
Maxilla, or mandible, fractures, treatment of 53403
Maxilla, or mandible, fractures, treatment of 53406
Maxilla, or mandible, fractures, treatment of 53409
Maxilla, or mandible, fractures, treatment of 53410
Maxilla, or mandible, fractures, treatment of 53411
Maxilla, or mandible, fractures, treatment of 53412
Maxilla, or mandible, fractures, treatment of 53413
Maxilla, or mandible, fractures, treatment of 53414
Maxilla, or mandible, fractures, treatment of 53415
Maxilla, or mandible, fractures, treatment of 53416
Maxilla, or mandible, fractures, treatment of 53418
Maxilla, or mandible, fractures, treatment of 53419
Maxilla, or mandible, fractures, treatment of 53422
Maxilla, or mandible, fractures, treatment of 53423
Maxilla, or mandible, fractures, treatment of 53424
Maxilla, or mandible, fractures, treatment of 53425
Maxilla, or mandible, fractures, treatment of 53427
Maxilla, or mandible, fractures, treatment of 53429
Maxilla, or mandible, fractures, treatment of 53439
Maxilla, osteectomy or osteotomy of 52342
Maxilla, osteectomy or osteotomy of 52375
Maxilla, osteectomy or osteotomy of 52348
Maxilla, osteectomy or osteotomy of 52351
Maxilla, osteectomy or osteotomy of 52354
Maxilla, osteectomy or osteotomy of 52357
Maxilla, osteectomy or osteotomy of 52360
Maxilla, osteectomy or osteotomy of 52363
Maxilla, osteectomy or osteotomy of 52366
Maxilla, osteectomy or osteotomy of 52369
Maxilla, osteectomy or osteotomy of 52345
Maxilla, osteectomy or osteotomy of 52372
Maxilla, removal of buried wire, pin or screw 52099
Maxilla, removal of buried wire, pin or screw 52102
Maxilla, removal of one or more plates 52105
Maxilla, sub-total resection of 52117
Maxilla, total resection of 52129
Maxilla, total resection of 52126
Maxillary antrum, artery, ligation of 52138
Maxillary antrum, frenulum, repair of 52084
Maxillary antrum, lavage of 53004
Maxillary antrum, proof puncture and lavage of 53003
Maxillary antrum, proof puncture and lavage of 53000
Maxillary antrum, sinus, drainage of, through tooth socket 53012
Maxillary antrum, sinus, operations on 53006
Maxillary antrum, sinus, operations on 53009
Maxillary antrum, sinus, sinus lift procedure 53019
Maxillary antrum, tuberosity, reduction of 52606
Melanoma, excision of 52036

Melanoma, excision of 52039
Melanoma, excision of 52042
Melanoma, excision of 52045
Melanoma, excision of 52048
Microvascular anastomosis repair using microsurgical techniques 52424
Microvascular anastomosis using microsurgical techniques 52430
Mouth, lowering of floor of (Oswegeser or similar) 52621
Mucous membrane, biopsy of 52024
Mucous membrane, repair of recent wound of 52003
Mucous membrane, repair of recent wound of 52000
Mucous membrane, repair of recent wound of 52009
Mucous membrane, repair of recent wound of 52006
Muscle, biopsy of 52027
Muscle, excision of 52060
Muscle, or other deep tissue, removal of foreign body 52018
Muscle, ruptured repair of 52062
Muscle, ruptured repair of 52061
Mylohyloid ridge, reduction of 52603

N

Naevus, excision of 52036
Naevus, excision of 52039
Naevus, excision of 52042
Naevus, excision of 52045
Nasal bones, treatment of fracture/s 53458
Nasal bones, treatment of fracture/s 53459
Nasal bones, treatment of fracture/s 53460
Nasal cavity and/or post nasal space, examination of 53056
Nasal cavity, packing for arrest of haemorrhage 53062
Nasal haemorrhage, arrest of 53058
Nasal haemorrhage, cryotherapy to 53064
Nasal septum, reconstruction 53017
Nasal septum, septoplasty 53016
Nasal, space, post, direct examination of 53052
Nasendoscopy 53054
Nerve, clock, regional or field 53700
Nerve, clock, regional or field 53704
Nerve, clock, regional or field 53702
Nerve, peripheral, neurectomy/neurotomy/tumour 52809
Nerve, peripheral, neurectomy/neurotomy/tumour 52806
Nerve, transposition of 52818
Nerve, trigeminal, cryosurgery of 52824
Nerve, trunk, graft to 52821
Nerve, trunk, neurolysis of 52803
Nerve, trunk, repair of 52812
Nerve, trunk, repair of 52815
Neurectomy, peripheral nerve 52809
Neurectomy, peripheral nerve 52806
Neurolysis by open operation 52800
Neurolysis, of nerve trunk 52803
Node, lymph, biopsy of 52027

O

Orbital cavity, bone or cartilage graft to wall or floor 53455
Orbital cavity, reconstruction of wall or floor 53453
Oro-antral fistula, plastic closure of 53015
Orthopaedic pin or wire, insertion of 52096
Orthopaedic pin or wire, removal of 52099
Orthopaedic pin or wire, removal of 52102
Orthopaedic, plates, removal of 52105
Osseointegration procedure 52636
Osseointegration procedure 52627
Osseointegration procedure 52630
Osseointegration procedure 52633
Osteectomy of mandible or maxilla 52363
Osteectomy of mandible or maxilla 52360
Osteectomy of mandible or maxilla 52357
Osteectomy of mandible or maxilla 52354
Osteectomy of mandible or maxilla 52351
Osteectomy of mandible or maxilla 52348
Osteectomy of mandible or maxilla 52345
Osteectomy of mandible or maxilla 52342
Osteectomy of mandible or maxilla 52366
Osteectomy of mandible or maxilla 52375
Osteectomy of mandible or maxilla 52372
Osteectomy of mandible or maxilla 52369
Osteomyelitis, operation on mandible or maxilla 52090
Osteomyelitis, operation on skull 52092
Osteomyelitis,operation on combination of adjoining bones 52094
Osteotomies, mid-facial 52382
Osteotomies, mid-facial 52380
Osteotomy, of mandible or maxilla 52357
Osteotomy, of mandible or maxilla 52360
Osteotomy, of mandible or maxilla 52363
Osteotomy, of mandible or maxilla 52372
Osteotomy, of mandible or maxilla 52369
Osteotomy, of mandible or maxilla 52366
Osteotomy, of mandible or maxilla 52354
Osteotomy, of mandible or maxilla 52375
Osteotomy, of mandible or maxilla 52348
Osteotomy, of mandible or maxilla 52345
Osteotomy, of mandible or maxilla 52342
Osteotomy, of mandible or maxilla 52351

P

Palatal exostosis, excision of 52600
Palate, cleft, repair of papillary hyperplasia removal of 52609,52612,52615
Palate, cleft, repair of 52333
Palate, cleft, repair of 52339
Palate, cleft, repair of 52336
Palate, papillary hyperplasia removal of 52609
Palate, papillary hyperplasia removal of 52612
Palate, papillary hyperplasia removal of 52615
Palate, plastic closure of defect of 52330
Papillary hyperplasia of the palate, removal of 52615
Papillary hyperplasia of the palate, removal of 52612
Papillary hyperplasia of the palate, removal of 52609
Papilloma, removal of 52036
Papilloma, removal of 52045
Papilloma, removal of 52042
Papilloma, removal of 52039
Parotid duct, repair of 52148
Pharyngeal flap for velo-pharyngeal incompetence 52460
Pin, orthopaedic removal of 52102
Pin, orthopaedic, insertion of 52096
Pin, orthopaedic, removal of 52099
Plastic repair, free grafts 52315
Plastic repair, free grafts 52312
Plastic repair, free grafts 52309
Plastic repair, single stage, local flap 52300
Plastic repair, single stage, local flap 52303
Plastic repair, single stage, local flap 52306
Plates, orthopaedic, removal of 52018
Plates, orthopaedic, removal of 52015
Post nasal space, direct examination of with/without biopsy 53052
Post nasal space, examination under GA 53056
preauricular sinus operation 52030
Premalignant lesions, cryotherapy, diathermy or carbon dioxide laser 52034
Proof puncture of maxillary antrum 53003
Proof puncture of maxillary antrum 53000

R

Radical antrostomy 53006
Ranula, removal of 52087
Reduction, of dislocation of mandible 53200
Reduction, of dislocation of mandible 53203
Rodent ulcer, operation for 52036
Rodent ulcer, operation for 52039
Rodent ulcer, operation for 52042
Rodent ulcer, operation for 52045

S

Salivary gland duct, diathermy or dilatation of 52072
Salivary gland duct, removal of calculus from 52075
Salivary gland duct, transposition of 52147
Salivary gland, incision of 52057
Salivary gland, repair of cutaneous fistula of 52073
Scar, removal of, not otherwise covered 52036
Scar, removal of, not otherwise covered 52039
Scar, removal of, not otherwise covered 52042
Scar, removal of, not otherwise covered 52045
Sebaceous cyst, removal of 52036
Sebaceous cyst, removal of 52045
Sebaceous cyst, removal of 52042
Sebaceous cyst, removal of 52039
Segmental resection, of mandible or maxilla for tumours 52114
Single stage local flap repair 52303
Single stage local flap repair 52306
Single stage local flap repair 52300
Sinus, excision of 52033
Sinus, excision of 52030
Sinus, maxillary, drainage of, through tooth socket 53012
Skin biopsy repair of recent wound 52006
Skin biopsy repair of recent wound 52009
Skin biopsy repair of recent wound 52003
Skin biopsy repair of recent wound 52000
Skin biopsy, of 52024
Skin, sensitivity testing 53600
Skull, operation on, for osteomyelitis 52092
Subcutaneous, foreign body, removal, other 52015
Subcutaneous, tissue, repair of recent wound 52000
Subcutaneous, tissue, repair of recent wound 52003
Subcutaneous, tissue, repair of recent wound 52009
Subcutaneous, tissue, repair of recent wound 52006
Sublingual gland duct, removal of calculus from 52075
Sublingual gland, extirpation of 52069
Submandibular abscess, incision of 52057
Submandibular ducts, relocation of 52158
Submandibular gland, extirpation of 52066
Submandibular gland, incision of 52057
Submaxillary gland, extirpation of 52066
Submaxillary gland, incision of 52057
Superficial foreign body, removal of 52012
Superficial, wound repair of 52000
Superficial, wound repair of 52009
Suture, of traumatic wounds 52009
Suture, of traumatic wounds 52003
Suture, of traumatic wounds 52000
Suture, of traumatic wounds 52006

T

Temporal, bone glenoid fossa/zygomatic arch, reconstruction of 53209
Temporomandibular joint, arthrodesis 53239
Temporomandibular joint, arthroscopy of 53218
Temporomandibular joint, arthroscopy of 53215
Temporomandibular joint, arthrotomy 53220
Temporomandibular joint, external fixation, application of 53242
Temporomandibular joint, irrigation of 53225
Temporomandibular joint, manipulation of 53206
Temporomandibular joint, open surgical exploration of 53225
Temporomandibular joint, open surgical exploration of 53226
Temporomandibular joint, open surgical exploration of 53224
Temporomandibular joint, open surgical exploration of 53221
Temporomandibular joint, open surgical exploration of 53227
Temporomandibular joint, open surgical exploration of 53230
Temporomandibular joint, open surgical exploration of 53233
Temporomandibular joint, stabilisation of 53236
Temporomandibular joint, synovectomy of 53226
Tendon, foreign body in, removal of 52018
Tendon, or other deep tissue, foreign body in, removal of 52018
Tissue, subcutaneous, repair of recent wound 52000
Tissue, subcutaneous, repair of recent wound 52009
Tissue, subcutaneous, repair of recent wound 52006
Tissue, subcutaneous, repair of recent wound 52003
Tongue, partial excision of 52078
Tongue, tie, repair of 52081
Tongue, tie, repair of 52084
Tracheostomy 52132
Traumatic wounds, repair of 52009
Traumatic wounds, repair of 52006
Traumatic wounds, repair of 52003
Traumatic wounds, repair of 52000
Trigeminal nerve, injection with alcohol, cortisone, etc 52826
Tuberosity, maxillary, reduction of 52606
Tumour, bone, innocent, excision of 52063
Tumour, mandible or maxilla, segmental resection of 52114
Tumour, not otherwise covered, removal of 52039
Tumour, not otherwise covered, removal of 52036
Tumour, not otherwise covered, removal of 52048
Tumour, not otherwise covered, removal of 52042
Tumour, not otherwise covered, removal of 52045
Tumour, peripheral nerve, removal of 52806
Tumour, peripheral nerve, removal of 52809
Tumour, soft tissue, excision of 52054
Tumour, soft tissue, excision of 52051
Turbinates, submucous resection of 53070

V

Vein, facial, mandibular or lingual, ligation of 52141
Vermilionectomy 52111
Vestibuloplasty, unilateral or bilateral 52618

W

Washout, antrum 53000
Washout, antrum 53003
Wire, orthopaedic, insertion of 52096
Wire, orthopaedic, removal of 52099
Wire, orthopaedic, removal of 52102
Wound, debridement under GA or major block 51900
Wound, dressing of, requiring GA 51902
Wound, traumatic, suture of 52000
Wound, traumatic, suture of 52003
Wound, traumatic, suture of 52006
Wound, traumatic, suture of 52009

Z

Zygomatic arch, reconstruction of 53209
bone, fracture, treatment of 53410,53411

DIAGNOSTIC IMAGING SERVICES

CATEGORY 5

SUMMARY OF CHANGES FROM 1/1/2016

The 1/1/2016 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

There are no changes to this Category for 1 January 2016.

DIA... 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

DIB... WHAT IS A DIAGNOSTIC IMAGING SERVICE

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

A diagnostic imaging procedure is defined in the Act as 'a procedure for the production of images (for example x-rays, computerised tomography scans, ultrasound scans, magnetic resonance imaging scans and nuclear scans) for use in the rendering of diagnostic imaging services'.

The Schedule fee for each diagnostic imaging service described in the DIST covers both the diagnostic imaging procedure and the reading and report on that procedure by the diagnostic imaging service provider. Exceptions to the reporting requirement are as follows:

(a) where the service is provided in conjunction with a surgical procedure, the findings may be noted on the operation record (items 55054, 55130, 55135, 55848, 55850, 57341, 57345, 59312, 59314, 60506, 60509 and 61109);
(b) where a service is provided in preparation of a radiological procedure (items 60918 and 60927).

As for all Medicare services, diagnostic imaging services have to be clinically relevant before they are eligible for Medicare benefits. A clinically relevant service is a service that is generally accepted in the profession as being necessary for the appropriate treatment of the patient.

For NR-type services (and R-type services provided without a request under the exemption provisions – see DID – 'Exemptions from the written request requirements for R-type diagnostic imaging services'), the clinical relevance of the service is determined by the providing practitioner. For R-type services rendered at the request of another practitioner, responsibility for determining the clinical relevance of the service lies with the requesting practitioner.

DIC... WHO MAY PROVIDE A DIAGNOSTIC IMAGING SERVICE

Unless otherwise stated, a diagnostic imaging service specified in the DIST may be provided by:

a) a medical practitioner; or
b) a person, other than a medical practitioner, who:
    i) is employed by a medical practitioner; or
    ii) provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

For the purposes of Medicare, however, the rendering practitioner is the medical practitioner who provides the report.

Medicare benefits are not payable, for example, when a medical practitioner refers patients to self-employed paramedical personnel, such as radiographers or other persons, who either bill the patient or the practitioner requesting the service.

Reports provided by practitioners located outside Australia

Under the Act, Medicare benefits are only payable for services rendered in Australia. Where a service consists of a number of components, such as a diagnostic imaging service, all components need to be rendered in Australia in order to qualify for Medicare benefits. For diagnostic imaging services, this means that all elements of the service, including the preparation of report on the procedure, would need to be rendered in Australia.

As such, Medicare benefits are not payable for services which have been reported on by medical practitioners located outside Australia.

Who may perform a Diagnostic Radiology Procedure:

All items in Group I3 (excluding Sub-group 10) must be performed by:
a) a medical practitioner;
b) a medical radiation practitioner who is;

i) employed by a medical practitioner; or
ii) performing the procedure under the supervision of a medical practitioner in accordance with accepted medical practice.

A medical radiation practitioner means a person registered or licenced as a medical radiation practitioner under a law of a State or Territory.

However, for a service mentioned in items 57901 to 57969, a diagnostic imaging procedure may also be performed by a dental practitioner who:
(a) may request the service because of the operation of subsection 16B (2) of the Health Insurance Act 1973; and
(b) either:
(i) is employed by a medical practitioner; or
(ii) provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

Exceptions to this requirement

Requirements on who must perform a diagnostic radiology procedure do not apply where the service is performed in:

a) RA2, RA3 OR RA4; OR
b) both:
i) in RA1; and
ii) RRMA4 or RRMA5

RA1 means an inner regional area as classified by the ASGC.
RA2 means an outer regional area as classified by the ASGC.
RA3 means a remote area as classified by the ASGC.
RA4 means a very remote area as classified by the ASCG
RRMA4 means a small rural centre as classified by the Rural, Remote and Metropolitan Areas Classification.
RRMA5 means a rural centre with an urban centre population of less than 10,000 persons as classified by the Rural, Remote and Metropolitan Areas Classification.

However, diagnostic radiology procedures in these areas must also be performed by a medical practitioner; or a person, other than a medical practitioner, who:
a) is employed by a medical practitioner; or
b) provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

DID... REQUESTS FOR DIAGNOSTIC IMAGING SERVICES

Request requirements

Medicare benefits are not payable for diagnostic imaging services that are classified as R-type (requested) services unless prior to commencing the relevant service, the practitioner receives a signed and dated request from a requesting practitioner who determined the service was necessary.

Before requesting a diagnostic imaging service, the requesting practitioner must turn his or her mind to the clinical relevance of the request and determine that the service is necessary for the appropriate professional care of the patient. For example: an ultrasound to determine the sex of a foetus is not a clinically relevant service (unless there is an indication that the sex of the foetus will determine further courses of treatment, eg. a genetic background to a sex-related disease or condition).

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

Who may request a diagnostic imaging service

The following practitioners may request a diagnostic imaging service:

- Specialists and consultant physicians can request any diagnostic imaging service.
- Other medical practitioners can request any service and specific Magnetic Resonance Imaging Services – see DIO.
- A medical practitioner, on behalf of the treating practitioner, for example, by a resident medical officer at a hospital on behalf of the patient's treating practitioner.

- Dental Practitioners, Physiotherapists, Chiropractors, Osteopaths and Podiatrists registered or licensed under State or Territory laws
- Participating nurse practitioners and participating midwives.

All dental practitioners may request the following items:

57509, 57515, 57521, 57527, 57901, 57902, 57903, 57906, 57909, 57912, 57915, 57918, 57921, 57924, 57927, 57930, 57933, 57939, 57942, 57945, 57960, 57963, 57966, 57969, 58100, 58300, 58503, 58903, 59733, 59739, 59751, 60100, 60500, 60503.

In addition to these items, oral and maxillofacial surgeons, prosthodontists, dental specialists (periodontists, endodontists, pedodontists, orthodontists) and specialists in oral medicine and oral pathology are also able to request the following items:

Oral and maxillofacial surgeons

55028, 55030, 55032, 56001, 56007, 56010, 56013, 56016, 56022, 56028, 56030, 56036, 56041, 56047 56050, 56053, 56056, 56062, 56068, 56070, 56076, 56101, 56107, 56141, 56147, 56219, 56220, 56224, 56227, 56230, 56259, 56301, 56307, 56341, 56347, 56401, 56407, 56409, 56412, 56441, 56447, 56449, 56452, 56501, 56507, 56541, 56547, 56801, 56807, 56841, 56847, 57001, 57007, 57041, 57047, 57341, 57345, 57362, 57363, 57703, 57709, 57712, 57715, 58103, 58106, 58108, 58109, 58112, 58115, 58306, 58506, 58521, 58524, 58527, 58909, 59103, 59703, 60000, 60003, 60006, 60009, 60506, 60509, 61109, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63007, 63334.

Prosthodontists

55028, 56013, 56016, 56022, 56028, 56053, 56056, 56062, 56068, 57362, 57363, 58306, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63334.

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

56022, 56062, 57362, 57363, 58306, 61421, 61454, 61457, 63334.

Specialists in oral medicine and/or oral pathology

55028, 55030, 55032, 56001, 56007, 56010, 56013, 56016, 56022, 56028, 56041, 56047, 56050, 56053, 56056, 56062, 56068, 56101, 56107, 56141, 56147, 56301, 56307, 56341, 56347, 56401, 56407, 56441, 56447, 57341, 57345, 57362, 57363, 58306, 58506, 58909, 59103, 59703, 60000, 60003, 60006, 60009, 60506, 60509, 61109, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63007, 63334.

Physiotherapists, Chiropractors and Osteopaths may request:

57712, 57715, 58100 to 58106 (inclusive), 58109, 58112, 58120 and 58121

See para DIM of explanatory notes

Podiatrists may request:

55836, 55840, 55844, 57521, 57527.

Participating Nurse Practitioners may request:

55036, 55070, 55076, 55600, 55800, 55804, 55808, 55812, 55816, 55820, 55824, 55828, 55832, 55836, 55840, 55844, 55848, 55850, 55852, 57509, 57515, 57521, and 58503 to 58527 (inclusive).

Participating Midwives may request:

55700, 55704, 55706, 55707 and 55718

Form of a request
Responsibility for the adequacy of requesting details rests with the requesting practitioner. A request for a diagnostic imaging service does not have to be in a particular form. However, the legislation provides that a request must be in writing and contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item/s of service requested. This includes, where relevant, noting on the request the clinical indication(s) for the requested

service. The provision of additional relevant clinical information can often assist the service provider and enhance the overall service provided to the patient. As such, this practice is actively encouraged.

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

Referral to specified provider not required

It is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider. Request forms containing relevant information about a diagnostic imaging provider supplied, or made available to, a requesting practitioner by a diagnostic imaging provider on, or after, 1 August 2012 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 $1000.
A practitioner who renders "R-type" diagnostic imaging services and who, without reasonable excuse, provides either directly or indirectly to a requesting practitioner a document to be used in the making of a request which would contravene the request information requirements is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine of $1000.

Exemptions from the written request requirements for R-type diagnostic imaging services
There are exemptions from the general written request requirements (R-type) diagnostic imaging services and these are outlined as follows:

Consultant physician or specialist

A consultant physician or specialist is a medical practitioner recognised for the purposes of the Health Insurance Act 1973 as a specialist or consultant physician, in a particular specialty.

Except for R-type items which in their description state that a referral is required (such as most R-type items in General Ultrasound and items 59300, 59303), a written request is not required for the payment of Medicare benefits when the diagnostic imaging service is provided by or on behalf of a consultant physician or a specialist (other than a specialist in diagnostic radiology) in his or her specialty and after clinical assessment he/she determines that the service was necessary.
For details required for accounts/receipts see DIF.

However, if in the referral to the consultant physician or specialist, the referring practitioner specifically requests a diagnostic imaging service (eg to a cardiologist to perform an echocardiogram) the service provided is a requested, not self-determined service. If further services are subsequently provided, these further services are self-determined – see "Additional services".

Additional services

A written request is not required for a diagnostic imaging service if that service was provided after one which has been formally requested and the providing practitioner determines that, on the basis of the results obtained from the requested service, that an additional service was necessary. However, the following services cannot be self- determined as "additional services":

- R-type items which in their description (such as most R-type items in General Ultrasound and items 59300, 59303) state that a referral is required (practitioners should claim the NR item in these circumstances);
- MRI services; and
- services not otherwise able to be requested by the original requesting practitioner.

For details required for accounts/receipts see DIF.

Substituted services

- A provider may substitute a service for the service originally requested when:
- the provider determines, from the clinical information provided on the request, that the substituted service would be more appropriate for the diagnosis of the patient's condition; and
- the provider has consulted with the requesting practitioner or taken all reasonable steps to do so before providing the substituted service; and
- the substituted service was one that would be accepted as a more appropriate service in the circumstances by the practitioner's speciality group.

However, the following services cannot be substituted:

- R-type items which in their description (such as most R-type items in General Ultrasound and items 59300, 59303) state that a referral is required;
- MRI services; and
- services not otherwise able to be requested by the original requesting practitioner.

For details required for accounts/receipts see DIF.

Remote areas

A written request is not required for the payment of Medicare benefits for a R-type diagnostic imaging service rendered by a medical practitioner in a remote area provided:

- the R-type service is not one for which there is a corresponding NR-type service; and
- the medical practitioner rendering the service has been granted a remote area exemption for that service.

For details required for accounts/receipts see DIF.

Definition of remote area

The definition of a remote area is one that is more than 30 kilometres by road from:

a) a hospital which provides a radiology service under the direction of a specialist in the specialty of diagnostic radiology; and
b) a free-standing radiology facility under the direction of a specialist in the specialty of diagnostic radiology.

Application for remote area exemption

A medical practitioner, other than a consultant physician or specialist, who believes that he or she qualifies for exemption under the remote area definition, should obtain an application form from the Department of Human Services' website www.medicareaustralia.gov.au or by contacting the Department of Human Services, Provider Liaison Section, on 132150 for the cost of a local call.
Quality assurance requirement for remote area exemption

Application for, or continuation of, a remote area exemption will be contingent on practitioners being enrolled in an approved continuing medical education and quality assurance program. For further information, please contact the Australian College of Rural and Remote Medicine (ACRRM) on (07) 3105 8200.

Emergencies

The written request requirement does not apply if the providing practitioner determines that, because the need for the service arose in an emergency, the service should be performed as quickly as possible.
For details required for accounts/receipts see DIF.

Lost requests

The written request requirement does not apply where:

- the person who received the diagnostic imaging service, or someone acting on that person's behalf, claimed that a written request had been made for such a service but that the request had been lost; and
- the provider of the diagnostic imaging service or that provider's agent or employee obtained confirmation from the requesting practitioner that the request had been made.

The lost request exemption is applicable only to services that the practitioner could originally request.

For details required for accounts/receipts see DIF.

Pre-existing diagnostic imaging practices

The legislation provides for exemption from the written request requirement for services provided by practitioners who have operated pre-existing diagnostic imaging practices. The exemption applies to the services covered by the following Items: 57712, 57715, 57901, 57902, 57903, 57912, 57915, 57921, 58100, 58103, 58106, 58108, 58109, 58112, 58115, 58521, 58524, 58527, 58700, 58924 and 59103.

To qualify for this "grandparent" exemption the providing practitioner must:

a) be treating his or her own patient;
b) have determined that the service was necessary;
c) have rendered between 17 October 1988 and 16 October 1990 at least 50 services (which resulted in the payment of Medicare benefits) of the kind which have been designated "R-type" services from 1 May 1991;
d) provide the exempted services at the practice location where the services which enabled the practitioner to qualify for the "grandparent" exemption were rendered; and
e) be enrolled in an approved continuing medical education and quality assurance program from 1 January 2001. For further information, please contact the Royal Australian College of General Practitioners (RACGP) on (03) 8699 0414 or Australian College of Rural and Remote Medicine (ACRRM) on (07) 3105 8200.

Benefits are only payable for services exempted under these provisions where the service was provided by the exempted medical practitioner at the exempted location. Exemptions are not transferable.

For details required for accounts/receipts see DIF.

Retention of requests

A 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 18 months commencing on the day on which the service was rendered.

A medical practitioner must, if requested by the Department of Human Services CEO, 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 the Department of Human Services CEO's request was made. An employee of the Department of Human Services is authorised to make and retain copies of or take and retain extracts from written requests or written confirmations of lost requests.

A medical practitioner who, without reasonable excuse, fails to comply with the above requirements is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine of $1000.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline to substantiate that a valid request existed (pathology or diagnostic imaging) which is located on the DHS website.

DIE... REGISTRATION OF SITE 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 the Department of Human Services for the purposes of Medicare.

Registered sites and bases for mobile equipment are allocated a Location Specific Practice Number (LSPN). The LSPN is a unique identifier comprising a six digit numeric and is required on all accounts, receipts and Medicare assignment of benefits forms for diagnostic imaging services before patients can receive Medicare benefits. In addition, benefits are not payable unless there is equipment of appropriate type listed on the register for the practice.

Sites or bases for mobile equipment need only register once. To maintain registration, sites are required to advise the Department of Human Services of any changes to their primary information within 28 days of the change occurring. Primary information is:

- proprietor details;
- ACN (for companies);
- business name and ABN;
- address of practice site or base for mobile equipment;
- type of equipment located at the site;
- information about any health care provider not employed at, or contracted to provide services for the site or base, who has an interest in any of the equipment listed on the register.

Every 12 months, the Department of Human Services will send the proprietor or authorised representative details of the information contained on the register for the practice site or base for mobile equipment. These details need to be either confirmed or updated (if necessary).

Registration will be suspended if a proprietor fails to respond to notices from the Department of Human Services 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 the Department of Human Services if the registration was obtained improperly (false information supplied) or if the proprietor fails to notify the Department of Human Services of primary information. A decision to cancel a registration will only be made following due consideration of a submission by the site or base. The proprietor may apply to the Administrative Appeals Tribunal for a review of this decision. If registration is cancelled involuntarily, the proprietor may not apply to re-register the site or base for a period of 12 months unless permitted to do so.

Proprietors of unregistered practices (including where the registration is under suspension or has been cancelled) need to either advise patients in writing or display a notice that no Medicare benefits will be payable for the diagnostic imaging services.

For full details about Location Specific Practice Numbers, including how to register a practice site. A list of LSPN registrations is available on the Department of Human Services' website at www.medicaraustralia.gov.au/yourhealth/our_services/lspn_search.htm and this allows practitioners and the general public to verify the registration status of practice sites eligible for Medicare benefits.

From 1 July 2010 practices applying for an LSPN will also need to apply for and be accredited under the Stage II Diagnostic Imaging Accreditation Scheme in order to be eligible to provide diagnostic imaging services under Medicare.

ACCREDITATION OF SITES UNDERTAKING DIAGNOSTIC IMAGING SERVICES

Background
In June 2007, legislation was enacted to amend the Health Insurance Act 1973 to establish a diagnostic imaging accreditation scheme under which mandatory accreditation would be linked to the payment of Medicare benefits for radiology and non-radiology services.

The Scheme commenced on 1 July 2008 and covered only practices providing radiology services. From 1 July 2010, the Scheme continued the accreditation arrangements for practices providing radiology services, and broadened the scope of the scheme to include practices providing non-radiology services such as cardiac ultrasound and angiography, obstetric and gynaecological ultrasound and nuclear medicine imaging services.

ACCREDITATION OF PRACTICES UNDERTAKING DIAGNOSTIC IMAGING SERVICES

Background
In 2007, the Diagnostic Imaging Accreditation Scheme (the Scheme) was established by the Health Insurance Amendment (Diagnostic Imaging Accreditation) Act 2007 to ensure Medicare funding is directed to diagnostic imaging services that are safe, effective and responsive to the needs of health care consumers.

The Scheme was implemented in two stages.

Stage 1
In 2008 Stage 1 of the Scheme commenced requiring practices providing radiology and some ultrasound services to meet a minimum of 3 entry level standards.

Stage 2
In 2009 the Scheme was broadened to mandate accreditation for all practices providing Medicare rebateable diagnostic imaging services and increasing the number of standards from 3 entry level Practice Standards to 15 full suite Practice Accreditation Standards.

The deadline for Practices to attain the full suite of accreditation standards was phased in to allow practices time to meet the increased number of standards. Practices accredited under Stage 1 of the Scheme were required to meet the new

standard by 1 July 2012, whereas Practices who gained entry into the Scheme in Stage 2 have until 2013 to become fully accredited.

First time accreditation
New practices entering the Scheme may choose to be accredited against either three entry-level Practice Standards or the full suite of Practice Accreditation Standards. Practices initially choosing to be accredited against the entry level Standards have a further period 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 Practice Standards and cannot apply for re-accreditation against the entry level Standards.

Medicare rebateable diagnostic imaging services
All Practices intending to render any diagnostic imaging services for the purpose of Medicare benefits must be accredited under the Scheme. This includes non-radiology services such as cardiac ultrasound and angiography, obstetrics and gynaecological ultrasound and nuclear medicine imaging services

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 providing non Medicare funded diagnostic imaging services are bound by the requirements of the Health Insurance Act 1973 (Div 5/Section 23DZZIAE) to 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

The Medical Imaging Accreditation Program (MIAP)
For a number of years the Royal Australian and New Zealand College of Radiologist (RANZCR) has delivered a voluntary accreditation program jointly with the National Association of Testing Authorities, Australia.

Practices participating in MIAP can seek recognition of their MIAP accreditation under the Scheme. 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 Accreditation Standards
The current Practice Accreditation Standards are made up of three entry level Practice Accreditation Standards and the full suite of Practice Accreditation Standards. If a practice is applying for accreditation against the entry level Practice Accreditation Standards, an accreditation decision will be made within 15 business days of the lodgement of an application for accreditation. If a practice is applying for accreditation against the full suite of Practice Accreditation Standards, an accreditation decision will be made 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.

<u>Entry Level Standards</u>
1. Registration and Licensing Standard
2. Radiation and Safety Standard
3. Equipment Inventory Standard

<u>Full Suite Accreditation Standards</u>
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 of Practice Accreditation 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 accreditation standards or the full suite Practice Accreditation Standards; or
- written evidence of accreditation under the Medical Imaging Accreditation Program (MIAP) jointly administered by the Royal Australian and New Zealand College of Radiologists (RANZCR) and the National Association of Testing Authorities Australia (NATA).

Renewal of Accreditation
Practices awarded accreditation against the full suite of Practice Accreditation 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:

Health and Disability Auditing Australia (HDAAu)	**Ph: 1800 601 696**
National Association of Testing Authorities (NATA)	**Ph: 1800 621 666**
Quality in Practice (QIP)	**Ph: 1300 888 329**

Further information
Website: www.diagnosticimaging.health.gov.au
Email: diagnosticimagingandaccreditation@health.gov.au
Phone: (02) 6289 8859.

DIF... 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 Location Specific Practice Number (LSPN) of the diagnostic imaging premises or mobile facility where the diagnostic imaging procedure was undertaken;

- if the professional service is provided by a specialist in diagnostic radiology the name and either the address of the place of practice, or the provider number, of that specialist;

- if the medical practitioner is not a specialist in diagnostic radiology the name and either the practice address or provider number of the practitioner who is claiming or receiving fees;

- for "R-type" (requested) services and services rendered subsequent to lost requests, the account or receipt or the Medicare assignment form must indicate the date of the request and the name and provider number, or the name and address, of the requesting practitioner.

    - services that are *self-determined* must be endorsed with the letters 'SD' to indicate that the service was self-determined. Services are classified as self determined when rendered:
    - **by a *consultant physician or specialist*, in the course of that consultant physician or specialist practicing his or her specialty (other than a specialist in diagnostic radiology), or**
    - **to provide *additional services* to those specified in the original request and the additional services are of the type that would have otherwise required a referral from a specialist or consultant physician; or**
- in a *remote area*, or
- **under a *pre-existing diagnostic imaging practice exemption.***

- *substituted services* the account etc. must be endorsed 'SS'.

- *emergencies*, the account etc. must be endorsed "emergency".

- *lost requests* the account etc. must be endorsed "lost request".

DIG... MAINTAINING RECORDS OF DIAGNOSTIC IMAGING SERVICES

Providers of diagnostic imaging services must keep records of diagnostic imaging services in a manner that facilitates retrieval on the basis of the patient's name and date of service. Records of R-type diagnostic imaging services must be retained for a period of 18 months commencing on the day on which the service was rendered.

The records must include the report by the providing practitioner on the diagnostic imaging service. For ultrasound services, where the service is performed on behalf of a medical practitioner the report must record the name of the sonographer.

- Where the provider *substitutes* a service for the service originally requested, the provider's records must include:
  - words indicating that the providing practitioner has consulted with the requesting practitioner and the date of consultation; or
  - if the providing practitioner has not consulted with the requesting practitioner, sufficient information to demonstrate that he or she has taken all reasonable steps to do so.

- For services rendered after a *lost request*, the records must include words to the effect that the request was lost but confirmed by the requesting practitioner and the manner of confirmation, eg. how and when.

- For *emergency services*, the records must indicate the nature of the emergency.

If requested by the Managing Director, the Department of Human Services, records retained by a providing practitioner must be produced to an officer of the Department of Human Services as soon as practicable but in any event within seven days after the day the Managing Director requests the production of those records. the Department of Human Services officers may make and retain copies, or take and retain extracts, of such records.

A medical practitioner who, without reasonable excuse, contravenes any of the above provisions is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine of $1000.

DIH... CONTRAVENTION OF STATE AND TERRITORY LAWS AND DISQUALIFIED PRACTITIONERS

Medicare benefits are not payable where a diagnostic imaging service is provided by, or on behalf of, a medical practitioner, and the provision of that service by that practitioner or any other person contravenes a State or Territory law which, directly or indirectly, relates to the use of diagnostic imaging procedures or equipment. The Managing Director of the Department of Human Services may notify the relevant State or Territory authorities if he/she believes that a person may have contravened a law of a State or Territory relating directly or indirectly to the use of diagnostic imaging procedures or equipment.

DII... PROHIBITED PRACTICES

Changes have been made to legislation relating to diagnostic imaging services provided under Medicare.

Amendments to the Health Insurance Act 1973 (the Act) relating to diagnostic services funded under Medicare came into effect on 1 March 2008. The changes were implemented following measures introduced in the *Health Insurance Amendment (Inappropriate and Prohibited Practices and other Measures) Act 2007*.

Who might be affected?

- Anyone who can provide or request a Medicare-funded diagnostic imaging service might be affected.
- 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;

Are there any benefits, other than those described in the Act, that are permitted?
- The Minister has determined that certain types of benefit are permitted. 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.

Further information on the *Health Insurance (Permitted Benefits – diagnostic imaging services) Determination 2008* can be found on the Department of Health website at www.health.gov.au/legislativeamendments

What are the penalties for those not complying with the provisions?
- If you breach the provisions, you could potentially be subject to a range of penalties, 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 website at www.health.gov.au/legislativeamendments

DIJ... 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 DID.

Rule A. When a medical practitioner renders two or more diagnostic imaging services to a patient on the same day, then:
the diagnostic imaging service with the highest Schedule fee has an unchanged Schedule fee; and
the Schedule fee for each additional diagnostic imaging service is reduced by $5.

Rule B. When a medical practitioner renders at least one R-type diagnostic imaging service and at least one consultation to a patient on the same day, there is a deduction to the Schedule fee for the diagnostic imaging service with the highest Schedule fee as follows:
if the Schedule fee for the consultation is $40 or more - by $35; or
if the Schedule fee for the consultation is less than $40 but more than $15 - by $15; or
if the Schedule fee for the consultation is less than $15 - by the amount of that fee.

The deduction under Rule B is made once only. If there is more than one consultation, the consultation with the highest Schedule fee determines the deduction amount. There is no further deduction for additional consultations.

A 'consultation' is a service rendered under an item from Category 1 of the Medicare Benefits Schedule (MBS), that is, items 1 to 10816 inclusive.

Rule C. When a medical practitioner renders an R-type diagnostic imaging service and at least one non-consultation service to the same patient on the same day, the Schedule fee for the diagnostic imaging service with the highest Schedule fee is reduced by $5.

A deduction under Rule C is made once only. There is no further deduction for any additional medical services.

For Rule C, a 'non-consultation' is defined as any following item from the MBS:
- Category 2, items 11000 to 12533;
- Category 3, items 13020 to 51318;
- Category 4, items 51700 to 53460;
- Cleft Lip and Palate services, items 75001 to 75854 (as specified in the 'Medicare Benefits for the treatment of cleft lip and cleft palate conditions' book.)

Pathology services are not included in Rule C.

When both Rules B and C apply, the sum of the deductions in the Schedule fee for the diagnostic imaging service with the highest Schedule fee is not to exceed that Schedule fee.

Ultrasound - Vascular
This rule applies to all vascular ultrasound items claimed on the same day of service ie whether performed at the same attendance by the same practitioner or at different attendances.

Where more than one vascular ultrasound service is provided to the same patient by the same practitioner on the same date of service, the following formula applies to the Schedule fee for each service:
- 100% for the item with the greatest Schedule fee
- plus 60% for the item with the next greatest Schedule fee
- plus 50% for each other item.

When the Schedule fee for some of the items are the same, the reduction is calculated in the following order:
- 100% for the item with the greatest Schedule fee and the lowest item number
- plus 60% for the item with the greatest Schedule fee and the second lowest item number
- plus 50% for each other item

Note: If 2 or more Schedule fees are equally the highest, the one with the lowest item number is taken to have the higher fee eg. Item 55238 and 55280, item 55238 would be considered the highest.

When calculating the benefit, it should be noted that despite the reduction, the collective items are treated as one service for the application of Rule A of the General Diagnostic Imaging Multiple Services rules and the patient gap. Examples can be found at the Department of Human Services' 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:
(a) the item with the highest schedule fee retains 100% of the schedule fee; and
(b) any other fee, except the highest is reduced by 50%.

Note: If 2 or more Schedule fees are equally the highest, the one with the lowest item number is taken to have the higher fee eg. Item 63322 and 63331, item 63322 would be considered the highest.

If the reduced fee is not a multiple of 5 cents, the reduced fee is taken to be the nearest amount that is a multiple of 5 cents.

In addition, the modifying item for contrast may only be claimed once for a group of services subject to this rule.

If a medical practitioner provides:
(a) 2 or more MRI services from subgroups 12 and 13 for the same patient on the same day; and
(b) 1 or more other diagnostic imaging services for that patient on that day
the amount of the fees payable for the MRI services is taken, for the purposes of this rule, to be an amount payable for 1 diagnostic imaging service in applying Rule A of the General Diagnostic Imaging Multiple Services rules.

DIK... GROUP I1 - ULTRASOUND

Professional supervision for ultrasound services – R-type eligible services

Ultrasound services (items 55028 to 55854) marked with the symbol *(R)* with the exception of items 55600 and 55603 are not eligible for a Medicare rebate unless the diagnostic imaging procedure is performed under the professional supervision of a:

(a) specialist or a consultant physician in the practice of his or her specialty who is available to monitor and influence the conduct and diagnostic quality of the examination, and if necessary to personally attend the patient; or

(b) practitioner who is not a specialist or consultant physician who meets the requirements of A or B hereunder, and who is available to monitor and influence the conduct and diagnostic quality of the examination and, if necessary, to personally attend the patient.

A. Between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner at the location where the service was rendered and the rendering of those services entitled the payment of Medicare benefits.

B. Between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner in nursing homes or patients' residences and the rendering of those services entitled payment of Medicare benefits.

If paragraph (a) or (b) cannot be complied with, ultrasound services are eligible for a Medicare rebate:

(i) in an emergency; or

(ii) in a location that is not less than 30 kilometres by the most direct road route from another practice where services that comply with paragraph (a) or (b) are available.

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

Sonographer accreditation

Sonographers performing medical ultrasound examinations (either R or NR type items) on behalf of a medical practitioner must be suitably qualified, involved in a relevant and appropriate Continuing Professional Development program and be Registered on the Register of Accredited Sonographers held by the Department of Human Services. For further information, please contact the Department of Human Services, Provider Liaison Section, on 132150 for the cost of a local call or the Australian Sonographer Accreditation Registry on (02) 9299 9785 or through their website at http://www.asar.com.au.

Eligibility for registration

In general, to be eligible for registration, the person must:

- hold an accredited postgraduate qualification in medical ultrasound; or
- be studying ultrasound; or
- have worked as a sonographer under the direction of a medical practitioner in Australia or New Zealand (conditions apply - for assessment of eligibility status, please contact the Australian Sonographer Accreditation Registry).

Report requirements

The sonographer's initial and surname is to be written on the report. The name of the sonographer is not required to be included on the copy of the report given to the patient. For the purpose of this rule, the "name" means the sonographer's initial and surname.

Benefits payable

As a rule, benefit is payable once only for ultrasonic examination at the one attendance, irrespective of the areas involved.

Except as indicated in the succeeding paragraphs, *attendance* means that there is a clear separation between one service and the next. For example, where there is a short time between one ultrasound and the next, benefits will be payable for one service only. As a guide, the Department of Human Services will look to a separation of three hours between services and this must be stated on accounts issued for more than one service on the one day.

Where more than one ultrasound service is rendered on the one occasion and the service relates to a non-contiguous body area, and they are "clinically relevant", (ie. the service is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered), benefits greater than the single rate may be payable. Accounts should be marked "non-contiguous body areas".

Benefits for two contiguous areas may be payable where it is generally accepted that there are different preparation requirements for the patient and a clear difference in set-up time and scanning. Accounts should be endorsed "contiguous body area with different set-up requirements".

Subgroup 1 – General Ultrasound
Post-void residual items 55084 and 55085
When a post-void residual is the only service clinically indicated and/or rendered, it is inappropriate to report a pelvic, urinary or abdominal ultrasound, instead of or in addition to this service (55084 or 55085). Similarly, if a complete pelvic, urinary or abdominal ultrasound is billed, it is inappropriate to bill separately for a post-void residual determination, since payment of this has already been included in the payment for the complete scans.

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

Subgroup 2 – Cardiac ultrasound
Transoesophageal echocardiography - Item 55135 and consequential amendment to Item 55130
The Medical Services Advisory Committee (MSAC) has reviewed intra-operative transoesophageal echocardiography and recommended that public funding for this procedure be supported on an interim basis and be restricted to assessment of cardiac valve competence following valve replacement or repair. Item 55135 has been developed for these indications in consultation with the Australian Society of Anaesthetists, the Australian Medical Association and the Cardiac Society of Australia and New Zealand. Indications other than those recommended by MSAC will continue to be funded under item 55130. Further research will be undertaken to assist MSAC in its future evaluation of the use of intra-operative transoesophageal echocardiography.

Subgroup 3 - Vascular ultrasound
Benefits payable
Medicare benefits are only payable for:
a maximum of two vascular ultrasound studies in a seven-day period. A vascular ultrasound study may include one or more items. Additionally where a patient is referred for a bilateral study of both arms or both legs (eg both arms for item 55238), the account should indicate 'bilateral' or 'left' and 'right' to enable benefit to be paid.

clinically relevant services, that is, the service is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered. Any decision to have a patient return on a different day to complete a multi-area diagnostic imaging service should only be made on the basis of clinical necessity.

Multiple Vascular Ultrasound Services – refer to DIJ
Separation of services on the one day/contiguous and non-contiguous body areas
These rules do not apply to the vascular ultrasound items and therefore will not impact on the MVUSSR.

Examination of peripheral vessels
Vascular ultrasound services can be claimed in conjunction with item 11612.

Subgroup 4: Urological ultrasound
Prostrate ultrasound (Items 55600 to 55604)
Benefits for these items are payable where the service is rendered in the following circumstances:

- a digital rectal examination of the prostate was personally performed by the medical practitioner who also personally rendered the ultrasound service; and
- the transducer probe or probes used meets specifications of normal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz and which can obtain both axial and sagittal scans in 2 planes at right angles; and
- the patient was assessed prior to the service by a medical practitioner recognised in one or more of the specialties specified, not more than 60 days prior to the ultrasound service.

Items 55600 and 55601 cover the situation where the service was rendered by a medical practitioner who **did not** assess the patient, whereas items 55603 and 55604 cover the situation where the service was rendered by a medical practitioner who **did** assess the patient.

Subgroup 5: Obstetric and Gynaecological ultrasound
NR Services
Medicare benefits are not payable for more than three NR-type ultrasound services in Subgroup 5 of Group I1 (ultrasound) that are performed on the same patient in any one pregnancy.

Clinical indications
For items where clinical indications are listed (items 55700, 55704, 55707, 55718, 55759 and 55768), or where a clinical indication is required (items 55712, 55721, 55764 and 55772) for performance of subsequent scans the referral must identify the relevant clinical indication for the service.

It should be noted that a patient must have previously had either a 55706 or 55709 ultrasound in the same pregnancy to be eligible to claim for either a 55712 or 55715 obstetric service. To be eligible to claim for either a 55721 or 55725 obstetric service, a patient must have previously had either a 55718 or 55723 ultrasound in the same pregnancy.

If the service is self-determined (items 55703, 55705, 55708, 55715, 55723, 55725, 55762, 55766, 55770 and 55774), the clinical condition or indication must be recorded in the medical practitioner's clinical notes.

Dating of pregnancy
When dating a pregnancy for the purpose of items 55700 to 55774, a patient is:
a) "less than 12 weeks of gestation" means up to 11 weeks and 6 days of pregnancy;
b) "12 to 16 weeks of gestation" means from 12 weeks 0 days of pregnancy up to 16 weeks plus 6 days of pregnancy (inclusive);
c) "17 to 22 weeks of gestation" means from 17 weeks 0 days of pregnancy up to 22 weeks plus 6 days of pregnancy (inclusive); or
d) "after 22 weeks of gestation" means from 23 weeks 0 days of pregnancy onwards
e) "after 24 weeks of gestation" means from 25 weeks 0 days of pregnancy onwards.

Nuchal Translucency Testing
Where a nuchal translucency measurement is performed when the pregnancy is dated by a crown rump length of 45-84mm in conjunction with items 55700 (R) or 55703 (NR) or 55704 (R) or 55705 (NR), then items 55707 (R) or 55708 (NR) should be claimed. If nuchal translucency measurement for risk of foetal abnormality is performed in conjunction with any additional condition in items 55700, 55703, 55704 or 55705, only one fee is payable.

It should be noted that the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) provides a credentialling program for providers of nuchal translucency scans. It is anticipated that use of items 55707 and 55708 will be restricted to credentialed medical practitioners and sonographers in the future.

Multiple pregnancies
Obstetric ultrasound items 55759 to 55774 cover scanning of a patient who is experiencing a multiple pregnancy. The items incorporate a fee adjustment in recognition of the added complexity and costs associated with scanning multiple pregnancies. Based on the recommendations of the profession, the items apply only to patients where a multiple pregnancy has been confirmed by ultrasound. The items include identical restrictions and provisions as the second and third trimester items (55706-55725), and include items for referred and non-referred services.

Obstetric ultrasound and non-metropolitan providers (Items 55712, 55721, 55764 and 55772)
Where a practitioner has obstetric privileges at a non-metropolitan hospital and refers for items 55712, 55721 and 55764 and 55772, the practitioner must confirm his/her eligibility by stating 'non-metropolitan obstetric privileges' on the referral form.

In relation to items 55712, 55721, 55764 and 55772, non-metropolitan area includes any location outside of the Sydney, Melbourne, Brisbane, Adelaide, Perth, Greater Hobart, Darwin or Canberra major statistical divisions, as defined in the Australian Standard Geographical Classification 2010 published by the Australian Bureau of Statistics (publication number 1216.0 of 2010).

Subgroup 6: Musculoskeletal (MSK) ultrasound
Personal attendance
Medicare Benefits are only payable for a musculoskeletal ultrasound service (items 55800 to 55854) if the medical practitioner responsible for the conduct and report of the examination personally attends during the performance of the scan and personally examines the patient. Services that are performed because of medical necessity in a remote location are exempt from this requirement – see DID for definition of remote area. Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Equipment
Items 55800 to 55854 only apply to an ultrasound service performed using an ultrasound system which has available on-site a transducer capable of operation at, at least 7.5 megahertz.

Multiple Musculoskeletal Ultrasound Scans - items 55800 to 55846
Generally Medicare benefits are payable for more than one musculoskeletal ultrasound scan performed on the same day, however the scans are subject to Rule A of the general diagnostic imaging multiple services rules.

It is not permitted to split a bilateral scan. Where bilateral ultrasound scans are performed (or more than one area is scanned under items 55844 or 55646) the relevant item should be itemised once only on accounts and receipts or Medicare bulk billing forms. For example if both shoulders are scanned, Item 55808 (or 55810 as the case may be) should be

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

Shoulder and knee (Items 55808 and 55810 and 55828 and 55830)
Benefits for shoulder ultrasound items 55808 and 55810 are only payable when referral is based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone.

Benefits for knee ultrasound items 55828 and 55830 are only payable when referral is based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee conditions including:
- meniscal and cruciate ligament tears; and
- assessment of chondral surfaces.

DIL... GROUP I2 - COMPUTED TOMOGRAPHY (CT)

Capital sensitive items
A reduced Schedule fee applies to CT services provided on equipment that is 10 years old or older. This equipment must have been first installed in Australia ten or more years ago, or in the case of imported pre-used equipment, must have been first manufactured ten or more years ago. A range of items cover services provided on older equipment. These items are:

56041, 56047, 56050, 56053, 56056, 56062, 56068, 56070, 56076, 56141, 56147, 56259, 56341, 56347, 56441, 56447, 56449, 56452, 56541, 56547, 56659, 56665, 56841, 56847, 57041, 57047, 57247, 57345, 57355, 57361.

These items are identified by the addition of the letter '(NK)' at the end of the item. These items should be used where services are performed on equipment ten years old or older, except where equipment is located in a remote area when items with the letter "K", as described below, will apply.

Items 56001 to 57356 (which contain the symbol (K) at the end of the item should be used for services which are performed on a date which is less than ten years after the date on which the CT equipment used in performing the service was first installed in Australia. In the case of imported pre-used CT equipment, the services must have been performed on a date which is less than ten years from the first date of manufacture of the equipment.

For the purposes of capital sensitive items CT equipment includes the following components:
(a) a gantry;
(b) a couch;
(c) a computer; and
(d) an operator station.

Professional supervision
CT services (items 56001 to 57356) are not eligible for a Medicare rebate unless the service is performed:
(a) under the professional supervision of a specialist in the specialty of diagnostic radiology who is available:
  (i) to monitor and influence the conduct and diagnostic quality of the examination; and
  (ii) if necessary, to personally attend on the patient; or
(b) if paragraph (a) cannot be complied with
  (i) in an emergency, or
  (ii) because of medical necessity in a remote area – refer to DID.4.4 for definition of remote area.

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

Items 57360 and 57361 apply 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:
  (i) to monitor and influence the conduct and diagnostic quality of the examination; and
  (ii) 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 paragraph (a) and (b) cannot be complied with
  (i) in an emergency, or
  (ii) because of medical necessity in a remote area – refer to DID.4.4 for definition of remote area.

Use of a hybrid PET/CT or SPECT/CT machine
CT scans rendered on hybrid Positron Emission Tomography (PET)/CT or hybrid Single Photon Emission Computed Tomography (SPECT)/CT units are eligible for a Medicare benefit provided:

- the CT scan is not solely used for the purposes of attenuation correction and anatomical correlation of any associated PET or SPECT scan; and
- the CT scan is rendered under the same conditions as those applying to services rendered on stand-alone CT equipment. For example, the service would need to be properly requested and performed under the professional supervision of a specialist radiologist, including specialist radiologists with dual nuclear medicine qualifications.

Scan of more than one area
Items have been provided to cover the common combinations of regions – see Multiple Regions below. However, where regions are scanned on the one occasion which are not covered by a combination item, for example, item 56220 (scan of the spine) with item 56619 (scan of extremities), both examinations would attract separate benefit.

Multiple regions
Items have been provided to cover the common combinations of regions. The items relating to the individual contiguous regions should not be used when scans of multiple regions are performed.

More than one attendance of the patient to complete a scan
Items 56220 to 56240 and 56619 to 56665 apply once only for a service described in any of those items, regardless of the number of patient attendances required to complete the service. For example, where a request relates to two or more regions of the spine and one region only is scanned on one occasion with the balance of regions being scanned on a subsequent occasion, benefits are payable for one combination service only upon completion.

Pre contrast scans
Pre contrast scans are included in an item of service with contrast medium only when the pre-contrast scans are of the same region.

Head
Exclusion of acoustic neuroma
If an axial scan is performed for the exclusion of acoustic neuroma, Medicare benefits are payable under item 56001 or 56007.

Assessment of headache
If the service described in item 56007 or 56047 is used for the assessment of headache of a patient, the fee mentioned in the item applies only if:
(a) a scan without intravenous contrast medium has been undertaken on the patient; and
(b) the service is required because the result of the scan is abnormal.

This rule applies to a patient who:
(i) is under 50 years; and
(ii) is (apart from the headache) otherwise well; and
(iii) has no localising symptoms or signs; and
(iv) has no history of malignancy or immunosuppression.

Spine
CT items exist which separate the examination of the spine into the cervical, thoracic and lumbosacral regions. These items are 56220 to 56240 inclusive. They include items for CT scans of two regions of the spine (56233, 56234, 56235 and 56236) and for all three regions of the spine (56237, 56238, 56239 and 56240). Restrictions apply to the following items:

(a) item 56233 is used where two examinations of the kind referred to in items 56220, 56221 and 56223 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed.
(b) item 56234 is used where two examinations of the kind referred to in items 56224, 56225 and 56226 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed.
(c) item 56235 is used where two examinations of the kind referred to in items 56227, 56228 and 56229 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed

(d) item 56236 is used where two examinations of the kind referred to in items 56230, 56231 and 56232 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed

Example: for a CT examination of the spine where the cervical and thoracic regions are to be studied (item 56233), item numbers 56220 and 56221 must be specified.

With intrathecal contrast medium (Item 56219)
The item incorporates the cost of contrast medium for intrathecal injection and associated x-rays. Benefits are not payable for this item when rendered in association with myelograms (Item 59724). Where a myelogram is rendered under item 59724 and a CT is necessary, the relevant item would be scan of spine without intravenous contrast (Item 56220, 56221 or 56223).

Upper abdomen and pelvis
Items 56501, 56507, 56541 and 56547 are not eligible for Medicare Benefits if performed for the purpose of performing a virtual colonoscopy (otherwise known as CT colonography and CT colography). CT Colonography is covered by items 56553 and 56555.

Computed Tomography of the Colon (Items 56553 and 56555)
In items 56553 and 56555 the terms 'high risk' and 'incomplete colonoscopy' are defined as follows:

High Risk
Asymptomatic people fit into this category if they have:
• three or more first-degree or a combination of first-degree and second-degree relatives on the same side of the family diagnosed with bowel cancer (suspected hereditary non-polyposis colorectal cancer or NPCC), or
• two or more first-degree or second-degree relatives on the same side of the family diagnosed with bowel cancer, including any of the following high-risk features:
– multiple bowel cancers in the one person
– bowel cancer before the age of 50 years
– at least one relative with cancer of the endometrium, ovary, stomach, small bowel, ureter, biliary tract or brain
• at least one first-degree relative with a large number of adenomas throughout the large bowel (suspected familial 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.

Spiral angiography
Items 57350 and 57355 and items 57351 and 57356
CT spiral angiography items 57351 and 57356 apply under certain circumstances specified in the items including where a service to which items 57350 or 57355 have been performed on the same patient within the previous 12 months, whereas items 57350 and 57355 apply under the circumstances specified in the items and where the service has not been performed on the same patient within the previous 12 months.

Computed tomography of the coronary arteries (Items 57360 and 57361)
Payment of Medicare rebates for items 57360 and 57361 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). The descriptors for CT spiral angiography items 57350, 57351, 57355 and 57356 and CT chest items 56301, 56307, 56341, 56347, 56801, 56807, 56841, 56847, 57001, 57007, 57041 and 57047 clarify that they are not to be used to image the coronary arteries.

DIM... GROUP I3 - DIAGNOSTIC RADIOLOGY

Examination and report
As for all diagnostic imaging services, the benefits allocated to each item from 57506 to 60509 inclusive cover the total service, ie. the image, reading and report. Separate benefits are not payable for individual components of the service, eg preliminary reading. Benefits are not separately payable for associated plain films involved with these items.

Exposure of more than one film
Where the radiographic examination of a specific area involves the exposure of more than one film, benefits are payable once only, except where special provision is made in the description of the item for the inclusion of all films taken for the purpose of the examination. This means that if a x-ray of the foot is requested, regardless of the number of exposures from different angles, the completed service comprises x-ray of the foot by one or more exposures and the report. The exception to this would be the plain x-ray of the spine items (58100 to 58115) where the item number differs dependent upon the regions of the spine that are examined at the same occasion, ie. 58112 applies where two regions are examined.

Comparison X-rays
Where it is necessary for one or more films of the opposite limb to be taken for comparison purposes, benefits are payable for radiographic examination and reporting of one limb only. Comparison views are considered to be part of the examination requested.

Subgroup 4: Radiographic examination of the spine
Multiple regions
Multiple region items require that the regions of the spine to be studied must be specified on any account issued or patient assignment form completed.

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 (ie from items 58100, 58103, 58106 and 58109).

Example: for a radiographic examination of the spine where the cervical and thoracic regions are to be studied, item numbers 58100 and 58103 must be specified on any account issued or patient assignment forms completed.

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 & 58108 – spine, three and four region

For three and four region radiographic examinations items 58115 and 58108 do not apply when requested by a physiotherapist, chiropractor or osteopath.

Items 58120 and 58121

Items 58120 and 58121 apply to physiotherapists, chiropractors and osteopaths who request a three or four region x-ray and only allow a benefit for one of the items, per patient, per calendar year.

Hand and wrist combination X-ray
An examination of the hand and the wrist on the same side should be claimed as item 57512 (NR) or 57515 (R). If items 57506 (NR) or 57509 (R) are claimed for multiple non-adjacent areas on the same side, or areas on different sides, the account should include annotation on this eg L and R hand, hand and humerus.

Images produced using Dual Energy X-ray Absorptiometry (DEXA) equipment
X-ray items of the spine 58100 to 58115 and hip 57712 and 57715 cannot be claimed when images are produced using Dual Energy X-ray Absorptiometry (DEXA) equipment.

Subgroup 8: Radiographic examination of alimentary tract and biliary system
Plain abdominal film (Items 58900/58903)
Benefits are not attracted for Items 58900/58903 in association with barium meal examinations or cholecystograms whether provided on the same day or previous day. Preliminary plain films are covered in each study.

Subgroup 10: Radiographic examination of the breasts
Request requirements (items 59300 and 59303)
Benefits under items 59300 and 59303 are attracted only where the patient has been referred in specific circumstances as indicated in the description of the items. To facilitate these provisions, the requesting medical practitioner is required to

include in the request the clinical indication for the procedure. The requesting practitioner must personally sign the request.

The reference to "with or without thermography" has been removed from the item descriptor for items 59300 and 59303 with effect from 1 November 2003. The Radiology Management Committee (RMC) at its meeting of 12 August 2003, agreed that there is no current scientific evidence to support the use of thermography in the early detection of breast cancer and in the reduction of mortality.

Professional supervision
Mammography services (items 59300 to 59318) are not eligible for a Medicare rebate unless the diagnostic imaging procedure is performed under the professional supervision of a:
(a) specialist in the specialty of diagnostic radiology who is available to monitor and influence the conduct and diagnostic quality of the examination, and, if necessary, to personally attend on the patient; or
(b) if paragraph (a) cannot be complied with:
(i) in an emergency; or
(ii) because of medical necessity in a remote location.
Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Subgroup 12: Radiographic examination with opaque or contrast media
Myelogram (Item 59724)
Benefits are not payable where a myelogram is rendered in association with a CT myelogram (Item 56219 - see DIL.9.1). Where it is necessary to render a CT and a myelogram, CT Items 56220, 56221 and 56223 would apply.

Subgroup 13: Angiography
Angiography services - meaning of (K) and (NK)
A reduced Schedule fees applies to cardiac angiography services provided on equipment that is 10 years old or older. This equipment must have been first installed in Australia ten or more years ago, or in the case of imported pre-used equipment, must have been first manufactured ten or more years ago.

A range of items cover services provided on older equipment. These items are 59971, 59972, 59973 and 59974, are identified by the addition of the letters '(NK)' at the end of the item and should be used where services are performed on equipment ten years old or older.

Items 59903, 59912, 59925 and 59970 have the letter '(K)' included at the end of the item. These items should be used where services are performed on equipment first installed in Australia less than ten years ago. In the case of imported pre-used equipment, the services must have been performed on a date which is less than ten years from the first date of manufacture of the equipment.

Digital subtraction angiography (DSA) (Items 60000-60078)
Benefits are payable only where these services are rendered in an angiography suite (a room that contains only equipment designed for angiography that is able to perform digital subtraction or rapid-sequence film angiography). Benefits are not payable when these services are rendered using mobile DSA imaging equipment as these services are covered by item 59970.

Each item includes all preparation and contrast injections other than for selective catheterisation. For Digital Subtraction Angiography (DSA), benefits are payable for a maximum of 1 DSA item (from Items 60000 to 60069). For selective DSA - 1 DSA item (from Items 60000 to 60069) and 1 item covering selective catheterisation (from 60072, 60075 or 60078).

If a DSA examination covers more than one of the specified regions/combinations, then the region/combination forming the major part of the examination should be selected, with itemisation to cover the total number of film runs obtained. A run is the injection of contrast, data acquisition, and the generation of a hard copy record.

Subgroup 16: Preparation for radiological procedure
Preparation items (Items 60918 and 60927)
Items 60918 and 60927 apply only to the preparation of a patient for a radiological procedure for a service to which any of items 59903 to 59974 apply. A report is not required for these services.

DIN... GROUP I4 - NUCLEAR MEDICINE IMAGING

General

Benefits for a nuclear scanning service are only payable when the service is performed by a specialist or consultant physician, or by a person acting on behalf of the specialist and the final report of the service is compiled by the specialist or consultant physician who performed the preliminary examination of the patient and the estimation and administration of the dosage.

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

Credentialling for nuclear medicine imaging services

Payment of Medicare rebates for nuclear medicine imaging services is limited to specialists or consultant physicians who are credentialled by the Joint Nuclear Medicine Credentialling and Accreditation Committee of the Royal Australian College of Physicians (RACP) and the Royal Australian and New Zealand College of Radiologists (RANZCR). The scheme has been developed by the profession in consultation with Government to ensure that specialists in nuclear medicine are appropriately trained and licensed, provide appropriate personal supervision of procedures and are involved in ongoing continuing medical education.

For information regarding the Scheme and for application forms, please phone the RACP or RANZCR.

Radiopharmaceuticals

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

Single Photon Emission Computed Tomography (SPECT)

Where SPECT has been performed in conjunction with another study and is not covered under the item descriptor or is not covered under Item 61462, no Medicare benefit is payable for the SPECT study.

Single 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.

Hepatobiliary study (pre-treatment) (Item 61360)

Item 61360 - the standard hepatobiliary item - also includes allowance of the pre-procedural CCK administration for preparatory emptying of the gall bladder and also morphine augmentation.

Hepatobiliary study (infusion) (Item 61361)

Item 61361 applies specifically to a standard hepatobiliary study to which has been added an infusion of sinaclide (CCK-8) following which acquisition is continued and quantification of gallbladder ejection fraction and/or common bile duct activity time curves are performed.

Whole body studies (Items 61426-61438)

"Whole body" studies must include the trunk, head and upper and lower limbs down to the elbow and knee joints respectively, whether acquired as multiple overlapping camera views or whole body sweeps (runs) with additional camera views as required. Any study that does not fulfil these criteria is a localised study.

Repeat studies (Item 61462)

Item 61462 covers repeat planar (whole body or localised) and/or SPECT imaging performed on a separate occasion using the same administration of radiopharmaceutical. The repeat planar and SPECT imaging when performed on a separate occasion using the same administration of radiopharmaceutical should be itemised as item 61462 and the original item and date of service should be indicated for reference purposes.

This item does not apply to bone scans, adrenal studies or gastro-oesophageal reflux studies, myocardial perfusion studies, colonic transit or CFS transport studies, where allowance for performance of the delayed study is incorporated into the baseline benefit fee.

Thyroid study (Item 61473)
Item 61473 incorporates the measurement of thyroid uptake on a gamma camera using a proven technique, where clinically indicated.

Positron Emission Tomography (PET; Items 61523 to 61646).
In patients with Hodgkin's and non- Hodgkin's lymphoma (excluding indolent non- Hodgkin's 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.

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:

1. performed by a:

    a) 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

    b) practitioner who is a Fellow of either 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;

2. 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;

3. provided using equipment that meets

    a) The Requirements for PET Accreditation (Instrumentation & Radiation Safety) 2nd Edition (2012) issued by the Australian and New Zealand Society of Nuclear Medicine Inc;

    b) The NEMA Standards Publications NU 2-2007, Performance Measurements of Positron Emission Tomographs, published by the National Electrical Manufacturers association (USA).

4. 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 the Department of Human Services.

DIO... GROUP I5 - MAGNETIC RESONANCE IMAGING

Itemisation
MRI items in Group I5, items 63001 to 63561, are divided into subgroups defined according to the area of the body to be scanned, (ie head, spine, musculoskeletal system, cardiovascular system or body) and the number of occasions in a defined period in which Medicare benefits may be claimed by a patient. Subgroups are divided into individual items, with each item being for a specific clinical indication.

Eligible services
Group I5 items 63001 to 63497 apply only to a MRI or MRA service performed:

a) on request by a recognised specialist or consultant physician, where the request made in writing identifies the clinical indication for the service;
b) under the professional supervision of an eligible provider; and
c) with eligible equipment.

Group I5 items 63464 to 63476 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 eligible equipment and partial eligible equipment.

Group I5 items 63507 to 63561 apply 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 and partial eligible equipment.

Group I5 items 63491 to 63497 to MRI 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 and partial eligible equipment.

Requests
A request must be in writing and identify the clinical indications for the service.

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

- All dental specialists, prosthodontists, oral and maxillofacial surgeons, oral medicine specialists and oral pathology specialists may request item 63334 – scan of musculoskeletal system for derangement of the temporomandibular joint (s); 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.

Professional supervision
Group I5 items must be performed as follows:

a) under the professional supervision of an eligible provider who is available to monitor and influence the conduct and diagnostic quality of the examination, including, if necessary, by personal attendance on the patient; or
b) if paragraph (a) is not complied with:
    i. in an emergency; or
    ii. because of medical necessity, in a remote location (refer to DID).

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

Eligible providers
In Group I5, an eligible provider is a specialist in diagnostic radiology who satisfies the Department of Human Services that:

a) he or she is a participant of the Royal Australian and New Zealand College of Radiologists' (RANZCR) Quality and Accreditation Program; and
b) the equipment he or she proposes to use for providing services of the kind mentioned in Group I5 is eligible equipment or partial eligible equipment.

Eligible Provider declaration
The specialist must give the Department of Human Services a statutory declaration:

a) stating that he or she is enrolled in the RANZCR Quality and Accreditation Program;
b) specifying the location of the MRI equipment;
c) specifying the kinds of diagnostic imaging equipment offered at the location;
d) stating the date of installation of the equipment (and the time of installation if this occurred on 12 May 1998); and
e) if the equipment had not been installed before 7.30pm on 12 May 1998 (Eastern Standard Time), the specialist must also give the Department of Human Services a copy of the contract for the purchase or lease of the equipment.

In addition the Department of Human Services may request further supporting documentation or information. Specialists or consultant physicians are advised to contact the Provider Liaison Section, the Department of Human Services on 132 150 prior to lodging a declaration.

Eligible equipment is equipment which is:

a) is located at premises of a comprehensive practice; and
b) is made available to the practice by a person:

i. who is subject to a deed with the Commonwealth that relates to the equipment; and
ii. 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 is:
Equipment that:

a) is located at premises of a comprehensive practice; and
b) is made available to the practice by a person:
    i. who is subject to a deed with the Commonwealth that relates to the equipment; and
    ii. 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 and Ageing's website at http://www.health.gov.au

Number of eligible services

- Items have been placed in subgroups according to frequency restrictions for Medicare eligibility as follows:
- Services in subgroups 1, 4, 6, 8, 11 and 18 have no frequency restriction.
- Services in subgroups 16 and 19 may be claimed on one occasion in any 12-month period.
- Services in subgroups 13, 14 and 17 may be claimed on two occasions in any 12-month period.
- Services in subgroups 2, 3, 5, 7, 9, 10, 12, 15, 21 33 and 34 may be claimed on three occasions only in any 12-month period.
- Items 63470 or 63473 in Subgroup 20 may be claimed only once in a patient's lifetime.
- Items 63476 in Subgroup 20 may be claimed only once in a patient's lifetime.
- Items in subgroup 22 may only be ordered in conjunction with an eligible MRI/MRA service.
- Items in subgroup 32 for item 63501 and 63502 may be claimed only one in a patient's lifetime, and 63504 and 63505 have no restrictions.

Example : Item 63271 in subgroup 10 can be claimed by a patient on three occasions in any 12 month period. If the patient had claimed Medicare benefits for the following:

Item	**Date of service**
63271	10/12/04
63271	18/4/05
63271	16/10/05
63271	11/12/05

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

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

The frequency restrictions are therefore considered to be rolling restrictions and not based on calendar or financial years.

In addition, restrictions on the number of services of the kind described in subgroup 12 apply to specific anatomical sites. Where an item description applies to more than one anatomical site the restriction on the number of services applies to each site.

– Item 63328, MRI scan for derangement of the knee or its supporting structures, applies to two specific anatomical sites, ie, right knee and left knee. Each anatomical site may be scanned up to 3 times in any 12-month period.

DIP... MANAGEMENT OF BULK-BILLED SERVICES

Additional bulk billing payment for diagnostic imaging services (item 64990 and 64991)
Item 64990 operates in the same way as item 10990 and item 64991 operates in the same way as item 10991, 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.

DIQ... BULK BILLING INCENTIVE

To provide an incentive to bulk-bill, for out of hospital services that are bulk billed the schedule fee is reduced by 5% and rebates paid at 100% of this revised fee (except for item 61369, and all items in Group I5 - Magnetic Resonance Imaging). For items in Group I5 - Magnetic Resonance Imaging, the bulk billing incentive for out of hospital services is 100% of the Schedule Fee listed in the table.

DIR... CAPITAL SENSITIVITY MEASURE FOR DIAGNOSTIC IMAGING EQUIPMENT

Almost all services listed in the Diagnostic Imaging Services Table of the Medicare Benefits Schedule (MBS), excluding Positron Emission Tomography (PET) services, have two different schedule fees – schedule '(K)' items (100 per cent of the MBS fee) and schedule '(NK)' items (approximately 50 per cent of the MBS fee) for diagnostic imaging services provided on aged equipment.

This is known as the 'capital sensitivity measure', and it is in place for almost all diagnostic imaging equipment providing services (excluding PET) under Medicare. The measure is intended to improve the quality of diagnostic imaging services by encouraging providers to upgrade and replace aged equipment as appropriate.

On 27 November 2013, the remote location exemptions provisions that apply to CT items 56001–57361 and angiography items 59903-59974 were amended so they are consistent with other diagnostic imaging modalities.

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 RA inner regional areas, where the location was previously under the Rural, Remote and Metropolitan Area (RRMA) classification system, RRMA4 or RRMA5.

As there may be a number of diagnostic imaging providers which met the previous exemption criteria, but not the current criteria, a grandfathering provision will be implemented. A diagnostic imaging provider which was eligible to claim schedule '(K)' items for CT and angiography services because they met the previous exemption criteria prior to 27 November 2013, may claim schedule '(K)' items until 1 July 2016. This transition period will allow affected providers an opportunity to upgrade or replace their equipment.

As part of the 2014-15 Federal Budget the Government announced *the 'Medicare Benefits Schedule – revised capital sensitivity provisions for diagnostic imaging equipment'* measure, which will strenthen the quality and safety of MBS diagnostic imaging services through alignment and consistency of the capital sensitivity measure across all modalities (except PET).

This measure includes:

- the extension of the capital sensitivity measure to all angiography services, including the previously excluded MBS items 60000 to 60078;
- introduction of a 'maximum extended life age' of 15 years for CT and angiography services; and
- increasing the 'maximum extended life age' for MRI services to 20 years.

The changes will take effect on 1 January 2015.

After 1 January 2015, any CT and angiography machine that has not reached maximum extended life age (15 years) but has reached its new effective life age, and is upgraded before 1 January 2015 is eligible for K items from 1 January 2015, until the machine reached its maximum extended life age.

After 1 January 2015, any CT and angiography machine that has not reached its maximum extended life age (15 years) but has reached its new effective life age, and is upgraded between 1 January 2015 and 1 January 2016 , is eligible for K items on and from the day that it is upgraded until the machine reached its maximum extended life age.

Further detail

For full details about the rules for claiming the schedule '(K)' and schedule '(NK)' items, the exemptions, and the definition of upgrade, providers should access the Department of Health's website at: www.health.gov.au/capitalsensitivity

DIS... RESTRICTION ON ITEM 55054

The Health Insurance (General Medical Services Table) Regulations now require that an item in Group T10 (Relative Value Guide) cannot be claimed in association with item 55054 (ultrasound when used in conjunction with procedures). This came into effect on 1 November 2012.

The use of ultrasound guidance provided in association with anaesthetic procedures is currently being assessed by the Medical Services Advisory Committee (MSAC) for safety, effectiveness and cost-effectiveness (MSAC Application 1183 - Ultrasound imaging in the practice of anaesthesia).

Medicare rebates 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.

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.

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

Higher rates of benefits are also provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons).

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.

GROUP I1 - ULTRASOUND

SUBGROUP 1 - GENERAL

55005	HEAD, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55	**Benefit:** 75% = $40.95	85% = $46.40
55007	HEAD, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95	**Benefit:** 75% = $14.25	85% = $16.15
55008	ORBITAL CONTENTS, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55	**Benefit:** 75% = $40.95	85% = $46.40
55010	ORBITAL CONTENTS, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95	**Benefit:** 75% = $14.25	85% = $16.15
55011	NECK, 1 or more structures of, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55	**Benefit:** 75% = $40.95	85% = $46.40
55013	NECK, 1 or more structures of, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95	**Benefit:** 75% = $14.25	85% = $16.15
55014	Abdomen, ultrasound scan of (including scan of urinary tract when performed), if: (a) the patient is referred by a medical practitioner or participating nurse practitioner; and (b) if the patient is referred by a medical practitioner—the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) if the patient is referred by a participating nurse practitioner—the nurse practitioner does not have a business or financial arrangement with the providing practitioner; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (e) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (f) within 24 hours of the service, a service mentioned in item 55017, 55038, 55067 or 55065 is not performed on the same patient by the providing practitioner (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.65	**Benefit:** 75% = $41.75	85% = $47.35
55016	ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service to which an item in Subgroup 4,applies where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95	**Benefit:** 75% = $14.25	85% = $16.15

55017	Urinary tract, ultrasound scan of, if: (a) the patient is referred by a medical practitioner; and (b) the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (e) within 24 hours of the service, a service mentioned in item 55014, 55038, 55067 or 55065 is not performed on the same patient by the providing practitioner (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55019	URINARY TRACT, ultrasound scan of, but not being a service associated with the service to which an item in Subgroup 4,applies, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55023	SCROTUM, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.75 **Benefit:** 75% = $41.10 85% = $46.55
55025	SCROTUM, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (NK) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55026	ULTRASONIC CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55028	HEAD, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55029	HEAD, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55030	ORBITAL CONTENTS, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55031	ORBITAL CONTENTS, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55032	NECK, 1 or more structures of, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75

55033	NECK, 1 or more structures of, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55036	Abdomen, ultrasound scan of (including scan of urinary tract when performed), if: (a) the patient is referred by a medical practitioner or participating nurse practitioner for ultrasonic examination; and (b) if the patient is referred by a medical practitioner—the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) if the patient is referred by a participating nurse practitioner—the nurse practitioner does not have a business or financial arrangement with the providing practitioner; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (e) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (f) within 24 hours of the service, a service mentioned in item 55017, 55038, 55067 or 55065 is not performed on the same patient by the providing practitioner (R) (K) *(See para DIQ of explanatory notes to this Category)* **Fee:** $111.30 **Benefit:** 75% = $83.50 85% = $94.65
55037	ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55038	Urinary tract, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination; and (b) the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (e) within 24 hours of the service, a service mentioned in item 55017, 55036, 55067 or 55065 is not performed on the same patient by the providing practitioner (R) (K) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55039	URINARY TRACT, ultrasound scan of, but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55048	SCROTUM, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.50 **Benefit:** 75% = $82.15 85% = $93.10
55049	SCROTUM, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55054	ULTRASONIC CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this Group applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75 **Extended Medicare Safety Net Cap:** $87.30

55059	BREAST, one, ultrasound scan of, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $49.15 **Benefit:** 75% = $36.90 85% = $41.80
55060	BREAST, one, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $17.05 **Benefit:** 75% = $12.80 85% = $14.50
55061	BREASTS, both, ultrasound scan of, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55062	BREASTS, both, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55063	Urinary bladder, ultrasound scan of, by any or all approaches, if: (a) the patient is referred by a medical practitioner for ultrasonic examination; and (b) the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) within 24 hours of the service, a service mentioned in item 11917, 55014, 55017, 55036, 55038, 55600, 55601, 55603, 55604, 55067 or 55065 is not performed on the same patient by the providing practitioner (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $49.15 **Benefit:** 75% = $36.90 85% = $41.80
55064	Urinary bladder, ultrasound scan of, by any or all approaches, if: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (c) within 24 hours of the service, a service mentioned in item 11917, 55016, 55019, 55037, 55039, 55600, 55601, 55603, 55604, 55068 or 55069 is not performed on the same patient by the providing practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $17.05 **Benefit:** 75% = $12.80 85% = $14.50
55065	PELVIS, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2, or 3, applies; and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (e) the service is not performed with item 55014, 55017, 55036 or 55038 on the same patient within 24 hours (R)(K) *(See para DIQ of explanatory notes to this Category)* **Fee:** $98.25 **Benefit:** 75% = $73.70 85% = $83.55

55067	PELVIS, ultrasound scan of, by any or all approaches, where: a) the patient is referred by a medical practitioner; and b) the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and d) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and e) within 24 hours of the service, a service mentioned in item 55014, 55017, 55036 or 55038 is not performed on the same patient by the providing practitioner (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $50.25 **Benefit:** 75% = $37.70 85% = $42.75
55068	PELVIS, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this Group applies; and (c) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs (NR)(K) *(See para DIQ of explanatory notes to this Category)* **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75
55069	PELVIS, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this Group applies; and (c) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $17.85 **Benefit:** 75% = $13.40 85% = $15.20
55070	BREAST, one, ultrasound scan of, where: (a) the patient is referred by a referring practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $98.25 **Benefit:** 75% = $73.70 85% = $83.55
55073	BREAST, one, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $34.05 **Benefit:** 75% = $25.55 85% = $28.95
55076	BREASTS, both, ultrasound scan of, where: (a) the patient is referred by a referring practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55079	BREASTS, both, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55084	Urinary bladder, ultrasound scan of, by any or all approaches, if: (a) the patient is referred by a medical practitioner; and (b) the medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) within 24 hours of the service, a service mentioned in item 11917, 55014, 55017, 55036, 55038, 55600, 55601, 55603, 55604, 55067 or 55065 is not performed on the same patient by the providing practitioner (R) (K) *(See para DIQ of explanatory notes to this Category)* **Fee:** $98.25 **Benefit:** 75% = $73.70 85% = $83.55

	Urinary bladder, ultrasound scan of, by any or all approaches, if: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (c) within 24 hours of the service, a service mentioned in item 11917, 55016, 55019, 55037, 55039, 55600, 55601, 55603, 55604, 55068 or 55069 is not performed on the same patient by the providing practitioner (NR) (K) *(See para DIQ of explanatory notes to this Category)* **Fee:** $34.05 **Benefit:** 75% = $25.55 85% = $28.95
55085	
	SUBGROUP 2 - CARDIAC
	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $230.65 **Benefit:** 75% = $173.00 85% = $196.10
55113	
	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of suspected or known acquired valvular, aortic, pericardial, thrombotic, or embolic disease, or heart tumour (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $230.65 **Benefit:** 75% = $173.00 85% = $196.10
55114	
	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of symptoms or signs of congenital heart disease (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $230.65 **Benefit:** 75% = $173.00 85% = $196.10
55115	
	EXERCISE STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before exercise (baseline) from at least three acoustic windows and matching recordings from the same windows at, or immediately after, peak exercise, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup applies (with the exception of items 55118 and 55130). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $261.65 **Benefit:** 75% = $196.25 85% = $222.45
55116	
	PHARMACOLOGICAL STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before drug infusion (baseline) from at least three acoustic windows and matching recordings from the same windows at least twice during drug infusion, including a recording at the peak drug dose not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup, applies (with the exception of items 55118 and 55130). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $261.65 **Benefit:** 75% = $196.25 85% = $222.45
55117	
	HEART, 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL EXAMINATION of, from at least two levels, and in more than one plane at each level: (a) with: (i) real time colour flow mapping and, if indicated, pulsed wave Doppler examination; and (ii) recordings on video tape or digital medium; and (b) not being an intra-operative service or a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, applies (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $275.50 **Benefit:** 75% = $206.65 85% = $234.20
55118	

55119	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this Subgroup (with the exception of items 55118, 55125, 55130 and 55131), applies, for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $115.35 **Benefit:** 75% = $86.55 85% = $98.05
55120	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this Subgroup (with the exception of items 55118, 55125, 55130 and 55131), applies, for the investigation of suspected or known acquired valvular, aortic, pericardial, thrombotic, or embolic disease, or heart tumour (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $115.35 **Benefit:** 75% = $86.55 85% = $98.05
55121	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this Subgroup (with the exception of items 55118, 55125, 55130 and 55131), applies, for the investigation of symptoms or signs of congenital heart disease (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $115.35 **Benefit:** 75% = $86.55 85% = $98.05
55122	EXERCISE STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before exercise (baseline) from at least three acoustic windows and matching recordings from the same windows at, or immediately after, peak exercise, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this Subgroup applies (with the exception of items 55118, 55125, 55130 and 55131). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $130.85 **Benefit:** 75% = $98.15 85% = $111.25
55123	PHARMACOLOGICAL STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before drug infusion (baseline) from at least three acoustic windows and matching recordings from the same windows at least twice during drug infusion, including a recording at the peak drug dose not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this Subgroup, applies (with the exception of items 55118, 55125, 55130 and 55131). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $130.85 **Benefit:** 75% = $98.15 85% = $111.25
55125	HEART, 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL EXAMINATION of, from at least two levels, and in more than one plane at each level: (a) with: (i) real time colour flow mapping and, if indicated, pulsed wave Doppler examination; and (ii) recordings on video tape or digital medium; and (b) not being an intra-operative service or a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $137.75 **Benefit:** 75% = $103.35 85% = $117.10
55130	INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac surgery incorporating sequential assessment of cardiac function before and after the surgical procedure - not associated with item 55135 (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $170.00 **Benefit:** 75% = $127.50 85% = $144.50
55131	INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac surgery incorporating sequential assessment of cardiac function before and after the surgical procedure - not associated with items 55135 and 55136 (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $85.00 **Benefit:** 75% = $63.75 85% = $72.25

55135	INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac valve surgery (repair or replacement) incorporating sequential assessment of cardiac function and valve competence before and after the surgical procedure - not associated with item 55130 (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $353.60 **Benefit:** 75% = $265.20 85% = $300.60
55136	INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac valve surgery (repair or replacement) incorporating sequential assessment of cardiac function and valve competence before and after the surgical procedure - not associated with items 55130 and 55131 (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $176.80 **Benefit:** 75% = $132.60 85% = $150.30
	SUBGROUP 3 - VASCULAR
55220	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb OR of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55221	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55222	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55223	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limb OR of arteries and bypass grafts in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55224	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55226	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of extra-cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri-orbital Doppler examination, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Groups applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55227	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-abdominal, aorta and iliac arteries or inferior vena cava and iliac veins OR of intra-abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05

55228	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of renal or visceral vessels OR of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55229	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-cranial vessels, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55230	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal artery of the penis following intracavernosal administration of a vasoactive agent, performed during the period of pharmacological activity of the injected agent, to confirm a diagnosis of vascular aetiology for impotence, where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55232	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal tissue of the penis to confirm a diagnosis and, where indicated, assess the progress and management of: (a) priapism; or (b) fibrosis of any type; or (c) fracture of the tunica; or (d) arteriovenous malformations; where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Groups applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55233	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of surgically created arteriovenous fistula or surgically created arteriovenous access graft in the upper or lower limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55235	DUPLEX SCANNING, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or veins OR arteries and veins, for mapping of bypass conduit prior to vascular surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054), 3 or 4 of this Group applies - including any associated skin marking (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05
55236	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow spectral analysis and marking of veins in the lower limb below the inguinal ligament prior to varicose vein surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054), 3 or 4 of this Group applies - including any associated skin marking (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.55 **Benefit:** 75% = $41.70 85% = $47.25
55238	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb OR of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10

ULTRASOUND				VASCULAR
55244	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50	**Benefit:** 75% = $127.15	85% = $144.10	
55246	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50	**Benefit:** 75% = $127.15	85% = $144.10	
55248	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limb OR of arteries and bypass grafts in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50	**Benefit:** 75% = $127.15	85% = $144.10	
55252	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50	**Benefit:** 75% = $127.15	85% = $144.10	
55274	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of extra-cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri-orbital Doppler examination, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Groups applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50	**Benefit:** 75% = $127.15	85% = $144.10	
55276	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-abdominal, aorta and iliac arteries or inferior vena cava and iliac veins OR of intra-abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50	**Benefit:** 75% = $127.15	85% = $144.10	
55278	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of renal or visceral vessels OR of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50	**Benefit:** 75% = $127.15	85% = $144.10	
55280	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-cranial vessels, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50	**Benefit:** 75% = $127.15	85% = $144.10	
55282	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal artery of the penis following intracavernosal administration of a vasoactive agent, performed during the period of pharmacological activity of the injected agent, to confirm a diagnosis of vascular aetiology for impotence, where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50	**Benefit:** 75% = $127.15	85% = $144.10	

55284	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal tissue of the penis to confirm a diagnosis and, where indicated, assess the progress and management of: (a) priapism; or (b) fibrosis of any type; or (c) fracture of the tunica; or (d) arteriovenous malformations; where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Groups applies - (R) *(See para DIQ of explanatory notes to this Category)*	**Fee:** $169.50	**Benefit:** 75% = $127.15 85% = $144.10
55292	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of surgically created arteriovenous fistula or surgically created arteriovenous access graft in the upper or lower limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies (R) *(See para DIQ of explanatory notes to this Category)*	**Fee:** $169.50	**Benefit:** 75% = $127.15 85% = $144.10
55294	DUPLEX SCANNING, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or veins OR arteries and veins, for mapping of bypass conduit prior to vascular surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054), 3 or 4 of this Group applies - including any associated skin marking (R) *(See para DIQ of explanatory notes to this Category)*	**Fee:** $169.50	**Benefit:** 75% = $127.15 85% = $144.10
55296	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow spectral analysis and marking of veins in the lower limb below the inguinal ligament prior to varicose vein surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054), 3 or 4 of this Group applies - including any associated skin marking (R) *(See para DIQ of explanatory notes to this Category)*	**Fee:** $111.05	**Benefit:** 75% = $83.30 85% = $94.40
	SUBGROUP 4 - UROLOGICAL		
55600	Prostate, bladder base and urethra, l 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: (i) have a nominal frequency of 7 to 7.5 MHz or a nominal frequency range that includes frequencies of 7 to 7.5 MHz; and (ii) 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 a specialist in urology, radiation oncology or medical oncology, a consultant physician in medical oncology, who has: (i) examined the patient in the 60 days before the scan; and (ii) recommended the scan for the management of the patient's current prostatic disease (R) (K) *(See para DIQ of explanatory notes to this Category)*	**Fee:** $109.10	**Benefit:** 75% = $81.85 85% = $92.75
55601	PROSTATE, bladder base and urethra, ultrasound scan of, where performed: (a) personally by a medical practitioner (not being the medical practitioner who assessed the patient as specified in (c)) using a transducer probe or probes that: (i) have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i) examined the patient in the 60 days prior to the scan; and (ii) recommended the scan for the management of the patient's current prostatic disease (R) (NK) *(See para DIQ of explanatory notes to this Category)*	**Fee:** $54.55	**Benefit:** 75% = $40.95 85% = $46.40

	PROSTATE, bladder base and urethra, ultrasound scan of, where performed: (a) personally by a medical practitioner who undertook the assessment referred to in (c) using a transducer probe or probes that: (i) have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i)examined the patient in the 60 days prior to the scan; and (ii)recommended the scan for the management of the patient's current prostatic disease (R) (K) *(See para DIQ of explanatory notes to this Category)*
55603	**Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
	PROSTATE, bladder base and urethra, ultrasound scan of, where performed: (a) personally by a medical practitioner who undertook the assessment referred to in (c) using a transducer probe or probes that: (i) have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i) examined the patient in the 60 days prior to the scan; and (ii) recommended the scan for the management of the patient's current prostatic disease (R) (NK) *(See para DIQ of explanatory notes to this Category)*
55604	**Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40

SUBGROUP 5 - OBSTETRIC AND GYNAECOLOGICAL

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, if:
(a) the patient is referred by a medical practitioner or participating midwife; and
(b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) if the patient is referred by a medical practitioner -- the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and
(e) if the patient is referred by a participating midwife - the referring midwife does not have a business or financial arrangement with the providing practitioner; and
(f) 1 or more of the following conditions are present:
- (i) hyperemesis gravidarum;
- (ii) diabetes mellitus;
- (iii) hypertension;
- (iv) toxaemia of pregnancy;
- (v) liver or renal disease;
- (vi) autoimmune disease;
- (vii) cardiac disease;
- (viii) alloimmunisation;
- (ix) maternal infection;
- (x) inflammatory bowel disease;
- (xi) bowel stoma;
- (xii) abdominal wall scarring;
- (xiii) previous spinal or pelvic trauma or disease;
- (xiv) drug dependency;
- (xv) thrombophilia;
- (xvi) significant maternal obesity;
- (xvii) advanced maternal age;
- (xviii) abdominal pain or mass;
- (xix) uncertain dates;
- (xx) high risk pregnancy;
- (xxi) previous post dates delivery;
- (xxii) previous caesarean section;
- (xxiii) poor obstetric history;
- (xxiv) suspicion of ectopic pregnancy;
- (xxv) risk of miscarriage;
- (xxvi) diminished symptoms of pregnancy;
- (xxvii) suspected or known cervical incompetence;
- (xxviii) suspected or known uterine abnormality;
- (xxix) pregnancy after assisted reproduction;
- (xxx) risk of fetal abnormality (R)

Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55707 (R). Fee is payable only for item 55700 or item 55707, not both items.
(See para DIQ of explanatory notes to this Category)

55700 **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00
Extended Medicare Safety Net Cap: $32.95

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where:

(a) the patient is referred by a medical practitioner; and

(b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and

(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and

(e) one or more of the following conditions are present:

- (i) hyperemesis gravidarum;
- (ii) diabetes mellitus;
- (iii) hypertension;
- (iv) toxaemia of pregnancy;
- (v) liver or renal disease;
- (vi) autoimmune disease;
- (vii) cardiac disease;
- (viii) alloimmunisation;
- (ix) maternal infection;
- (x) inflammatory bowel disease;
- (xi) bowel stoma;
- (xii) abdominal wall scarring;
- (xiii) previous spinal or pelvic trauma or disease;
- (xiv) drug dependency;
- (xv) thrombophilia;
- (xvi) significant maternal obesity;
- (xvii) advanced maternal age;
- (xviii) abdominal pain or mass;
- (xix) uncertain dates;
- (xx) high risk pregnancy;
- (xxi) previous post dates delivery;
- (xxii) previous caesarean section;
- (xxiii) poor obstetric history;
- (xxiv) suspicion of ectopic pregnancy;
- (xxv) risk of miscarriage;
- (xxvi) diminished symptoms of pregnancy;
- (xxvii) suspected or known cervical incompetence;
- (xxviii) suspected or known uterine abnormality;
- (xxix) pregnancy after assisted reproduction;
- (xxx) risk of fetal abnormality (R)

Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55707 or 55714 (R) (NK). Fee is payable only for item 55700 or 55701, or, or item 55707 or 55714, not both items

(See para DIQ of explanatory notes to this Category)

Fee: $30.00 **Benefit:** 75% = $22.50 85% = $25.50

55701 **Extended Medicare Safety Net Cap:** $16.50

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where:

(a) the patient is not referred by a medical practitioner; and

(b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and

(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

(d) one or more of the following conditions are present:

- (i) hyperemesis gravidarum;
- (ii) diabetes mellitus;
- (iii) hypertension;
- (iv) toxaemia of pregnancy;
- (v) liver or renal disease;
- (vi) autoimmune disease;
- (vii) cardiac disease;
- (viii) alloimmunisation;
- (ix) maternal infection;
- (x) inflammatory bowel disease;
- (xi) bowel stoma;
- (xii) abdominal wall scarring;
- (xiii) previous spinal or pelvic trauma or disease;
- (xiv) drug dependency;
- (xv) thrombophilia;
- (xvi) significant maternal obesity;
- (xvii) advanced maternal age;
- (xviii) abdominal pain or mass;
- (xix) uncertain dates;
- (xx) high risk pregnancy;
- (xxi) previous post dates delivery;
- (xxii) previous caesarean section;
- (xxiii) poor obstetric history;
- (xxiv) suspicion of ectopic pregnancy;
- (xxv) risk of miscarriage;
- (xxvi) diminished symptoms of pregnancy;
- (xxvii) suspected or known cervical incompetence;
- (xxviii) suspected or known uterine abnormality;
- (xxix) pregnancy after assisted reproduction;
- (xxx) risk of fetal abnormality (NR)

Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55708 or 55716 (R) (NK). Fee is payable only for item 55702 or 55703, or, item 55707 or 55714, not both items

(See para DIQ of explanatory notes to this Category)

Fee: $17.50 **Benefit:** 75% = $13.15 85% = $14.90

55702 **Extended Medicare Safety Net Cap:** $8.30

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where:

(a) the patient is not referred by a medical practitioner; and

(b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and

(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

(d) one or more of the following conditions are present:

- (i) hyperemesis gravidarum;
- (ii) diabetes mellitus;
- (iii) hypertension;
- (iv) toxaemia of pregnancy;
- (v) liver or renal disease;
- (vi) autoimmune disease;
- (vii) cardiac disease;
- (viii) alloimmunisation;
- (ix) maternal infection;
- (x) inflammatory bowel disease;
- (xi) bowel stoma;
- (xii) abdominal wall scarring;
- (xiii) previous spinal or pelvic trauma or disease;
- (xiv) drug dependency;
- (xv) thrombophilia;
- (xvi) significant maternal obesity;
- (xvii) advanced maternal age;
- (xviii) abdominal pain or mass;
- (xix) uncertain dates;
- (xx) high risk pregnancy;
- (xxi) previous post dates delivery;
- (xxii) previous caesarean section;
- (xxiii) poor obstetric history;
- (xxiv) suspicion of ectopic pregnancy;
- (xxv) risk of miscarriage;
- (xxvi) diminished symptoms of pregnancy;
- (xxvii) suspected or known cervical incompetence;
- (xxviii) suspected or known uterine abnormality;
- (xxix) pregnancy after assisted reproduction;
- (xxx) risk of fetal abnormality (NR)

Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55708 (R). Fee is payable only for item 55703 or item 55707, not both items.

(See para DIQ of explanatory notes to this Category)

Fee: $35.00 **Benefit:** 75% = $26.25 85% = $29.75

55703 **Extended Medicare Safety Net Cap:** $16.55

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if:

(a) the patient is referred by a medical practitioner or participating midwife; and

(b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and

(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

(d) if the patient is referred by a medical practitioner -- the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and

(e) if the patient is referred by a participating midwife -- the referring midwife does not have a business or financial arrangement with the providing practitioner; and

(f) one or more of the following conditions are present:

- (i) hyperemesis gravidarum;
- (ii) diabetes mellitus;
- (iii) hypertension;
- (iv) toxaemia of pregnancy;
- (v) liver or renal disease;
- (vi) autoimmune disease;
- (vii) cardiac disease;
- (viii) alloimmunisation;
- (ix) maternal infection;
- (x) inflammatory bowel disease;
- (xi) bowel stoma;
- (xii) abdominal wall scarring;
- (xiii) previous spinal or pelvic trauma or disease;
- (xiv) drug dependency;
- (xv) thrombophilia;
- (xvi) significant maternal obesity;
- (xvii) advanced maternal age;
- (xviii) abdominal pain or mass;
- (xix) uncertain dates;
- (xx) high risk pregnancy;
- (xxi) previous post dates delivery;
- (xxii) previous caesarean section;
- (xxiii) poor obstetric history;
- (xxiv) suspicion of ectopic pregnancy;
- (xxv) risk of miscarriage;
- (xxvi) diminished symptoms of pregnancy;
- (xxvii) suspected or known cervical incompetence;
- (xxviii) suspected or known uterine abnormality;
- (xxix) pregnancy after assisted reproduction;
- (xxx) risk of fetal abnormality (R)

Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55707 (R). Fee is payable only for item 55704 or item 55707, not both items.

(See para DIQ of explanatory notes to this Category)

55704 **Fee:** $70.00 **Benefit:** 75% = $52.50 85% = $59.50

Extended Medicare Safety Net Cap: $38.50

55705	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) one or more of the following conditions are present: (i) hyperemesis gravidarum (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (NR) Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55708 (R). Fee is payable only for item 55705 or item 55708, not both items. *(See para DIQ of explanatory notes to this Category)* **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75 **Extended Medicare Safety Net Cap:** $16.55
55706	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the patient is referred by a medical practitioner or participating midwife; and (b) the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) if the patient is referred by a medical practitioner - the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife - the referring midwife does not have a business or financial arrangement with the providing practitioner; and (f) the service is not performed in the same pregnancy as item 55709 (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00 **Extended Medicare Safety Net Cap:** $54.90

55707	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, if; (a) the patient is referred by a medical practitioner or participating midwife; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) if the patient is referred by a medical practitioner – the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife – the referring midwife does not have a business or financial arrangement with the providing practitioner; and (f) at least 1 condition mentioned in paragraph (f) of item 55704 is present; and (g) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (h) the service is not performed with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $70.00 **Benefit:** 75% = $52.50 85% = $59.50 **Extended Medicare Safety Net Cap:** $38.50
55708	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where; (a) the patient is not referred by a medical practitioner; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) one or more of the conditions in subparagraphs (e) (i) to (xxx) of item 55704 are present; and (e) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (f) the service is not performed in conjunction with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75 **Extended Medicare Safety Net Cap:** $16.55
55709	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the service is not performed in the same pregnancy as item 55706 (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $38.00 **Benefit:** 75% = $28.50 85% = $32.30 **Extended Medicare Safety Net Cap:** $22.00

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where:

(a) the patient is referred by a medical practitioner; and
(b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and
(e) one or more of the following conditions are present:
- (i) hyperemesis gravidarum;
- (ii) diabetes mellitus;
- (iii) hypertension;
- (iv) toxaemia of pregnancy;
- (v) liver or renal disease;
- (vi) autoimmune disease;
- (vii) cardiac disease;
- (viii) alloimmunisation;
- (ix) maternal infection;
- (x) inflammatory bowel disease;
- (xi) bowel stoma;
- (xii) abdominal wall scarring;
- (xiii) previous spinal or pelvic trauma or disease;
- (xiv) drug dependency;
- (xv) thrombophilia;
- (xvi) significant maternal obesity;
- (xvii) advanced maternal age;
- (xviii) abdominal pain or mass;
- (xix) uncertain dates;
- (xx) high risk pregnancy;
- (xxi) previous post dates delivery;
- (xxii) previous caesarean section;
- (xxiii) poor obstetric history;
- (xxiv) suspicion of ectopic pregnancy;
- (xxv) risk of miscarriage;
- (xxvi) diminished symptoms of pregnancy;
- (xxvii) suspected or known cervical incompetence;
- (xxviii) suspected or known uterine abnormality;
- (xxix) pregnancy after assisted reproduction;
- (xxx) risk of fetal abnormality (R)

Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item 55704 or 55707 (R) (NK). Fee is payable only for item 55704 or 55710, or, item 55707 or 55714, not both items
(See para DIQ of explanatory notes to this Category)

55710 **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75
Extended Medicare Safety Net Cap: $19.30

55711	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) one or more of the following conditions are present: (i) hyperemesis gravidarum (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (NR) Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item 55708 or 55716 (R) (NK). Fee is payable only for item 55705 or 55711, or, item 55708 or 55716, not both items *(See para DIQ of explanatory notes to this Category)* **Fee:** $17.50 **Benefit:** 75% = $13.15 85% = $14.90 **Extended Medicare Safety Net Cap:** $8.30
55712	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $115.00 **Benefit:** 75% = $86.25 85% = $97.75 **Extended Medicare Safety Net Cap:** $65.90

55713	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner; and (b) the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) the service is not performed in the same pregnancy as item 55709 or 55717 (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $50.00 **Benefit:** 75% = $37.50 85% = $42.50 **Extended Medicare Safety Net Cap:** $27.50
55714	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where; (a) the patient is referred by a medical practitioner; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) one or more of the conditions mentioned in subparagraphs (e) (i) to (xxx) of item 55704 or 55710 are present; and (f) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (g) the service is not performed with item 55700, 55701, 55702, 55703, 55704, 55705, 55710 or 55711 on the same patient within 24 hours (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75 **Extended Medicare Safety Net Cap:** $19.30
55715	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $40.00 **Benefit:** 75% = $30.00 85% = $34.00 **Extended Medicare Safety Net Cap:** $22.00
55716	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where; (a) the patient is not referred by a medical practitioner; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) one or more of the conditions in subparagraphs (e) (i) to (xxx) of item 55704 or 55710 are present; and (e) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (f) the service is not performed in conjunction with item 55700, 55701, 55702, 55703, 55704, 55705, 55710 or 55711 on the same patient within 24 hours (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $17.50 **Benefit:** 75% = $13.15 85% = $14.90 **Extended Medicare Safety Net Cap:** $8.30
55717	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the service is not performed in the same pregnancy as item 55706 or 55713 (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $19.00 **Benefit:** 75% = $14.25 85% = $16.15 **Extended Medicare Safety Net Cap:** $11.05

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, if:

(a) the patient is referred by a medical practitioner or participating midwife; and

(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and

(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

(d) if the patient is referred by a medical practitioner -- the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and

(e) if the patient is referred by a participating midwife -- the referring midwife does not have a business or financial arrangement with the providing practitioner; and

(f) the service is not performed in the same pregnancy as item 55723; and

(g) 1 or more of the following conditions are present:

- (i) known or suspected fetal abnormality or fetal cardiac arrhythmia;
- (ii) fetal anatomy (late booking or incomplete mid-trimester scan);
- (iii) malpresentation;
- (iv) cervical assessment;
- (v) clinical suspicion of amniotic fluid abnormality;
- (vi) clinical suspicion of placental or umbilical cord abnormality;
- (vii) previous complicated delivery;
- (viii) uterine scar assessment;
- (ix) uterine fibroid;
- (x) previous fetal death in utero or neonatal death;
- (xi) antepartum haemorrhage;
- (xii) clinical suspicion of intrauterine growth retardation;
- (xiii) clinical suspicion of macrosomia;
- (xiv) reduced fetal movements;
- (xv) suspected fetal death;
- (xvi) abnormal cardiotocography;
- (xvii) prolonged pregnancy;
- (xviii) premature labour;
- (xix) fetal infection;
- (xx) pregnancy after assisted reproduction;
- (xxi) trauma;
- (xxii) diabetes mellitus;
- (xxiii) hypertension;
- (xxiv) toxaemia of pregnancy;
- (xxv) liver or renal disease;
- (xxvi) autoimmune disease;
- (xxvii) cardiac disease;
- (xxviii) alloimmunisation;
- (xxix) maternal infection;
- (xxx) inflammatory bowel disease;
- (xxxi) bowel stoma;
- (xxxii) abdominal wall scarring;
- (xxxiii) previous spinal or pelvic trauma or disease;
- (xxxiv) drug dependency;
- (xxxv) thrombophilia;
- (xxxvi) significant maternal obesity;
- (xxxvii) advanced maternal age;
- (xxxviii) abdominal pain or mass (R)

(See para DIQ of explanatory notes to this Category)

55718 **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00

Extended Medicare Safety Net Cap: $54.90

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where:

(a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and

(b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and

(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and

(e) further examination is clinically indicated in the same pregnancy to which item 55706, 55709, 55713 or 55717 applies (R) (NK)

(See para DIQ of explanatory notes to this Category)

55719 **Fee:** $57.50 **Benefit:** 75% = $43.15 85% = $48.90

Extended Medicare Safety Net Cap: $32.95

55720	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55706, 55709, 55713 or 55717 applies (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $20.00 **Benefit:** 75% = $15.00 85% = $17.00 **Extended Medicare Safety Net Cap:** $11.05
55721	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of by any or all approaches, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has qualifications recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $115.00 **Benefit:** 75% = $86.25 85% = $97.75 **Extended Medicare Safety Net Cap:** $65.90

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:

(a) the patient is referred by a medical practitioner; and

(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and

(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and

(e) the service is not performed in the same pregnancy as item 55723 or 55726; and

(f) one or more of the following conditions are present:

- (i) known or suspected fetal abnormality or fetal cardiac arrhythmia;
- (ii) fetal anatomy (late booking or incomplete mid-trimester scan);
- (iii) malpresentation;
- (iv) cervical assessment;
- (v) clinical suspicion of amniotic fluid abnormality;
- (vi) clinical suspicion of placental or umbilical cord abnormality;
- (vii) previous complicated delivery;
- (viii) uterine scar assessment;
- (ix) uterine fibroid;
- (x) previous fetal death in utero or neonatal death;
- (xi) antepartum haemorrhage;
- (xii) clinical suspicion of intrauterine growth retardation;
- (xiii) clinical suspicion of macrosomia;
- (xiv) reduced fetal movements;
- (xv) suspected fetal death;
- (xvi) abnormal cardiotocography;
- (xvii) prolonged pregnancy;
- (xviii) premature labour;
- (xix) fetal infection;
- (xx) pregnancy after assisted reproduction;
- (xxi) trauma;
- (xxii) diabetes mellitus;
- (xxiii) hypertension;
- (xxiv) toxaemia of pregnancy;
- (xxv) liver or renal disease;
- (xxvi) autoimmune disease;
- (xxvii) cardiac disease;
- (xxviii) alloimmunisation;
- (xxix) maternal infection;
- (xxx) inflammatory bowel disease;
- (xxxi) bowel stoma;
- (xxxii) abdominal wall scarring;
- (xxxiii) previous spinal or pelvic trauma or disease;
- (xxxiv) drug dependency;
- (xxxv) thrombophilia;
- (xxxvi) significant maternal obesity;
- (xxxvii) advanced maternal age;
- (xxxviii) abdominal pain or mass (R) (NK)

(See para DIQ of explanatory notes to this Category)

55722 **Fee:** $50.00 **Benefit:** 75% = $37.50 85% = $42.50

Extended Medicare Safety Net Cap: $27.50

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:

(a) the patient is not referred by a medical practitioner; and
(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) the service is not performed in the same pregnancy as item 55718; and
(e) one or more of the following conditions are present:
- (i) known or suspected fetal abnormality or fetal cardiac arrhythmia;
- (ii) fetal anatomy (late booking or incomplete mid-trimester scan);
- (iii) malpresentation;
- (iv) cervical assessment;
- (v) clinical suspicion of amniotic fluid abnormality;
- (vi) clinical suspicion of placental or umbilical cord abnormality;
- (vii) previous complicated delivery;
- (viii) uterine scar assessment;
- (ix) uterine fibroid;
- (x) previous fetal death in utero or neonatal death;
- (xi) antepartum haemorrhage;
- (xii) clinical suspicion of intrauterine growth retardation;
- (xiii) clinical suspicion of macrosomia;
- (xiv) reduced fetal movements;
- (xv) suspected fetal death;
- (xvi) abnormal cardiotocography;
- (xvii) prolonged pregnancy;
- (xviii) premature labour;
- (xix) fetal infection;
- (xx) pregnancy after assisted reproduction;
- (xxi) trauma;
- (xxii) diabetes mellitus;
- (xxiii) hypertension;
- (xxiv) toxaemia of pregnancy;
- (xxv) liver or renal disease;
- (xxvi) autoimmune disease;
- (xxvii) cardiac disease;
- (xxviii) alloimmunisation;
- (xxix) maternal infection;
- (xxx) inflammatory bowel disease;
- (xxxi) bowel stoma;
- (xxxii) abdominal wall scarring;
- (xxxiii) previous spinal or pelvic trauma or disease;
- (xxxiv) drug dependency;
- (xxxv) thrombophilia;
- (xxxvi) significant maternal obesity;
- (xxxvii) advanced maternal age;
- (xxxviii) abdominal pain or mass (NR)

(See para DIQ of explanatory notes to this Category)

55723 **Fee:** $38.00 **Benefit:** 75% = $28.50 85% = $32.30
Extended Medicare Safety Net Cap: $22.00

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of by any or all approaches, where:

(a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has qualifications recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and
(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and
(e) further examination is clinically indicated in the same pregnancy to which item 55718, 55722, 55723 or 55726 applies (R) NK)

(See para DIQ of explanatory notes to this Category)

55724 **Fee:** $57.50 **Benefit:** 75% = $43.15 85% = $48.90
Extended Medicare Safety Net Cap: $32.95

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where:

(a) the patient is not referred by a medical practitioner; and

(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and

(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

(d) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (NR)

(See para DIQ of explanatory notes to this Category)

Fee: $40.00 **Benefit:** 75% = $30.00 85% = $34.00

55725 **Extended Medicare Safety Net Cap:** $22.00

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:

(a) the patient is not referred by a medical practitioner; and

(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and

(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

(d) the service is not performed in the same pregnancy as item 55718 or 55722; and

(e) one or more of the following conditions are present:

- (i) known or suspected fetal abnormality or fetal cardiac arrhythmia;
- (ii) fetal anatomy (late booking or incomplete mid-trimester scan);
- (iii) malpresentation;
- (iv) cervical assessment;
- (v) clinical suspicion of amniotic fluid abnormality;
- (vi) clinical suspicion of placental or umbilical cord abnormality;
- (vii) previous complicated delivery;
- (viii) uterine scar assessment;
- (ix) uterine fibroid;
- (x) previous fetal death in utero or neonatal death;
- (xi) antepartum haemorrhage;
- (xii) clinical suspicion of intrauterine growth retardation;
- (xiii) clinical suspicion of macrosomia;
- (xiv) reduced fetal movements;
- (xv) suspected fetal death;
- (xvi) abnormal cardiotocography;
- (xvii) prolonged pregnancy;
- (xviii) premature labour;
- (xix) fetal infection;
- (xx) pregnancy after assisted reproduction;
- (xxi) trauma;
- (xxii) diabetes mellitus;
- (xxiii) hypertension;
- (xxiv) toxaemia of pregnancy;
- (xxv) liver or renal disease;
- (xxvi) autoimmune disease;
- (xxvii) cardiac disease;
- (xxviii) alloimmunisation;
- (xxix) maternal infection;
- (xxx) inflammatory bowel disease;
- (xxxi) bowel stoma;
- (xxxii) abdominal wall scarring;
- (xxxiii) previous spinal or pelvic trauma or disease;
- (xxxiv) drug dependency;
- (xxxv) thrombophilia;
- (xxxvi) significant maternal obesity;
- (xxxvii) advanced maternal age;
- (xxxviii) abdominal pain or mass (NR) (NK)

(See para DIQ of explanatory notes to this Category)

Fee: $19.00 **Benefit:** 75% = $14.25 85% = $16.15

55726 **Extended Medicare Safety Net Cap:** $11.05

55727	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55718, 55722, 55723 or 55726 applies (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $20.00 **Benefit:** 75% = $15.00 85% = $17.00 **Extended Medicare Safety Net Cap:** $11.05
55729	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of the umbilical artery, and measured assessment of amniotic fluid volume after the 24th week of gestation where the patient is referred by a medical practitioner for this procedure and where there is reason to suspect intrauterine growth retardation or a significant risk of foetal death, not being a service associated with a service to which an item in this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $27.25 **Benefit:** 75% = $20.45 85% = $23.20 **Extended Medicare Safety Net Cap:** $16.55
55730	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of the umbilical artery, and measured assessment of amniotic fluid volume after the 24th week of gestation where the patient is referred by a medical practitioner for this procedure and where there is reason to suspect intrauterine growth retardation or a significant risk of foetal death, not being a service associated with a service to which an item in this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $13.65 **Benefit:** 75% = $10.25 85% = $11.65 **Extended Medicare Safety Net Cap:** $8.30
55735	PELVIS, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of medical practitioners of which the providing practitioner is a member; and (d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00
55736	PELVIS, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of medical practitioners of which the providing practitioner is a member; and (d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $127.00 **Benefit:** 75% = $95.25 85% = $107.95
55737	PELVIS, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $28.50 **Benefit:** 75% = $21.40 85% = $24.25
55739	PELVIS, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $57.00 **Benefit:** 75% = $42.75 85% = $48.45

55759	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) the service is not performed in conjunction with item 55706, 55709, 55712, 55715 or 55762 during the same pregnancy (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50
55760	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) the service is not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719, 57721, 55762 or 55763 during the same pregnancy (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $75.00 **Benefit:** 75% = $56.25 85% = $63.75
55762	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not performed in conjunction with item 55706, 55709, 55712, 55715 or 55759during the same pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00 **Extended Medicare Safety Net Cap:** $32.95
55763	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719, 55720, 55759 or 55760 during the same pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $30.00 **Benefit:** 75% = $22.50 85% = $25.50 **Extended Medicare Safety Net Cap:** $16.50

55764	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) further examination is clinically indicated in the same pregnancy to which item 55759 or 55762 has been performed; and (g) not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $160.00 **Benefit:** 75% = $120.00 85% = $136.00 **Extended Medicare Safety Net Cap:** $87.85
55765	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) further examination is clinically indicated in the same pregnancy to which item 55759, 55760, 55762 or 55763 has been performed; and (g) not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719 during the same pregnancy (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $80.00 **Benefit:** 75% = $60.00 85% = $68.00 **Extended Medicare Safety Net Cap:** $44.00
55766	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; (e) further examination is clinically indicated in the same pregnancy to which item 55759, or 55762 has been performed; and (f) not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $65.00 **Benefit:** 75% = $48.75 85% = $55.25 **Extended Medicare Safety Net Cap:** $32.95
55767	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; (e) further examination is clinically indicated in the same pregnancy to which item 55759, 55760, 55762 or 55763 has been performed; and (f) not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719 or 55720 during the same pregnancy (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.50 **Benefit:** 75% = $24.40 85% = $27.65 **Extended Medicare Safety Net Cap:** $16.50

55768	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where: (a) dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) the ultrasound confirms a multiple pregnancy; and (c) the patient is referred by a medical practitioner; and (d) the service is not performed in the same pregnancy as item 55770; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55723 or 55725 during the same pregnancy (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50 **Extended Medicare Safety Net Cap:** $82.40
55769	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where: (a) dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) the ultrasound confirms a multiple pregnancy; and (c) the patient is referred by a medical practitioner; and (d) the service is not performed in the same pregnancy as item 55770 or 55771; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55722, 55723, 55724, 55725, 55726 or 55727 during the same pregnancy (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $75.00 **Benefit:** 75% = $56.25 85% = $63.75 **Extended Medicare Safety Net Cap:** $41.25
55770	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy), by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) the service is not performed in the same pregnancy as item 55768; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721, 55723 or 55725 during the same pregnancy (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00 **Extended Medicare Safety Net Cap:** $32.95
55771	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy), by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) the service is not performed in the same pregnancy as item 55768 or 55759; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721, 55723, 55724,,55725, 55726 or 55727 during the same pregnancy (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $30.00 **Benefit:** 75% = $22.50 85% = $25.50 **Extended Medicare Safety Net Cap:** $16.50

55772	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55723 or 55725 during the same pregnancy (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $160.00 **Benefit:** 75% = $120.00 85% = $136.00 **Extended Medicare Safety Net Cap:** $87.85
55773	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (c) further examination is clinically indicated in the same pregnancy to which item 55768, 55769, 55770 or 55771 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55722, 55723, 55724, 55725, 55726 or 55727 during the same pregnancy (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $80.00 **Benefit:** 75% = $60.00 85% = $68.00 **Extended Medicare Safety Net Cap:** $44.00
55774	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed ;and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721 55723 or 55725 during the same pregnancy (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $65.00 **Benefit:** 75% = $48.75 85% = $55.25 **Extended Medicare Safety Net Cap:** $38.50
55775	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) further examination is clinically indicated in the same pregnancy to which item 55768, 55769, 55770 or 5571 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721, 55722, 55723, 55724, 55725, 55726 or 55727 during the same pregnancy (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.50 **Benefit:** 75% = $24.40 85% = $27.65 **Extended Medicare Safety Net Cap:** $19.30

	SUBGROUP 6 - MUSCULOSKELETAL
55800	HAND OR WRIST, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55801	HAND OR WRIST, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55802	HAND OR WRIST, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55803	HAND OR WRIST, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55804	FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55805	FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
55806	FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
55807	FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
55808	SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions: - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, suspraspinatus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology.(R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75

	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone*. SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions: - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, supraspinatus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology (R) (NK) *(See para DIQ of explanatory notes to this Category)*
55809	**Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
	SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions: - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, supraspinatus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology.(NR) *(See para DIQ of explanatory notes to this Category)*
55810	**Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
	Note: Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone. SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions: - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, supraspinatus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology (NR) (NK) *(See para DIQ of explanatory notes to this Category)*
55811	**Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
	CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*
55812	**Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
	CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)*
55813	**Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40

	CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*		
55814	**Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
	CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)*		
55815	**Fee:** $18.95	**Benefit:** 75% = $14.25	85% = $16.15
	HIP OR GROIN, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*		
55816	**Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
	HIP OR GROIN, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
55817	**Fee:** $54.55	**Benefit:** 75% = $40.95	85% = $46.40
	HIP OR GROIN, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies: and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*		
55818	**Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
	HIP OR GROIN, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies: and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)*		
55819	**Fee:** $18.95	**Benefit:** 75% = $14.25	85% = $16.15
	PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*		
55820	**Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
	PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
55821	**Fee:** $54.55	**Benefit:** 75% = $40.95	85% = $46.40
	PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*		
55822	**Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
	PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)*		
55823	**Fee:** $18.95	**Benefit:** 75% = $14.25	85% = $16.15

	BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*		
55824	**Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
	BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
55825	**Fee:** $54.55	**Benefit:** 75% = $40.95	85% = $46.40
	BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*		
55826	**Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
	BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK)		
55827	**Fee:** $18.95	**Benefit:** 75% = $14.25	85% = $16.15
	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee condition including:* - meniscal and cruciate ligament tears - assessment of chondral surfaces KNEE, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided for the assessment of one or more of the following conditions or suspected conditions: - abnormality of tendons or bursae about the knee; or - meniscal cyst, popliteal fossa cyst, mass or pseudomass; or - nerve entrapment, nerve or nerve sheath tumour; or - injury of collateral ligaments.(R) *(See para DIQ of explanatory notes to this Category)*		
55828	**Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee condition including:* - meniscal and cruciate ligament tears - assessment of chondral surfaces KNEE, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided for the assessment of one or more of the following conditions or suspected conditions: - abnormality of tendons or bursae about the knee; or - meniscal cyst, popliteal fossa cyst, mass or pseudomass; or - nerve entrapment, nerve or nerve sheath tumour; or - injury of collateral ligaments (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
55829	**Fee:** $54.55	**Benefit:** 75% = $40.95	85% = $46.40

	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee condition including:* - meniscal and cruciate ligament tears - assessment of chondral surfaces KNEE, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner and where the service is provided for the assessment of one or more of the following conditions or suspected conditions: - abnormality of tendons or bursae about the knee; or - meniscal cyst, popliteal fossa cyst, mass or pseudomass; or - nerve entrapment, nerve or nerve sheath tumour; or - injury of collateral ligaments.(NR) *(See para DIQ of explanatory notes to this Category)*
55830	**Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
	Note: Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee condition including: - meniscal and cruciate ligament tears - assessment of chondral surfaces KNEE, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner and where the service is provided for the assessment of one or more of the following conditions or suspected conditions: - abnormality of tendons or bursae about the knee; or - meniscal cyst, popliteal fossa cyst, mass or pseudomass; or - nerve entrapment, nerve or nerve sheath tumour; or - injury of collateral ligaments (NR) (NK) *(See para DIQ of explanatory notes to this Category)*
55831	**Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
	LOWER LEG, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*
55832	**Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
	LOWER LEG, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)*
55833	**Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
	LOWER LEG, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*
55834	**Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
	LOWER LEG, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)*
55835	**Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
	ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*
55836	**Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75

55837	ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, where: (a) the services is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55	**Benefit:** 75% = $40.95	85% = $46.40
55838	ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
55839	ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95	**Benefit:** 75% = $14.25	85% = $16.15
55840	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
55841	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55	**Benefit:** 75% = $40.95	85% = $46.40
55842	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
55843	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95	**Benefit:** 75% = $14.25	85% = $16.15
55844	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $87.35	**Benefit:** 75% = $65.55	85% = $74.25
55845	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $43.70	**Benefit:** 75% = $32.80	85% = $37.15
55846	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20

	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)*		
55847	**Fee:** $18.95	**Benefit:** 75% = $14.25	85% = $16.15
	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies, and not performed in conjunction with item 55054 (R) *(See para DIQ of explanatory notes to this Category)*		
55848	**Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies, and not performed in conjunction with item 55054 or 55026 (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
55849	**Fee:** $54.55	**Benefit:** 75% = $40.95	85% = $46.40
	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, where: (a) the referring practitioner has indicated on a referral for a musculoskeletal ultrasound that a ultrasound guided intervention be performed if clinically indicated; (b) the service is not performed in conjunction with items 55054, or 55800 to 55848, and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*		
55850	**Fee:** $152.85	**Benefit:** 75% = $114.65	85% = $129.95
	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, where: (a) the referring practitioner has indicated on a referral for a musculoskeletal ultrasound that a ultrasound guided intervention be performed if clinically indicated; (b) the service is not performed in conjunction with items 55026, 55054, or 55800 to 55849, and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
55851	**Fee:** $76.45	**Benefit:** 75% = $57.35	85% = $65.00
	PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where: a) the patient is referred by a referring practitioner b) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*		
55852	**Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
	PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where: a) the patient is referred by a medical practitioner b) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
55853	**Fee:** $54.55	**Benefit:** 75% = $40.95	85% = $46.40
	PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where: a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*		
55854	**Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
	PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where: a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)*		
55855	**Fee:** $18.95	**Benefit:** 75% = $14.25	85% = $16.15

GROUP I2 - COMPUTED TOMOGRAPHY

HEAD

56001	COMPUTED TOMOGRAPHY - scan of brain without intravenous contrast medium, not being a service to which item 57001 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $195.05	**Benefit:** 75% = $146.30	85% = $165.80
56007	COMPUTED TOMOGRAPHY - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57007 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $250.00	**Benefit:** 75% = $187.50	85% = $212.50
56010	COMPUTED TOMOGRAPHY - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $252.10	**Benefit:** 75% = $189.10	85% = $214.30
56013	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $250.00	**Benefit:** 75% = $187.50	85% = $212.50
56016	COMPUTED TOMOGRAPHY - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $290.00	**Benefit:** 75% = $217.50	85% = $246.50
56022	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $225.00	**Benefit:** 75% = $168.75	85% = $191.25
56028	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to intravenous contrast injection, when undertaken (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $336.80	**Benefit:** 75% = $252.60	85% = $286.30
56030	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $225.00	**Benefit:** 75% = $168.75	85% = $191.25
56036	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $336.80	**Benefit:** 75% = $252.60	85% = $286.30
56041	COMPUTED TOMOGRAPHY - scan of brain without intravenous contrast medium, not being a service to which item 57041 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $98.75	**Benefit:** 75% = $74.10	85% = $83.95
56047	COMPUTED TOMOGRAPHY - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57047 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $126.10	**Benefit:** 75% = $94.60	85% = $107.20
56050	COMPUTED TOMOGRAPHY - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $128.20	**Benefit:** 75% = $96.15	85% = $109.00

56053	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $128.20	**Benefit:** 75% = $96.15	85% = $109.00
56056	COMPUTED TOMOGRAPHY - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $155.45	**Benefit:** 75% = $116.60	85% = $132.15
56062	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $113.15	**Benefit:** 75% = $84.90	85% = $96.20
56068	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to intravenous contrast injection, when undertaken (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $168.40	**Benefit:** 75% = $126.30	85% = $143.15
56070	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $113.15	**Benefit:** 75% = $84.90	85% = $96.20
56076	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $168.40	**Benefit:** 75% = $126.30	85% = $143.15
	NECK		
56101	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56801 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $230.00	**Benefit:** 75% = $172.50	85% = $195.50
56107	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) - with intravenous contrast medium and with any scans of soft tissues of neck including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) prior to intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56807 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $340.00	**Benefit:** 75% = $255.00	85% = $289.00
56141	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56841 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $116.45	**Benefit:** 75% = $87.35	85% = $99.00
56147	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) - with intravenous contrast medium and with any scans of soft tissues of neck including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) prior to intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56847 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $171.60	**Benefit:** 75% = $128.70	85% = $145.90
	SPINE		
56219	COMPUTED TOMOGRAPHY - scan of spine, 1 or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated plain X-rays, not being a service to which item 59724 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $326.20	**Benefit:** 75% = $244.65	85% = $277.30

56220	COMPUTED TOMOGRAPHY - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $240.00	**Benefit:** 75% = $180.00	85% = $204.00
56221	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $240.00	**Benefit:** 75% = $180.00	85% = $204.00
56223	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $240.00	**Benefit:** 75% = $180.00	85% = $204.00
56224	COMPUTED TOMOGRAPHY - scan of spine, cervical region, with intravenous contrast medium and with any scans of the cervical region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $351.40	**Benefit:** 75% = $263.55	85% = $298.70
56225	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken, only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $351.40	**Benefit:** 75% = $263.55	85% = $298.70
56226	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $351.40	**Benefit:** 75% = $263.55	85% = $298.70
56227	COMPUTED TOMOGRAPHY - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $122.50	**Benefit:** 75% = $91.90	85% = $104.15
56228	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $122.50	**Benefit:** 75% = $91.90	85% = $104.15
56229	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $122.50	**Benefit:** 75% = $91.90	85% = $104.15
56230	COMPUTED TOMOGRAPHY - scan of spine, cervical region, with intravenous contrast medium, and with any scans to the cerival region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $177.45	**Benefit:** 75% = $133.10	85% = $150.85
56231	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $177.45	**Benefit:** 75% = $133.10	85% = $150.85
56232	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $177.45	**Benefit:** 75% = $133.10	85% = $150.85

	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item
56233	COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56220, 56221 and 56223 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $240.00 **Benefit:** 75% = $180.00 85% = $204.00
	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item
56234	COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56224, 56225 and 56226 with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item
56235	COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56227, 56228 and 56229 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $122.45 **Benefit:** 75% = $91.85 85% = $104.10
	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item
56236	COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56230, 56231 and 56232 with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $177.45 **Benefit:** 75% = $133.10 85% = $150.85
56237	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $240.00 **Benefit:** 75% = $180.00 85% = $204.00
56238	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit, payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
56239	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $122.45 **Benefit:** 75% = $91.85 85% = $104.10
56240	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit, payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $177.45 **Benefit:** 75% = $133.10 85% = $150.85
56259	COMPUTED TOMOGRAPHY - scan of spine, 1 or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated plain X-rays, not being a service to which item 59724 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $164.80 **Benefit:** 75% = $123.60 85% = $140.10

CHEST AND UPPER ABDOMEN

56301 COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56801 or 57001 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.)
(See para DIQ of explanatory notes to this Category)
Fee: $295.00 **Benefit:** 75% = $221.25 85% = $250.75

56307 COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56807 or 57007 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.)
(See para DIQ of explanatory notes to this Category)
Fee: $400.00 **Benefit:** 75% = $300.00 85% = $340.00

56341 COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56841 or 57041 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.)
(See para DIQ of explanatory notes to this Category)
Fee: $149.45 **Benefit:** 75% = $112.10 85% = $127.05

56347 COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56847 or 57047 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.)
(See para DIQ of explanatory notes to this Category)
Fee: $202.00 **Benefit:** 75% = $151.50 85% = $171.70

UPPER ABDOMEN

56401 COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) without intravenous contrast medium, not being a service to which item 56301, 56501, 56801 or 57001 applies (R) (K) (Anaes.)
(See para DIQ of explanatory notes to this Category)
Fee: $250.00 **Benefit:** 75% = $187.50 85% = $212.50

56407 COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) with intravenous contrast medium and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56307, 56507, 56807 or 57007 applies (R) (K) (Anaes.)
(See para DIQ of explanatory notes to this Category)
Fee: $360.00 **Benefit:** 75% = $270.00 85% = $306.00

56409 COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium not being a service associated with a service to which item 56401 applies (R) (K) (Anaes.)
(See para DIQ of explanatory notes to this Category)
Fee: $250.00 **Benefit:** 75% = $187.50 85% = $212.50

56412 COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) with intravenous contrast medium and with any scans of pelvis (iliac crest to pubic symphysis) prior to intravenous contrast injection, when undertaken, not being a service to which item 56407 applies (R) (K) (Anaes.)
(See para DIQ of explanatory notes to this Category)
Fee: $360.00 **Benefit:** 75% = $270.00 85% = $306.00

56441 COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest), without intravenous contrast medium, not being a service to which item 56341, 56541, 56841 or 57041 applies (R) (NK) (Anaes.)
(See para DIQ of explanatory notes to this Category)
Fee: $126.80 **Benefit:** 75% = $95.10 85% = $107.80

56447 COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) with intravenous contrast medium, and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56347, 56547, 56847 or 57047 applies (R) (NK) (Anaes.)
(See para DIQ of explanatory notes to this Category)
Fee: $181.50 **Benefit:** 75% = $136.15 85% = $154.30

56449	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium, not being a service to which item 56441 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $126.80 **Benefit:** 75% = $95.10 85% = $107.80
56452	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) with intravenous contrast medium, and with any scans of pelvis (iliac crest to pubic symphysis) prior to intravenous contrast injection, when undertaken, not being a service to which item 56447 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $181.50 **Benefit:** 75% = $136.15 85% = $154.30
	UPPER ABDOMEN AND PELVIS
56501	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis without intravenous contrast medium, not for the purposes of virtual colonoscopy, not being a service to which item 56801 or 57001 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $385.00 **Benefit:** 75% = $288.75 85% = $327.25
56507	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis with intravenous contrast medium and with any scans of upper abdomen and pelvis prior to intravenous contrast injection, when undertaken, not for the purposes of virtual colonoscopy, not being a service to which item 56807 or 57007 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $480.05 **Benefit:** 75% = $360.05 85% = $408.05
56541	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis without intravenous contrast medium, not for the purposes of virtual colonoscopy, not being a service to which item 56841 or 57041 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $193.15 **Benefit:** 75% = $144.90 85% = $164.20
56547	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis with intravenous contrast medium, and with any scans of upper abdomen and pelvis prior to intravenous contrast injection, when undertaken, not for the purposes of virtual colonoscopy, not being a service to which item 56847 or 57047 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $243.75 **Benefit:** 75% = $182.85 85% = $207.20
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 patient is referred by a specialist or consultant physician who performs colonoscopies [in the practice of his or her 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) (K) (Anaes.) *(See para DIL of explanatory notes to this Category)* **Fee:** $520.00 **Benefit:** 75% = $390.00 85% = $442.00
56555	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 patient is referred by a specialist or consultant physician who performs colonoscopies [in the practice of his or her 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) (NK) (Anaes.) *(See para DIL of explanatory notes to this Category)* **Fee:** $260.00 **Benefit:** 75% = $195.00 85% = $221.00
	EXTREMITIES
56619	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions without intravenous contrast medium, payable once only whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $220.00 **Benefit:** 75% = $165.00 85% = $187.00

56625	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions with intravenous contrast medium and with any scans of extremities prior to intravenous contrast injection, when undertaken; only 1 benefit is payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $334.65	**Benefit:** 75% = $251.00	85% = $284.50
56659	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions without intravenous contrast medium, payable once only whether 1 or more attendances are required to complete (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $112.10	**Benefit:** 75% = $84.10	85% = $95.30
56665	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions with intravenous contrast medium, and with any scans of extremities prior to intravenous contrast injection, when undertaken; only 1 benefit is payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $167.40	**Benefit:** 75% = $125.55	85% = $142.30
	CHEST, ABDOMEN, PELVIS AND NECK		
56801	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $466.55	**Benefit:** 75% = $349.95	85% = $396.60
56807	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $560.00	**Benefit:** 75% = $420.00	85% = $480.50
56841	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $233.35	**Benefit:** 75% = $175.05	85% = $198.35
56847	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $283.85	**Benefit:** 75% = $212.90	85% = $241.30
	BRAIN, CHEST AND UPPER ABDOMEN		
57001	COMPUTED TOMOGRAPHY - scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $466.65	**Benefit:** 75% = $350.00	85% = $396.70
57007	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $567.75	**Benefit:** 75% = $425.85	85% = $488.25
57041	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $233.40	**Benefit:** 75% = $175.05	85% = $198.40

57047	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $283.90 **Benefit:** 75% = $212.95 85% = $241.35
	PELVIMETRY
57201	COMPUTED TOMOGRAPHY - PELVIMETRY (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $155.20 **Benefit:** 75% = $116.40 85% = $131.95
57247	COMPUTED TOMOGRAPHY - PELVIMETRY (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $77.55 **Benefit:** 75% = $58.20 85% = $65.95
	INTERVENTIONAL TECHNIQUES
57341	COMPUTED TOMOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $470.00 **Benefit:** 75% = $352.50 85% = $399.50
57345	COMPUTED TOMOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $241.60 **Benefit:** 75% = $181.20 85% = $205.40
	SPIRAL ANGIOGRAPHY
57350	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $510.00 **Benefit:** 75% = $382.50 85% = $433.50
57351	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgery; acute ruptured aneurysm; or acute dissection of the aorta, carotid or vertebral artery; and (c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $510.00 **Benefit:** 75% = $382.50 85% = $433.50
57355	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $264.15 **Benefit:** 75% = $198.15 85% = $224.55

57356	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: a) the service is not a service to which another item in this group applies; and b) the service is performed for the exclusion of acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgery; or acute ruptured aneurysm; acute dissection of the aorta, carotid or vertebral artery; and (c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*	**Fee:** $264.15	**Benefit:** 75% = $198.15 85% = $224.55
57360	COMPUTED TOMOGRAPHY OF THE CORONARY ARTERIES performed on a minimum of a 64 slice (or equivalent) scanner, where the request is made by a specialist or consultant physician, and: – 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; or – the patient requires exclusion of coronary artery anomaly or fistula; or – the patient will be undergoing non-coronary cardiac surgery (R) (K) (Anaes.) *(See para DIL and DIQ of explanatory notes to this Category)*	**Fee:** $700.00	**Benefit:** 75% = $525.00 85% = $620.50
57361	COMPUTED TOMOGRAPHY OF THE CORONARY ARTERIES performed on a minimum of a 64 slice (or equivalent) scanner, where the request is made by a specialist or consultant physician, and: a) 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; or b) the patient requires exclusion of coronary artery anomaly or fistula; or c) the patient will be undergoing non-coronary cardiac surgery (R) (NK) (Anaes.) *(See para DIL and DIQ of explanatory notes to this Category)*	**Fee:** $350.00	**Benefit:** 75% = $262.50 85% = $297.50
57362	Dental & temporo-mandibular joint imaging for diagnosis and management of mandibular and dento-alveolar fractures, dental implant planning, orthodontics, endodontic, periodontal and temporo-mandibular joint conditions: without contrast medium. Restricted to requesting by dental specialists and medical practitioners and must be performed on equipment located in practices accredited under the Diagnostic Imaging Accreditation Scheme using dedicated (rather than hybrid) CBCT units. Claims for more than one CBCT per patient per day are excluded. Claiming with two-dimensional imaging in the same episode (items 57959-57969) and with CT in the same episode (items 56001-57361) are also excluded. (K) *(See para DID of explanatory notes to this Category)*	**Fee:** $113.15	**Benefit:** 75% = $84.90 85% = $96.20
57363	Dental & temporo-mandibular joint imaging for diagnosis and management of mandibular and dento-alveolar fractures, dental implant planning, orthodontics, endodontic, periodontal and temporo-mandibular joint conditions: without contrast medium. Restricted to requesting by dental specialists and medical practitioners and must be performed on equipment located in practices accredited under the Diagnostic Imaging Accreditation Scheme using dedicated (rather than hybrid) CBCT units. Claims for more than one CBCT per patient per day are excluded. Claiming with two-dimensional imaging in the same episode (items 57959-57969) and with CT in the same episode (items 56001-57361) are also excluded. (NK) *(See para DID of explanatory notes to this Category)*	**Fee:** $56.60	**Benefit:** 75% = $42.45 85% = $48.15

GROUP I3 - DIAGNOSTIC RADIOLOGY

SUBGROUP 1 - RADIOGRAPHIC EXAMINATION OF EXTREMITIES

57506	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $29.75	**Benefit:** 75% = $22.35	85% = $25.30
57509	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $39.75	**Benefit:** 75% = $29.85	85% = $33.80
57512	HAND AND WRIST OR HAND, WRIST AND FOREARM OR FOREARM AND ELBOW OR ELBOW AND HUMERUS (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $40.50	**Benefit:** 75% = $30.40	85% = $34.45
57515	HAND AND WRIST OR HAND, WRIST AND FOREARM OR FOREARM AND ELBOW OR ELBOW AND HUMERUS (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.00	**Benefit:** 75% = $40.50	85% = $45.90
57518	FOOT, ANKLE, LEG, KNEE OR FEMUR (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.50	**Benefit:** 75% = $24.40	85% = $27.65
57521	FOOT, ANKLE, LEG, KNEE OR FEMUR (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $43.40	**Benefit:** 75% = $32.55	85% = $36.90
57524	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $49.40	**Benefit:** 75% = $37.05	85% = $42.00
57527	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $65.75	**Benefit:** 75% = $49.35	85% = $55.90
57529	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $14.90	**Benefit:** 75% = $11.20	85% = $12.70
57530	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $19.90	**Benefit:** 75% = $14.95	85% = $16.95
57532	HAND AND WRIST OR HAND, WRIST AND FOREARM OR FOREARM AND ELBOW OR ELBOW AND HUMERUS (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $20.25	**Benefit:** 75% = $15.20	85% = $17.25
57533	HAND AND WRIST OR HAND, WRIST AND FOREARM OR FOREARM AND ELBOW OR ELBOW AND HUMERUS (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $27.00	**Benefit:** 75% = $20.25	85% = $22.95
57535	FOOT, ANKLE, LEG, KNEE OR FEMUR (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $16.25	**Benefit:** 75% = $12.20	85% = $13.85
57536	FOOT, ANKLE, LEG, KNEE OR FEMUR (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $21.70	**Benefit:** 75% = $16.30	85% = $18.45
57538	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $24.70	**Benefit:** 75% = $18.55	85% = $21.00

	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
57539	**Fee:** $32.90	**Benefit:** 75% = $24.70	85% = $28.00
	SUBGROUP 2 - RADIOGRAPHIC EXAMINATION OF SHOULDER OR PELVIS		
	SHOULDER OR SCAPULA (NR) *(See para DIQ of explanatory notes to this Category)*		
57700	**Fee:** $40.50	**Benefit:** 75% = $30.40	85% = $34.45
	SHOULDER OR SCAPULA (NR) (NK) *(See para DIQ of explanatory notes to this Category)*		
57702	**Fee:** $20.25	**Benefit:** 75% = $15.20	85% = $17.25
	SHOULDER OR SCAPULA (R) *(See para DIQ of explanatory notes to this Category)*		
57703	**Fee:** $54.00	**Benefit:** 75% = $40.50	85% = $45.90
	SHOULDER OR SCAPULA (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
57705	**Fee:** $27.00	**Benefit:** 75% = $20.25	85% = $22.95
	CLAVICLE (NR) *(See para DIQ of explanatory notes to this Category)*		
57706	**Fee:** $32.50	**Benefit:** 75% = $24.40	85% = $27.65
	CLAVICLE (NR) (NK) *(See para DIQ of explanatory notes to this Category)*		
57708	**Fee:** $16.25	**Benefit:** 75% = $12.20	85% = $13.85
	CLAVICLE (R) *(See para DIQ of explanatory notes to this Category)*		
57709	**Fee:** $43.40	**Benefit:** 75% = $32.55	85% = $36.90
	CLAVICLE (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
57711	**Fee:** $21.70	**Benefit:** 75% = $16.30	85% = $18.45
	HIP JOINT (R) *(See para DIQ of explanatory notes to this Category)*		
57712	**Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10
	HIP JOINT (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
57714	**Fee:** $23.60	**Benefit:** 75% = $17.70	85% = $20.10
	PELVIC GIRDLE (R) *(See para DIQ of explanatory notes to this Category)*		
57715	**Fee:** $60.90	**Benefit:** 75% = $45.70	85% = $51.80
	PELVIC GIRDLE (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
57717	**Fee:** $30.45	**Benefit:** 75% = $22.85	85% = $25.90
	FEMUR, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R) *(See para DIQ of explanatory notes to this Category)*		
57721	**Fee:** $99.25	**Benefit:** 75% = $74.45	85% = $84.40
	FEMUR, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
57723	**Fee:** $49.65	**Benefit:** 75% = $37.25	85% = $42.25
	SUBGROUP 3 - RADIOGRAPHIC EXAMINATION OF HEAD		
	SKULL, not in association with item 57902 (R) *(See para DIQ of explanatory notes to this Category)*		
57901	**Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85

57902	CEPHALOMETRY, not in association with item 57901 (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85
57903	SINUSES (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.30	**Benefit:** 75% = $35.50	85% = $40.25
57906	MASTOIDS (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85
57909	PETROUS TEMPORAL BONES (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85
57911	SKULL, not in association with item 57902 or 57914 (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.25	**Benefit:** 75% = $24.20	85% = $27.45
57912	FACIAL BONES orbit, maxilla or malar, any or all (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10
57914	CEPHALOMETRY, not in association with item 57901 or 57911 (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.25	**Benefit:** 75% = $24.20	85% = $27.45
57915	MANDIBLE, not by orthopantomography technique (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10
57917	SINUSES (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.65	**Benefit:** 75% = $17.75	85% = $20.15
57918	SALIVARY CALCULUS (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10
57920	MASTOIDS (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.25	**Benefit:** 75% = $24.20	85% = $27.45
57921	NOSE (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10
57923	PETROUS TEMPORAL BONES (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.25	**Benefit:** 75% = $24.20	85% = $27.45
57924	EYE (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10
57926	FACIAL BONES orbit, maxilla or malar, any or all (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.60	**Benefit:** 75% = $17.70	85% = $20.10
57927	TEMPOROMANDIBULAR JOINTS (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $49.65	**Benefit:** 75% = $37.25	85% = $42.25
57929	MANDIBLE, not by orthopantomography technique (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.60	**Benefit:** 75% = $17.70	85% = $20.10

57930	TEETH SINGLE AREA (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.90	**Benefit:** 75% = $24.70	85% = $28.00
57932	SALIVARY CALCULUS (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.60	**Benefit:** 75% = $17.70	85% = $20.10
57933	TEETH FULL MOUTH (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $78.25	**Benefit:** 75% = $58.70	85% = $66.55
57935	NOSE (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.60	**Benefit:** 75% = $17.70	85% = $20.10
57938	EYE (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.60	**Benefit:** 75% = $17.70	85% = $20.10
57939	PALATOPHARYNGEAL STUDIES with fluoroscopic screening (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85
57941	TEMPOROMANDIBULAR JOINTS (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $24.85	**Benefit:** 75% = $18.65	85% = $21.15
57942	PALATOPHARYNGEAL STUDIES without fluoroscopic screening (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $49.65	**Benefit:** 75% = $37.25	85% = $42.25
57944	TEETH SINGLE AREA (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $16.45	**Benefit:** 75% = $12.35	85% = $14.00
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 DIQ of explanatory notes to this Category)* **Fee:** $43.40	**Benefit:** 75% = $32.55	85% = $36.90
57947	TEETH FULL MOUTH (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $39.15	**Benefit:** 75% = $29.40	85% = $33.30
57950	PALATOPHARYNGEAL STUDIES with fluoroscopic screening (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.25	**Benefit:** 75% = $24.20	85% = $27.45
57953	PALATOPHARYNGEAL STUDIES without fluoroscopic screening (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $24.85	**Benefit:** 75% = $18.65	85% = $21.15
57956	LARYNX, LATERAL AIRWAYS AND SOFT TISSUES OF THE NECK, not being a service associated with a service to which item 57939, 57942, 57950 or 57953 applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $21.70	**Benefit:** 75% = $16.30	85% = $18.45
57959	Orthopantomography, for diagnosis and/or management of trauma, infection, tumours, congenital conditions or surgical conditions of the teeth or maxillofacial region (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.70	**Benefit:** 75% = $17.80	85% = $20.15
57960	Orthopantomography, for diagnosis and/or management of trauma, infection, tumours, congenital conditions or surgical conditions of the teeth or maxillofacial region (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.40	**Benefit:** 75% = $35.55	85% = $40.30

57962	Orthopantomography, for diagnosis and/or management of impacted teeth, caries, periodontal or peripical pathology where signs or symptoms of those conditions are evident (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.70	**Benefit:** 75% = $17.80	85% = $20.15
57963	Orthopantomography, for diagnosis and/or management of impacted teeth, caries, periodontal or peripical pathology where signs or symptoms of those conditions are evident (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.40	**Benefit:** 75% = $35.55	85% = $40.30
57965	Orthopantomography, for diagnosis and/or management of missing or crowded teeth, or developmental anomalies of the teeth or jaws (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.70	**Benefit:** 75% = $17.80	85% = $20.15
57966	Orthopantomography, for diagnosis and/or management of missing or crowded teeth, or developmental anomalies of the teeth or jaws (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.40	**Benefit:** 75% = $35.55	85% = $40.30
57968	Orthopantomography, for diagnosis and/or management of temporomandibular joint arthroses or dysfunction (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.70	**Benefit:** 75% = $17.80	85% = $20.15
57969	Orthopantomography, for diagnosis and/or management of temporomandibular joint arthroses or dysfunction (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.40	**Benefit:** 75% = $35.55	85% = $40.30
	SUBGROUP 4 - RADIOGRAPHIC EXAMINATION OF SPINE		
58100	SPINE CERVICAL (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $67.15	**Benefit:** 75% = $50.40	85% = $57.10
58102	SPINE CERVICAL (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $33.60	**Benefit:** 75% = $25.20	85% = $28.60
58103	SPINE THORACIC (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.10	**Benefit:** 75% = $41.35	85% = $46.85
58105	SPINE THORACIC (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $27.55	**Benefit:** 75% = $20.70	85% = $23.45
58106	SPINE LUMBOSACRAL (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $77.00	**Benefit:** 75% = $57.75	85% = $65.45
58108	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50
58109	SPINE SACROCOCCYGEAL (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.00	**Benefit:** 75% = $35.25	85% = $39.95
58111	SPINE LUMBOSACRAL (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $38.50	**Benefit:** 75% = $28.90	85% = $32.75

	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item		
58112	Spine, two examinations of the kind referred to in items 58100, 58103, 58106 and 58109 (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $97.25	**Benefit:** 75% = $72.95	85% = $82.70
58114	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.00	**Benefit:** 75% = $41.25	85% = $46.75
	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item		
58115	Spine, three examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50
58117	SPINE SACROCOCCYGEAL (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.50	**Benefit:** 75% = $17.65	85% = $20.00
58120	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (R), if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50
	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item		
58121	Spine, three examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R), if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50
	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item		
58123	Spine, two examinations of the kind referred to in items 58100, 58102, 58103, 58105, 58106, 58109, 58111 and 58117 (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $48.65	**Benefit:** 75% = $36.50	85% = $41.40
	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item		
58124	Spine, three examinations of the kind mentioned in items 58100, 58102, 58103, 58105, 58106, 58109, 58111 and 58117 (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.00	**Benefit:** 75% = $41.25	85% = $46.75
58126	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal, if the service to which item 58120, 58121, 58126 or 58127 applies has not been performed on the same patient within the same calendar year (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.00	**Benefit:** 75% = $41.25	85% = $46.75
	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item		
58127	Spine, three examinations of the kind mentioned in items 58100, 58102, 58103, 58105, 58106 and 58109, 58111 and 58117 if the service to which item 58120, 58121, 58126 or 58127 applies has not been performed on the same patient within the same calendar year (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.00	**Benefit:** 75% = $41.25	85% = $46.75
	SUBGROUP 5 - BONE AGE STUDY AND SKELETAL SURVEYS		
58300	BONE AGE STUDY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $40.10	**Benefit:** 75% = $30.10	85% = $34.10

	BONE AGE STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
58302	**Fee:** $20.05	**Benefit:** 75% = $15.05	85% = $17.05
	SKELETAL SURVEY (R) *(See para DIQ of explanatory notes to this Category)*		
58306	**Fee:** $89.40	**Benefit:** 75% = $67.05	85% = $76.00
	SKELETAL SURVEY (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
58308	**Fee:** $44.70	**Benefit:** 75% = $33.55	85% = $38.00
	SUBGROUP 6 - RADIOGRAPHIC EXAMINATION OF THORACIC REGION		
	CHEST (lung fields) by direct radiography (NR) *(See para DIQ of explanatory notes to this Category)*		
58500	**Fee:** $35.35	**Benefit:** 75% = $26.55	85% = $30.05
	CHEST (lung fields) by direct radiography (NR) (NK) *(See para DIQ of explanatory notes to this Category)*		
58502	**Fee:** $17.70	**Benefit:** 75% = $13.30	85% = $15.05
	CHEST (lung fields) by direct radiography (R) *(See para DIQ of explanatory notes to this Category)*		
58503	**Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10
	CHEST (lung fields) by direct radiography (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
58505	**Fee:** $23.60	**Benefit:** 75% = $17.70	85% = $20.10
	CHEST (lung fields) by direct radiography with fluoroscopic screening (R) *(See para DIQ of explanatory notes to this Category)*		
58506	**Fee:** $60.75	**Benefit:** 75% = $45.60	85% = $51.65
	CHEST (lung fields) by direct radiography with fluoroscopic screening (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
58508	**Fee:** $30.40	**Benefit:** 75% = $22.80	85% = $25.85
	THORACIC INLET OR TRACHEA (R) *(See para DIQ of explanatory notes to this Category)*		
58509	**Fee:** $39.75	**Benefit:** 75% = $29.85	85% = $33.80
	THORACIC INLET OR TRACHEA (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
58511	**Fee:** $19.90	**Benefit:** 75% = $14.95	85% = $16.95
	LEFT RIBS, RIGHT RIBS OR STERNUM (R) *(See para DIQ of explanatory notes to this Category)*		
58521	**Fee:** $43.40	**Benefit:** 75% = $32.55	85% = $36.90
	LEFT RIBS, RIGHT RIBS OR STERNUM (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
58523	**Fee:** $21.70	**Benefit:** 75% = $16.30	85% = $18.45
	LEFT AND RIGHT RIBS, LEFT RIBS AND STERNUM, OR RIGHT RIBS AND STERNUM (R) *(See para DIQ of explanatory notes to this Category)*		
58524	**Fee:** $56.50	**Benefit:** 75% = $42.40	85% = $48.05
	LEFT AND RIGHT RIBS, LEFT RIBS AND STERNUM, OR RIGHT RIBS AND STERNUM (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
58526	**Fee:** $28.25	**Benefit:** 75% = $21.20	85% = $24.05
	LEFT RIBS, RIGHT RIBS AND STERNUM (R) *(See para DIQ of explanatory notes to this Category)*		
58527	**Fee:** $69.40	**Benefit:** 75% = $52.05	85% = $59.00

	LEFT RIBS, RIGHT RIBS AND STERNUM (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
58529	**Fee:** $34.70	**Benefit:** 75% = $26.05	85% = $29.50
	SUBGROUP 7 - RADIOGRAPHIC EXAMINATION OF URINARY TRACT		
	PLAIN RENAL ONLY (R) *(See para DIQ of explanatory notes to this Category)*		
58700	**Fee:** $46.05	**Benefit:** 75% = $34.55	85% = $39.15
	PLAIN RENAL ONLY (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
58702	**Fee:** $23.05	**Benefit:** 75% = $17.30	85% = $19.60
	INTRAVENOUS PYELOGRAPHY, with or without preliminary plain films and with or without tomography - (R) *(See para DIQ of explanatory notes to this Category)*		
58706	**Fee:** $157.90	**Benefit:** 75% = $118.45	85% = $134.25
	INTRAVENOUS PYELOGRAPHY, with or without preliminary plain films and with or without tomography - (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
58708	**Fee:** $78.95	**Benefit:** 75% = $59.25	85% = $67.15
	ANTEGRADE OR RETROGRADE PYELOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - 1 side - (R) *(See para DIQ of explanatory notes to this Category)*		
58715	**Fee:** $151.55	**Benefit:** 75% = $113.70	85% = $128.85
	ANTEGRADE OR RETROGRADE PYELOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - 1 side - (R) (NK) *(See para DIQ of explanatory notes to this Category)*		
58717	**Fee:** $75.80	**Benefit:** 75% = $56.85	85% = $64.45
	RETROGRADE CYSTOGRAPHY OR RETROGRADE URETHROGRAPHY with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
58718	**Fee:** $126.10	**Benefit:** 75% = $94.60	85% = $107.20
	RETROGRADE CYSTOGRAPHY OR RETROGRADE URETHROGRAPHY with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
58720	**Fee:** $63.05	**Benefit:** 75% = $47.30	85% = $53.60
	RETROGRADE MICTURATING CYSTOURETHROGRAPHY, with preparation and contrast injection - (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
58721	**Fee:** $138.25	**Benefit:** 75% = $103.70	85% = $117.55
	RETROGRADE MICTURATING CYSTOURETHROGRAPHY, with preparation and contrast injection - (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
58723	**Fee:** $69.15	**Benefit:** 75% = $51.90	85% = $58.80
	SUBGROUP 8 - RADIOGRAPHIC EXAMINATION OF ALIMENTARY TRACT AND BILIARY SYSTEM		
	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58912, 58915 or 58924 applies (NR) *(See para DIQ of explanatory notes to this Category)*		
58900	**Fee:** $35.70	**Benefit:** 75% = $26.80	85% = $30.35
	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58911, 58912, 58914, 58915, 58917, 58924 or 58926 applies (NR) (NK) *(See para DIQ of explanatory notes to this Category)*		
58902	**Fee:** $17.85	**Benefit:** 75% = $13.40	85% = $15.20
	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58912, 58915 or 58924 applies (R) *(See para DIQ of explanatory notes to this Category)*		
58903	**Fee:** $47.60	**Benefit:** 75% = $35.70	85% = $40.50

58905	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58911, 58912, 58914, 58915, 58917, 58924 or 58926 applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.80	**Benefit:** 75% = $17.85	85% = $20.25
58909	BARIUM or other opaque meal of 1 or more of PHARYNX, OESOPHAGUS, STOMACH OR DUODENUM, with or without preliminary plain films of pharynx, chest or duodenum, not being a service associated with a service to which item 57939 or 57942 or 57945 applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $89.95	**Benefit:** 75% = $67.50	85% = $76.50
58911	BARIUM or other opaque meal of 1 or more of PHARYNX, OESOPHAGUS, STOMACH OR DUODENUM, with or without preliminary plain films of pharynx, chest or duodenum, not being a service associated with a service to which item 57939, 57942, 57945, 57950, 57953 or 57956 applies - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $45.00	**Benefit:** 75% = $33.75	85% = $38.25
58912	BARIUM or other opaque meal OF OESOPHAGUS, STOMACH, DUODENUM AND FOLLOW THROUGH TO COLON, with or without screening of chest, with or without preliminary plain film (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $110.25	**Benefit:** 75% = $82.70	85% = $93.75
58914	BARIUM or other opaque meal OF OESOPHAGUS, STOMACH, DUODENUM AND FOLLOW THROUGH TO COLON, with or without screening of chest, with or without preliminary plain film (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.15	**Benefit:** 75% = $41.40	85% = $46.90
58915	BARIUM or other opaque meal, SMALL BOWEL SERIES ONLY, with or without preliminary plain film (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $78.95	**Benefit:** 75% = $59.25	85% = $67.15
58916	SMALL BOWEL ENEMA, barium or other opaque study of the small bowel, including DUODENAL INTUBATION, with or without preliminary plain films, not being a service associated with a service to which item 30488 applies - (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $138.50	**Benefit:** 75% = $103.90	85% = $117.75
58917	BARIUM or other opaque meal, SMALL BOWEL SERIES ONLY, with or without preliminary plain film (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $39.50	**Benefit:** 75% = $29.65	85% = $33.60
58920	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) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $69.25	**Benefit:** 75% = $51.95	85% = $58.90
58921	OPAQUE ENEMA, with or without air contrast study and with or without preliminary plain films - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $135.25	**Benefit:** 75% = $101.45	85% = $115.00
58923	OPAQUE ENEMA, with or without air contrast study and with or without preliminary plain films - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $67.65	**Benefit:** 75% = $50.75	85% = $57.55
58924	GRAHAM'S TEST (cholecystography), with preliminary plain films and with or without tomography - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.05	**Benefit:** 75% = $63.05	85% = $71.45
58926	GRAHAM'S TEST (cholecystography), with preliminary plain films and with or without tomography - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $42.05	**Benefit:** 75% = $31.55	85% = $35.75
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 DIQ of explanatory notes to this Category)* **Fee:** $76.45	**Benefit:** 75% = $57.35	85% = $65.00

58929	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) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $38.25 **Benefit:** 75% = $28.70 85% = $32.55
58933	CHOLEGRAPHY, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $205.60 **Benefit:** 75% = $154.20 85% = $174.80
58935	CHOLEGRAPHY, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $102.80 **Benefit:** 75% = $77.10 85% = $87.40
58936	CHOLEGRAPHY, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $195.95 **Benefit:** 75% = $147.00 85% = $166.60
58938	CHOLEGRAPHY, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $98.00 **Benefit:** 75% = $73.50 85% = $83.30
58939	DEFAECOGRAM (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $139.30 **Benefit:** 75% = $104.50 85% = $118.45
58941	DEFAECOGRAM (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $69.65 **Benefit:** 75% = $52.25 85% = $59.25
	SUBGROUP 9 - RADIOGRAPHIC EXAMINATION FOR LOCALISATION OF FOREIGN BODIES
59103	Localisation of foreign body, if provided in conjunction with a service described in Subgroups 1 to 12 of Group I3 (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $21.30 **Benefit:** 75% = $16.00 85% = $18.15
59104	Localisation of foreign body, if provided in conjunction with a service described in Subgroups 1 to 12 of Group I3 (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $10.65 **Benefit:** 75% = $8.00 85% = $9.10
	SUBGROUP 10 - RADIOGRAPHIC EXAMINATION OF BREASTS
59300	*(Note: These items are intended for use in the investigation of a clinical abnormality of the breast/s and NOT for individual, group or opportunistic screening of asymptomatic patients)* MAMMOGRAPHY OF BOTH BREASTS, if there is a reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner. Unless otherwise indicated, mammography includes both breasts (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $89.50 **Benefit:** 75% = $67.15 85% = $76.10
59301	*(Note: These items are intended for use in the investigation of a clinical abnormality of the breast/s and NOT for individual, group or opportunistic screening of asymptomatic patients)* MAMMOGRAPHY OF BOTH BREASTS, if there is a reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner. Unless otherwise indicated, mammography includes both breasts (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $44.75 **Benefit:** 75% = $33.60 85% = $38.05

59303	MAMMOGRAPHY OF ONE BREAST, if: (a) the patient is referred with a specific request for a unilateral mammogram; and (b) there is reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $53.95	**Benefit:** 75% = $40.50	85% = $45.90
59304	MAMMOGRAPHY OF ONE BREAST, if: (a) the patient is referred with a specific request for a unilateral mammogram; and (b) there is reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $27.00	**Benefit:** 75% = $20.25	85% = $22.95
59306	MAMMARY DUCTOGRAM (galactography) - 1 breast (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $100.30	**Benefit:** 75% = $75.25	85% = $85.30
59307	MAMMARY DUCTOGRAM (galactography) - 1 breast (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $50.15	**Benefit:** 75% = $37.65	85% = $42.65
59309	MAMMARY DUCTOGRAM (galactography) - 2 breasts (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $200.60	**Benefit:** 75% = $150.45	85% = $170.55
59310	MAMMARY DUCTOGRAM (galactography) - 2 breasts (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $100.30	**Benefit:** 75% = $75.25	85% = $85.30
59312	RADIOGRAPHIC EXAMINATION OF BOTH BREASTS, in conjunction with a surgical procedure on each breast, using interventional techniques - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $87.00	**Benefit:** 75% = $65.25	85% = $73.95
59313	RADIOGRAPHIC EXAMINATION OF BOTH BREASTS, in conjunction with a surgical procedure on each breast, using interventional techniques - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $43.50	**Benefit:** 75% = $32.65	85% = $37.00
59314	RADIOGRAPHIC EXAMINATION OF 1 BREAST, in conjunction with a surgical procedure using interventional techniques - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $52.50	**Benefit:** 75% = $39.40	85% = $44.65
59315	RADIOGRAPHIC EXAMINATION OF 1 BREAST, in conjunction with a surgical procedure using interventional techniques - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $26.25	**Benefit:** 75% = $19.70	85% = $22.35
59318	RADIOGRAPHIC EXAMINATION OF EXCISED BREAST TISSUE to confirm satisfactory excision of 1 or more lesions in 1 breast or both following pre-operative localisation in conjunction with a service under item 31536 - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.05	**Benefit:** 75% = $35.30	85% = $40.00
59319	RADIOGRAPHIC EXAMINATION OF EXCISED BREAST TISSUE to confirm satisfactory excision of 1 or more lesions in 1 breast or both following pre-operative localisation in conjunction with a service under item 31536 - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.55	**Benefit:** 75% = $17.70	85% = $20.05
	SUBGROUP 11 - RADIOGRAPHIC EXAMINATION IN CONNECTION WITH PREGNANCY		
59503	PELVIMETRY, not being a service associated with a service to which item 57201 applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $89.40	**Benefit:** 75% = $67.05	85% = $76.00

59504	PELVIMETRY, not being a service associated with a service to which item 57201 or 57247 applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $44.70 **Benefit:** 75% = $33.55 85% = $38.00
	SUBGROUP 12 - RADIOGRAPHIC EXAMINATION WITH OPAQUE OR CONTRAST MEDIA
59700	DISCOGRAPHY, each disc, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $96.55 **Benefit:** 75% = $72.45 85% = $82.10
59701	DISCOGRAPHY, each disc, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $48.30 **Benefit:** 75% = $36.25 85% = $41.10
59703	DACRYOCYSTOGRAPHY, 1 side, with or without preliminary plain film and with preparation and contrast injection - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $75.90 **Benefit:** 75% = $56.95 85% = $64.55
59704	DACRYOCYSTOGRAPHY, 1 side, with or without preliminary plain film and with preparation and contrast injection - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.95 **Benefit:** 75% = $28.50 85% = $32.30
59712	HYSTEROSALPINGOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $113.70 **Benefit:** 75% = $85.30 85% = $96.65
59713	HYSTEROSALPINGOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $56.85 **Benefit:** 75% = $42.65 85% = $48.35
59715	BRONCHOGRAPHY, 1 side, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $143.55 **Benefit:** 75% = $107.70 85% = $122.05
59716	BRONCHOGRAPHY, 1 side, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $71.80 **Benefit:** 75% = $53.85 85% = $61.05
59718	PHLEBOGRAPHY, 1 side, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $134.65 **Benefit:** 75% = $101.00 85% = $114.50
59719	PHLEBOGRAPHY, 1 side, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $67.35 **Benefit:** 75% = $50.55 85% = $57.25
59724	MYELOGRAPHY, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 56219 applies - (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $226.45 **Benefit:** 75% = $169.85 85% = $192.50
59725	MYELOGRAPHY, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 56219 or 56259 applies - (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $113.25 **Benefit:** 75% = $84.95 85% = $96.30
59733	SIALOGRAPHY, 1 side, with preparation and contrast injection, not being a service associated with a service to which item 57918 applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $107.70 **Benefit:** 75% = $80.80 85% = $91.55

59734	SIALOGRAPHY, 1 side, with preparation and contrast injection, not being a service associated with a service to which item 57918 or 57932 applies - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $53.85	**Benefit:** 75% = $40.40	85% = $45.80
59736	VASOEPIDIDYMOGRAPHY, 1 side, - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $62.00	**Benefit:** 75% = $46.50	85% = $52.70
59737	VASOEPIDIDYMOGRAPHY, 1 side, - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $31.00	**Benefit:** 75% = $23.25	85% = $26.35
59739	SINOGRAM OR FISTULOGRAM, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $73.75	**Benefit:** 75% = $55.35	85% = $62.70
59740	SINOGRAM OR FISTULOGRAM, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $36.90	**Benefit:** 75% = $27.70	85% = $31.40
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 DIQ of explanatory notes to this Category)* **Fee:** $139.15	**Benefit:** 75% = $104.40	85% = $118.30
59752	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) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $69.60	**Benefit:** 75% = $52.20	85% = $59.20
59754	LYMPHANGIOGRAPHY, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $219.35	**Benefit:** 75% = $164.55	85% = $186.45
59755	LYMPHANGIOGRAPHY, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.70	**Benefit:** 75% = $82.30	85% = $93.25
59760	PERITONEOGRAM (herniography) with or without contrast medium including preparation - performed on a person over 14 years of age (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $115.15	**Benefit:** 75% = $86.40	85% = $97.90
59761	PERITONEOGRAM (herniography) with or without contrast medium including preparation - performed on a person over 14 years of age (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $57.60	**Benefit:** 75% = $43.20	85% = $49.00
59763	AIR INSUFFLATION during video - fluoroscopic imaging including associated consultation (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $133.90	**Benefit:** 75% = $100.45	85% = $113.85
59764	AIR INSUFFLATION during video - fluoroscopic imaging including associated consultation (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $66.95	**Benefit:** 75% = $50.25	85% = $56.95
	SUBGROUP 13 - ANGIOGRAPHY		
Amend 59903	Angiocardiography, including the service mentioned in item 59970, 59974, 61109 or 61110, not being a service to which item 59912 or 59925 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $114.55	**Benefit:** 75% = $85.95	85% = $97.40

Amend 59912	Selective coronary arteriography, including the service mentioned in item 59970, 59974, 61109 or 61110, not being a service to which item 59903 or 59925 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $305.20	**Benefit:** 75% = $228.90	85% = $259.45
Amend 59925	Selective coronary arteriography and angiocardiography, including a service mentioned in item 59903, 59912, 59970, 59974, 61109 or 61110 (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $362.45	**Benefit:** 75% = $271.85	85% = $308.10
59970	ANGIOGRAPHY AND/OR DIGITAL SUBTRACTION ANGIOGRAPHY with fluoroscopy and image acquisition using a mobile image intensifier, 1 or more regions including any preliminary plain films, preparation and contrast injection (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $168.30	**Benefit:** 75% = $126.25	85% = $143.10
Amend 59971	Angiocardiography, including the service mentioned in item 59970, 59974, 61109 or 61110, not being a service to which item 59972 or 59973 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $57.30	**Benefit:** 75% = $43.00	85% = $48.75
Amend 59972	Selective coronary arteriography, including the service mentioned in item 59970, 59974, 61109 or 61110, not being a service to which item 59971 or 59973 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $152.60	**Benefit:** 75% = $114.45	85% = $129.75
Amend 59973	Selective coronary arteriography and angiocardiography, including a service mentioned in item 59970, 59971, 59972, 59974, 61109 or 61110 (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $181.25	**Benefit:** 75% = $135.95	85% = $154.10
59974	ANGIOGRAPHY AND/OR DIGITAL SUBTRACTION ANGIOGRAPHY with fluoroscopy and image acquisition using a mobile image intensifier, 1 or more regions including any preliminary plain films, preparation and contrast injection (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.20	**Benefit:** 75% = $63.15	85% = $71.60
	BY DIGITAL SUBTRACTION TECHNIQUE		
60000	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 1 to 3 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $564.00	**Benefit:** 75% = $423.00	85% = $484.50
60001	Digital subtraction angiography, examination of head and neck with or without arch aortography - 1 to 3 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $282.00	**Benefit:** 75% = $211.50	85% = $239.70
60003	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 4 to 6 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $827.10	**Benefit:** 75% = $620.35	85% = $747.60
60004	Digital subtraction angiography, examination of head and neck with or without arch aortography - 4 to 6 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $413.55	**Benefit:** 75% = $310.20	85% = $351.55
60006	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 7 to 9 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,176.10	**Benefit:** 75% = $882.10	85% = $1,096.60

60007	Digital subtraction angiography, examination of head and neck with or without arch aortography - 7 to 9 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $588.05	**Benefit:** 75% = $441.05	85% = $508.55
60009	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 10 or more data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,296.80
60010	Digital subtraction angiography, examination of head and neck with or without arch aortography - 10 or more data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $688.15	**Benefit:** 75% = $516.15	85% = $608.65
60012	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 1 to 3 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $564.00	**Benefit:** 75% = $423.00	85% = $484.50
60013	Digital subtraction angiography, examination of thorax - 1 to 3 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $282.00	**Benefit:** 75% = $211.50	85% = $239.70
60015	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 4 to 6 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $827.10	**Benefit:** 75% = $620.35	85% = $747.60
60016	Digital subtraction angiography, examination of thorax - 4 to 6 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $413.55	**Benefit:** 75% = $310.20	85% = $351.55
60018	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 7 to 9 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,176.10	**Benefit:** 75% = $882.10	85% = $1,096.60
60019	Digital subtraction angiography, examination of thorax - 7 to 9 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $588.05	**Benefit:** 75% = $441.05	85% = $508.55
60021	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 10 or more data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,296.80
60022	Digital subtraction angiography, examination of thorax - 10 or more data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $688.15	**Benefit:** 75% = $516.15	85% = $608.65
60024	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 1 to 3 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $564.00	**Benefit:** 75% = $423.00	85% = $484.50
60025	Digital subtraction angiography, examination of abdomen - 1 to 3 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $282.00	**Benefit:** 75% = $211.50	85% = $239.70
60027	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 4 to 6 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $827.10	**Benefit:** 75% = $620.35	85% = $747.60
60028	Digital subtraction angiography, examination of abdomen - 4 to 6 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $413.55	**Benefit:** 75% = $310.20	85% = $351.55
60030	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 7 to 9 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,176.10	**Benefit:** 75% = $882.10	85% = $1,096.60

60031	Digital subtraction angiography, examination of abdomen - 7 to 9 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $588.05	**Benefit:** 75% = $441.05	85% = $508.55
60033	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 10 or more data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,296.80
60034	Digital subtraction angiography, examination of abdomen - 10 or more data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $688.15	**Benefit:** 75% = $516.15	85% = $608.65
60036	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 1 to 3 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $564.00	**Benefit:** 75% = $423.00	85% = $484.50
60037	Digital subtraction angiography, examination of upper limb or limbs - 1 to 3 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $282.00	**Benefit:** 75% = $211.50	85% = $239.70
60039	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 4 to 6 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $827.10	**Benefit:** 75% = $620.35	85% = $747.60
60040	Digital subtraction angiography, examination of upper limb or limbs - 4 to 6 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $413.55	**Benefit:** 75% = $310.20	85% = $351.55
60042	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 7 to 9 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,176.10	**Benefit:** 75% = $882.10	85% = $1,096.60
60043	Digital subtraction angiography, examination of upper limb or limbs - 7 to 9 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $588.05	**Benefit:** 75% = $441.05	85% = $508.55
60045	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 10 or more data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,296.80
60046	Digital subtraction angiography, examination of upper limb or limbs - 10 or more data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $688.15	**Benefit:** 75% = $516.15	85% = $608.65
60048	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 1 to 3 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $564.00	**Benefit:** 75% = $423.00	85% = $484.50
60049	Digital subtraction angiography, examination of lower limb or limbs - 1 to 3 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $282.00	**Benefit:** 75% = $211.50	85% = $239.70
60051	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 4 to 6 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $827.10	**Benefit:** 75% = $620.35	85% = $747.60
60052	Digital subtraction angiography, examination of lower limb or limbs - 4 to 6 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $413.55	**Benefit:** 75% = $310.20	85% = $351.55
60054	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 7 to 9 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,176.10	**Benefit:** 75% = $882.10	85% = $1,096.60

60055	Digital subtraction angiography, examination of lower limb or limbs - 7 to 9 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $588.05	**Benefit:** 75% = $441.05	85% = $508.55
60057	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 10 or more data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,296.80
60058	Digital subtraction angiography, examination of lower limb or limbs - 10 or more data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $688.15	**Benefit:** 75% = $516.15	85% = $608.65
60060	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 1 to 3 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $564.00	**Benefit:** 75% = $423.00	85% = $484.50
60061	Digital subtraction angiography, examination of aorta and lower limb or limbs - 1 to 3 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $282.00	**Benefit:** 75% = $211.50	85% = $239.70
60063	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 4 to 6 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $827.10	**Benefit:** 75% = $620.35	85% = $747.60
60064	Digital subtraction angiography, examination of aorta and lower limb or limbs - 4 to 6 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $413.55	**Benefit:** 75% = $310.20	85% = $351.55
60066	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 7 to 9 data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,176.10	**Benefit:** 75% = $882.10	85% = $1,096.60
60067	Digital subtraction angiography, examination of aorta and lower limb or limbs - 7 to 9 data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $588.05	**Benefit:** 75% = $441.05	85% = $508.55
60069	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 10 or more data acquisition runs (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,296.80
60070	Digital subtraction angiography, examination of aorta and lower limb or limbs - 10 or more data acquisition runs (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $688.15	**Benefit:** 75% = $516.15	85% = $608.65
60072	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 1 vessel (NR) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $48.10	**Benefit:** 75% = $36.10	85% = $40.90
60073	Selective arteriography or selective venography by digital subtraction angiography technique - one vessel (NR) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $24.05	**Benefit:** 75% = $18.05	85% = $20.45
60075	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 2 vessels (NR) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $96.10	**Benefit:** 75% = $72.10	85% = $81.70
60076	Selective arteriography or selective venography by digital subtraction angiography technique - 2 vessels (NR) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $48.05	**Benefit:** 75% = $36.05	85% = $40.85

60078	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 3 or more vessels (NR) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $144.25	**Benefit:** 75% = $108.20	85% = $122.65
60079	Selective arteriography or selective venography by digital subtraction angiography technique - 3 or more vessels (NR) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $72.15	**Benefit:** 75% = $54.15	85% = $61.35
	SUBGROUP 14 - TOMOGRAPHY		
60100	TOMOGRAPHY OF ANY REGION (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $60.75	**Benefit:** 75% = $45.60	85% = $51.65
60101	TOMOGRAPHY OF ANY REGION (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $30.40	**Benefit:** 75% = $22.80	85% = $25.85
	SUBGROUP 15 - FLUOROSCOPIC EXAMINATION		
60500	FLUOROSCOPY, with general anaesthesia (not being a service associated with a radiographic examination) (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $43.40	**Benefit:** 75% = $32.55	85% = $36.90
60501	FLUOROSCOPY, with general anaesthesia (not being a service associated with a radiographic examination) (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $21.70	**Benefit:** 75% = $16.30	85% = $18.45
60503	FLUOROSCOPY, without general anaesthesia (not being a service associated with a radiographic examination) (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $29.75	**Benefit:** 75% = $22.35	85% = $25.30
60504	FLUOROSCOPY, without general anaesthesia (not being a service associated with a radiographic examination) (R) (NK) **Fee:** $14.90	**Benefit:** 75% = $11.20	85% = $12.70
60506	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service associated with a service to which another item in this Table applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $63.75	**Benefit:** 75% = $47.85	85% = $54.20
60507	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service associated with a service to which another item in this Table applies (R) (NK) **Fee:** $31.90	**Benefit:** 75% = $23.95	85% = $27.15
60509	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this Table applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $98.90	**Benefit:** 75% = $74.20	85% = $84.10
60510	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this Table applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $49.45	**Benefit:** 75% = $37.10	85% = $42.05
	SUBGROUP 16 - PREPARATION FOR RADIOLOGICAL PROCEDURE		
60918	ARTERIOGRAPHY (peripheral) or PHLEBOGRAPHY 1 vessel, when used in association with a service to which items 59903, 59912, 59925, 59970, 59971 59972, 59973 or 59974 applies, not being a service associated with a service to which items 60000 to 60079 inclusive apply (NR) (Anaes.) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10

60927	SELECTIVE ARTERIOGRAM or PHLEBOGRAM, when used in association with a service to which items 59903, 59912, 59925, 59970, 59971 59972, 59973 or 59974 applies, not being a service associated with a service to which items 60000 to 60079 inclusive apply (NR) (Anaes.) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $38.05 **Benefit:** 75% = $28.55 85% = $32.35
	SUBGROUP 17 - INTERVENTIONAL TECHNIQUES
61109	FLUOROSCOPY in an ANGIOGRAPHY SUITE with image intensification, in conjunction with a surgical procedure, using interventional techniques, not being a service associated with a service to which another item in this Table applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $258.90 **Benefit:** 75% = $194.20 85% = $220.10
61110	FLUOROSCOPY in an ANGIOGRAPHY SUITE with image intensification, in conjunction with a surgical procedure, using interventional techniques, not being a service associated with a service to which another item in this Table applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $129.45 **Benefit:** 75% = $97.10 85% = $110.05

	GROUP I4 - NUCLEAR MEDICINE IMAGING		
61302	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - planar imaging (R) *(See para DIQ 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 undertaken (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $565.30	**Benefit:** 75% = $424.00	85% = $485.80
61306	COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - planar imaging (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $709.70	**Benefit:** 75% = $532.30	85% = $630.20
61307	COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - with single photon emission tomography and with planar imaging when undertaken (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $834.90	**Benefit:** 75% = $626.20	85% = $755.40
61310	MYOCARDIAL INFARCT-AVID-STUDY, with planar imaging and single photon emission tomography, OR planar imaging or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $367.30	**Benefit:** 75% = $275.50	85% = $312.25
61313	GATED CARDIAC BLOOD POOL STUDY, (equilibrium), with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $303.35	**Benefit:** 75% = $227.55	85% = $257.85
61314	GATED CARDIAC BLOOD POOL STUDY, and first pass blood flow or cardiac shunt study, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $420.00	**Benefit:** 75% = $315.00	85% = $357.00
61316	GATED CARDIAC BLOOD POOL STUDY, with intervention, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $381.15	**Benefit:** 75% = $285.90	85% = $324.00
61317	GATED CARDIAC BLOOD POOL STUDY, with intervention and first pass blood flow study or cardiac shunt study, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $492.40	**Benefit:** 75% = $369.30	85% = $418.55
61320	CARDIAC FIRST PASS BLOOD FLOW STUDY OR CARDIAC SHUNT STUDY, not being a service to which another item in this Group applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $228.90	**Benefit:** 75% = $171.70	85% = $194.60
61328	LUNG PERFUSION STUDY, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $227.65	**Benefit:** 75% = $170.75	85% = $193.55
61340	LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $253.00	**Benefit:** 75% = $189.75	85% = $215.05
61348	LUNG PERFUSION STUDY AND LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $443.35	**Benefit:** 75% = $332.55	85% = $376.85

61352	LIVER AND SPLEEN STUDY (colloid) - planar imaging (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $259.35	**Benefit:** 75% = $194.55	85% = $220.45
61353	LIVER AND SPLEEN STUDY (colloid), with single photon emission tomography and with planar imaging when undertaken (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $386.60	**Benefit:** 75% = $289.95	85% = $328.65
61356	RED BLOOD CELL SPLEEN OR LIVER STUDY, including single photon emission tomography when undertaken (R) *(See para DIQ 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) (K) *(See para DIQ 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) (K) *(See para DIQ of explanatory notes to this Category)* **Fee:** $461.40	**Benefit:** 75% = $346.05	85% = $392.20
61364	BOWEL HAEMORRHAGE STUDY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $496.95	**Benefit:** 75% = $372.75	85% = $422.45
61368	MECKEL'S DIVERTICULUM STUDY (R) *(See para DIQ 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, where: (a) there is a suspected gastro-entero-pancreatic endocrine tumour, based on biochemical evidence, with negative or equivocal conventional imaging; or (b) a surgically amenable gastro-entero-pancreatic endocrine tumour has been identified based on conventional techniques, in order to exclude additional disease sites. (R) **Fee:** $2,015.75	**Benefit:** 75% = $1,511.85	85% = $1,936.25
61372	SALIVARY STUDY (R) *(See para DIQ 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 undertaken (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $489.70	**Benefit:** 75% = $367.30	85% = $416.25
61376	OESOPHAGEAL CLEARANCE STUDY (R) *(See para DIQ 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 DIQ of explanatory notes to this Category)* **Fee:** $574.35	**Benefit:** 75% = $430.80	85% = $494.85
61383	COMBINED SOLID AND LIQUID GASTRIC EMPTYING STUDY using dual isotope technique or the same isotope on separate days (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $624.95	**Benefit:** 75% = $468.75	85% = $545.45
61384	RADIONUCLIDE COLONIC TRANSIT STUDY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $687.70	**Benefit:** 75% = $515.80	85% = $608.20
61386	RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R) *(See para DIQ 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 DIQ 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 DIQ of explanatory notes to this Category)* **Fee:** $370.55	**Benefit:** 75% = $277.95	85% = $315.00
61390	RENAL STUDY with diuretic administration following a baseline study (R) *(See para DIQ 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 DIQ of explanatory notes to this Category)* **Fee:** $605.50	**Benefit:** 75% = $454.15	85% = $526.00
61397	CYSTOURETEROGRAM (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.85	**Benefit:** 75% = $185.15	85% = $209.85
61401	TESTICULAR STUDY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $162.30	**Benefit:** 75% = $121.75	85% = $138.00
61402	CEREBRAL PERFUSION STUDY, with single photon emission tomography and with planar imaging when undertaken (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $605.05	**Benefit:** 75% = $453.80	85% = $525.55
61405	BRAIN STUDY WITH BLOOD BRAIN BARRIER AGENT, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $346.00	**Benefit:** 75% = $259.50	85% = $294.10
61409	CEREBRO-SPINAL FLUID TRANSPORT STUDY, with imaging on 2 or more separate occasions (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $873.50	**Benefit:** 75% = $655.15	85% = $794.00
61413	CEREBRO-SPINAL FLUID SHUNT PATENCY STUDY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $225.95	**Benefit:** 75% = $169.50	85% = $192.10
61417	DYNAMIC BLOOD FLOW STUDY OR REGIONAL BLOOD VOLUME QUANTITATIVE STUDY, not being a service associated with a service to which another item in this Group applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $118.85	**Benefit:** 75% = $89.15	85% = $101.05
61421	BONE STUDY - whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) *(See para DIQ 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 DIQ of explanatory notes to this Category)* **Fee:** $600.70	**Benefit:** 75% = $450.55	85% = $521.20
61426	WHOLE BODY STUDY using iodine (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $554.80	**Benefit:** 75% = $416.10	85% = $475.30
61429	WHOLE BODY STUDY using gallium (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $543.00	**Benefit:** 75% = $407.25	85% = $463.50
61430	WHOLE BODY STUDY using gallium, with single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $659.45	**Benefit:** 75% = $494.60	85% = $579.95
61433	WHOLE BODY STUDY using cells labelled with technetium (R) *(See para DIQ 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 DIQ of explanatory notes to this Category)* **Fee:** $615.40	**Benefit:** 75% = $461.55	85% = $535.90
61437	WHOLE BODY STUDY using thallium (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $542.75	**Benefit:** 75% = $407.10	85% = $463.25
61438	WHOLE BODY STUDY using thallium, with single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $672.95	**Benefit:** 75% = $504.75	85% = $593.45
61441	BONE MARROW STUDY - whole body using technetium labelled bone marrow agents (R) *(See para DIQ 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 DIQ of explanatory notes to this Category)* **Fee:** $752.35	**Benefit:** 75% = $564.30	85% = $672.85
61445	BONE MARROW STUDY - localised using technetium labelled agent (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $286.80	**Benefit:** 75% = $215.10	85% = $243.80
61446	LOCALISED BONE OR JOINT STUDY, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $333.55	**Benefit:** 75% = $250.20	85% = $283.55
61449	LOCALISED BONE OR JOINT STUDY and single photon emission tomography, including when undertaken, blood flow, blood pool and imaging on a separate occasion (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $456.20	**Benefit:** 75% = $342.15	85% = $387.80
61450	LOCALISED STUDY using gallium (R) *(See para DIQ 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 DIQ 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 DIQ 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 DIQ of explanatory notes to this Category)* **Fee:** $470.45	**Benefit:** 75% = $352.85	85% = $399.90
61458	LOCALISED STUDY using thallium (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $396.95	**Benefit:** 75% = $297.75	85% = $337.45
61461	LOCALISED STUDY using thallium, with single photon emission tomography (R) *(See para DIQ 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 any one of items 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469, 61484 or 61485 where there is no additional administration of radiopharmaceutical and where the previous radionuclide scan was abnormal or equivocal. (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $129.00	**Benefit:** 75% = $96.75	85% = $109.65

61465	VENOGRAPHY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $265.50	**Benefit:** 75% = $199.15	85% = $225.70
61469	LYMPHOSCINTIGRAPHY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $348.10	**Benefit:** 75% = $261.10	85% = $295.90
61473	THYROID STUDY including uptake measurement when undertaken (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $175.40	**Benefit:** 75% = $131.55	85% = $149.10
61480	PARATHYROID STUDY, planar imaging and single photon emission tomography when undertaken (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $386.85	**Benefit:** 75% = $290.15	85% = $328.85
61484	ADRENAL STUDY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $880.85	**Benefit:** 75% = $660.65	85% = $801.35
61485	ADRENAL STUDY, with single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $999.20	**Benefit:** 75% = $749.40	85% = $919.70
61495	TEAR DUCT STUDY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $223.10	**Benefit:** 75% = $167.35	85% = $189.65
61499	PARTICLE PERFUSION STUDY (intra-arterial) or Le Veen shunt study (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $253.00	**Benefit:** 75% = $189.75	85% = $215.05
61505	CT scan performed at the same time and covering the same body area as single photon emission tomography for the purpose of anatomic localisation or attenuation correction where no separate diagnostic CT report is issued and only in association with items 61302 - 61650 (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $100.00	**Benefit:** 75% = $75.00	85% = $85.00
61523	Whole body FDG PET study, performed for evaluation of a solitary pulmonary nodule where the lesion is considered unsuitable for transthoracic fine needle aspiration biopsy, or for which an attempt at pathological characterisation has failed.(R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $953.00	**Benefit:** 75% = $714.75	85% = $873.50
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 DIQ of explanatory notes to this Category)* **Fee:** $953.00	**Benefit:** 75% = $714.75	85% = $873.50
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% = $821.50
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 DIQ of explanatory notes to this Category)* **Fee:** $953.00	**Benefit:** 75% = $714.75	85% = $873.50
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 DIQ of explanatory notes to this Category)* **Fee:** $999.00	**Benefit:** 75% = $749.25	85% = $919.50
61559	FDG PET study of the brain, performed for the evaluation of refractory epilepsy which is being evaluated for surgery (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $918.00	**Benefit:** 75% = $688.50	85% = $838.50

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 DIQ of explanatory notes to this Category)* **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $873.50
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% = $873.50
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% = $873.50
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% = $873.50
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% = $873.50
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% = $873.50
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% = $873.50
61616	Whole body FDG PET study for the initial staging of indolent non–Hodgkin's lymphoma where clinical, pathological and imaging findings indicate that the stage is I or IIA and the proposed management is definitive radiotherapy with curative intent. (R) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $873.50
61620	Whole body FDG PET study for the initial staging of newly diagnosed or previously untreated Hodgkin's or non-Hodgkin's lymphoma (excluding indolent non-Hodgkin's lymphoma. (R) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $873.50
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's or non-Hodgkin's lymphoma (excluding indolent non-Hodgkin's lymphoma), (R) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $873.50
61628	Whole body FDG PET study for restaging following confirmation of recurrence of Hodgkin's or non-Hodgkin's lymphoma (excluding indolent non-Hodgkin's lymphoma). (R) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $873.50
61632	Whole body FDG PET study to assess response to second-line chemotherapy when stem cell transplantation is being considered, for Hodgkin's or non-Hodgkin's lymphoma (excluding indolent non-Hodgkin's lymphoma). (R) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $873.50
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% = $919.50
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% = $919.50
61650	LEUKOSCAN STUDY, for use in diagnostic imaging of the long bones and feet in patients with suspected osteomyelitis, and where patients do not have access to *ex-vivo WBC scanning.* (R) *Note* LeukoScan is only indicated for diagnostic imaging in patients suspected of infection in the long bones and feet, including those with diabetic ulcers. The descriptor does not cover patients who are being investigated for other sites of infection *(See para DIQ of explanatory notes to this Category)* **Fee:** $878.70 **Benefit:** 75% = $659.05 85% = $799.20

61651	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - planar imaging (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.45	**Benefit:** 75% = $168.35	85% = $190.80
61652	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - with single photon emission tomography and with planar imaging when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $282.65	**Benefit:** 75% = $212.00	85% = $240.30
61653	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) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $354.85	**Benefit:** 75% = $266.15	85% = $301.65
61654	COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - with single photon emission tomography and with planar imaging when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $417.45	**Benefit:** 75% = $313.10	85% = $354.85
61655	MYOCARDIAL INFARCT-AVID-STUDY, with planar imaging and single photon emission tomography, OR planar imaging or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $183.65	**Benefit:** 75% = $137.75	85% = $156.15
61656	GATED CARDIAC BLOOD POOL STUDY, (equilibrium), with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $151.70	**Benefit:** 75% = $113.80	85% = $128.95
61657	GATED CARDIAC BLOOD POOL STUDY, and first pass blood flow or cardiac shunt study, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $210.00	**Benefit:** 75% = $157.50	85% = $178.50
61658	GATED CARDIAC BLOOD POOL STUDY, with intervention, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $190.60	**Benefit:** 75% = $142.95	85% = $162.05
61659	GATED CARDIAC BLOOD POOL STUDY, with intervention and first pass blood flow study or cardiac shunt study, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.20	**Benefit:** 75% = $184.65	85% = $209.30
61660	CARDIAC FIRST PASS BLOOD FLOW STUDY OR CARDIAC SHUNT STUDY, not being a service to which another item in this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $114.45	**Benefit:** 75% = $85.85	85% = $97.30
61661	LUNG PERFUSION STUDY, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $113.85	**Benefit:** 75% = $85.40	85% = $96.80
61662	LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $126.50	**Benefit:** 75% = $94.90	85% = $107.55
61663	LUNG PERFUSION STUDY AND LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $221.70	**Benefit:** 75% = $166.30	85% = $188.45

61664	LIVER AND SPLEEN STUDY (colloid) - planar imaging (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $129.70	**Benefit:** 75% = $97.30	85% = $110.25
61665	LIVER AND SPLEEN STUDY (colloid), with single photon emission tomography and with planar imaging when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $193.30	**Benefit:** 75% = $145.00	85% = $164.35
61666	RED BLOOD CELL SPLEEN OR LIVER STUDY, including single photon emission tomography when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $196.40	**Benefit:** 75% = $147.30	85% = $166.95
61667	HEPATOBILIARY STUDY, including morphine administration or pre-treatment with a cholagogue when performed (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.70	**Benefit:** 75% = $151.30	85% = $171.45
61668	HEPATOBILIARY STUDY with formal quantification following baseline imaging, using a cholagogue (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $230.70	**Benefit:** 75% = $173.05	85% = $196.10
61669	BOWEL HAEMORRHAGE STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $248.50	**Benefit:** 75% = $186.40	85% = $211.25
61670	MECKEL'S DIVERTICULUM STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $111.55	**Benefit:** 75% = $83.70	85% = $94.85
61671	INDIUM-LABELLED OCTREOTIDE STUDY - including single photon emission tomography when undertaken, where: (a) there is a suspected gastro-entero-pancreatic endocrine tumour, based on biochemical evidence, with negative or equivocal conventional imaging; or (b) a surgically amenable gastro-entero-pancreatic endocrine tumour has been identified based on conventional techniques, in order to exclude additional disease sites. (Ministerial Determination) (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,007.90	**Benefit:** 75% = $755.95	85% = $928.40
61672	SALIVARY STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $111.55	**Benefit:** 75% = $83.70	85% = $94.85
61673	GASTRO-OESOPHAGEAL REFLUX STUDY, including delayed imaging on a separate occasion when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $244.85	**Benefit:** 75% = $183.65	85% = $208.15
61674	OESOPHAGEAL CLEARANCE STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $71.70	**Benefit:** 75% = $53.80	85% = $60.95
61675	GASTRIC EMPTYING STUDY, using single tracer (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $287.20	**Benefit:** 75% = $215.40	85% = $244.15
61676	COMBINED SOLID AND LIQUID GASTRIC EMPTYING STUDY using dual isotope technique or the same isotope on separate days (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $312.50	**Benefit:** 75% = $234.40	85% = $265.65
61677	RADIONUCLIDE COLONIC TRANSIT STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $343.85	**Benefit:** 75% = $257.90	85% = $292.30
61678	RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $166.25	**Benefit:** 75% = $124.70	85% = $141.35

61679	RENAL CORTICAL STUDY, with single photon emission tomography and planar quantification (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $215.40	**Benefit:** 75% = $161.55	85% = $183.10
61680	SINGLE RENAL STUDY with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $185.30	**Benefit:** 75% = $139.00	85% = $157.55
61681	RENAL STUDY with diuretic administration following a baseline study (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $205.00	**Benefit:** 75% = $153.75	85% = $174.25
61682	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) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $302.75	**Benefit:** 75% = $227.10	85% = $257.35
61683	CYSTOURETEROGRAM (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $123.45	**Benefit:** 75% = $92.60	85% = $104.95
61684	TESTICULAR STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $81.15	**Benefit:** 75% = $60.90	85% = $69.00
61685	CEREBRAL PERFUSION STUDY, with single photon emission tomography and with planar imaging when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $302.55	**Benefit:** 75% = $226.95	85% = $257.20
61686	BRAIN STUDY WITH BLOOD BRAIN BARRIER AGENT, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $173.00	**Benefit:** 75% = $129.75	85% = $147.05
61687	CEREBRO-SPINAL FLUID TRANSPORT STUDY, with imaging on 2 or more separate occasions (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $436.75	**Benefit:** 75% = $327.60	85% = $371.25
61688	CEREBRO-SPINAL FLUID SHUNT PATENCY STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $113.00	**Benefit:** 75% = $84.75	85% = $96.05
61689	DYNAMIC BLOOD FLOW STUDY OR REGIONAL BLOOD VOLUME QUANTITATIVE STUDY, not being a service associated with a service to which another item in this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $59.45	**Benefit:** 75% = $44.60	85% = $50.55
61690	BONE STUDY - whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $239.90	**Benefit:** 75% = $179.95	85% = $203.95
61691	BONE STUDY - whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $300.35	**Benefit:** 75% = $225.30	85% = $255.30
61692	WHOLE BODY STUDY using iodine (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $277.40	**Benefit:** 75% = $208.05	85% = $235.80
61693	WHOLE BODY STUDY using gallium (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $271.50	**Benefit:** 75% = $203.65	85% = $230.80

61694	WHOLE BODY STUDY using gallium, with single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $329.75	**Benefit:** 75% = $247.35	85% = $280.30
61695	WHOLE BODY STUDY using cells labelled with technetium (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $248.50	**Benefit:** 75% = $186.40	85% = $211.25
61696	WHOLE BODY STUDY using cells labelled with technetium, with single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $307.70	**Benefit:** 75% = $230.80	85% = $261.55
61697	WHOLE BODY STUDY using thallium (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $271.40	**Benefit:** 75% = $203.55	85% = $230.70
61698	WHOLE BODY STUDY using thallium, with single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $336.50	**Benefit:** 75% = $252.40	85% = $286.05
61699	BONE MARROW STUDY - whole body using technetium labelled bone marrow agents (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $244.85	**Benefit:** 75% = $183.65	85% = $208.15
61700	WHOLE BODY STUDY, using gallium - with single photon emission tomography of 2 or more body regions acquired separately (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $376.20	**Benefit:** 75% = $282.15	85% = $319.80
61701	BONE MARROW STUDY - localised using technetium labelled agent (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $143.40	**Benefit:** 75% = $107.55	85% = $121.90
61702	LOCALISED BONE OR JOINT STUDY, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $166.80	**Benefit:** 75% = $125.10	85% = $141.80
61703	LOCALISED BONE OR JOINT STUDY and single photon emission tomography, including when undertaken, blood flow, blood pool and imaging on a separate occasion (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $228.10	**Benefit:** 75% = $171.10	85% = $193.90
61704	LOCALISED STUDY using gallium (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $198.80	**Benefit:** 75% = $149.10	85% = $169.00
61705	LOCALISED STUDY using gallium, with single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $257.35	**Benefit:** 75% = $193.05	85% = $218.75
61706	LOCALISED STUDY using cells labelled with technetium (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $174.05	**Benefit:** 75% = $130.55	85% = $147.95
61707	LOCALISED STUDY using cells labelled with technetium, with single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $235.25	**Benefit:** 75% = $176.45	85% = $200.00
61708	LOCALISED STUDY using thallium (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $198.50	**Benefit:** 75% = $148.90	85% = $168.75
61709	LOCALISED STUDY using thallium, with single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $263.95	**Benefit:** 75% = $198.00	85% = $224.40

61710	REPEAT PLANAR AND SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING, OR REPEAT PLANAR IMAGING OR SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING on an occasion subsequent to the performance of any one of items 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469, 61484, 61485, 61669, 61692, 61693, 61694, 61700, 61704, 61705, 61712, 61715 or 61716 where there is no additional administration of radiopharmaceutical and where the previous radionuclide scan was abnormal or equivocal. (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85
61711	VENOGRAPHY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $132.75	**Benefit:** 75% = $99.60	85% = $112.85
61712	LYMPHOSCINTIGRAPHY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $174.05	**Benefit:** 75% = $130.55	85% = $147.95
61713	THYROID STUDY including uptake measurement when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $87.70	**Benefit:** 75% = $65.80	85% = $74.55
61714	PARATHYROID STUDY, planar imaging and single photon emission tomography when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $193.45	**Benefit:** 75% = $145.10	85% = $164.45
61715	ADRENAL STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $440.45	**Benefit:** 75% = $330.35	85% = $374.40
61716	ADRENAL STUDY, with single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $499.60	**Benefit:** 75% = $374.70	85% = $424.70
61717	TEAR DUCT STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $111.55	**Benefit:** 75% = $83.70	85% = $94.85
61718	PARTICLE PERFUSION STUDY (intra-arterial) or Le Veen shunt study (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $126.50	**Benefit:** 75% = $94.90	85% = $107.55
61719	CT scan performed at the same time and covering the same body area as single photon emission tomography for the purpose of anatomic localisation or attenuation correction where no separate diagnostic CT report is issued and only in association with items 61302 - 61729 (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $50.00	**Benefit:** 75% = $37.50	85% = $42.50
61729	LEUKOSCAN STUDY, for use in diagnostic imaging of the long bones and feet in patients with suspected osteomyelitis, and where patients do not have access to ex-vivo WBC scanning. (Ministerial Determination) (NK) Note LeukoScan is only indicated for diagnostic imaging in patients suspected of infection in the long bones and feet, including those with diabetic ulcers. The descriptor does not cover patients who are being investigated for other sites of infection *(See para DIQ of explanatory notes to this Category)* **Fee:** $439.35	**Benefit:** 75% = $329.55	85% = $373.45

	GROUP I5 - MAGNETIC RESONANCE IMAGING
	SUBGROUP 1 - SCAN OF HEAD - FOR SPECIFIED CONDITIONS
63001	MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head** for: - tumour of the brain or meninges (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63004	- inflammation of the brain or meninges (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63007	- skull base or orbital tumour (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63010	- stereotactic scan of brain, with Fiducials in place, for the sole purpose to allow planning for stereotactic neurosurgery (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $336.00 **Benefit:** 75% = $252.00 85% = $285.60
63013	MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head** for: - tumour of the brain or meninges (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63014	- inflammation of the brain or meninges (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63016	- skull base or orbital tumour (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63017	- stereotactic scan of brain, with Fiducials in place, for the sole purpose to allow planning for stereotactic neurosurgery (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $168.00 **Benefit:** 75% = $126.00 85% = $142.80
	SUBGROUP 2 - SCAN OF HEAD - FOR SPECIFIED CONDITIONS
63040	**NOTE: Benefits are payable for each service included by Subgroup 2 on three occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head** for: - acoustic neuroma (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $336.00 **Benefit:** 75% = $252.00 85% = $285.60
63043	- pituitary tumour (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63046	- toxic or metabolic or ischaemic encephalopathy (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

	- demyelinating disease of the brain (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63049	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75
	- congenital malformation of the brain or meninges (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63052	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75
	- venous sinus thrombosis (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63055	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75
	- head trauma (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63058	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75
	- epilepsy (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63061	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75
	- stroke (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63064	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75
	- carotid or vertebral artery desection (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63067	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75
	- intracranial aneurysm (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63070	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75
	- intracranial arteriovenous malformation (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63073	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75
	NOTE: Benefits are payable for each service included by Subgroup 2 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head** for: - acoustic neuroma (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63074	**Fee:** $168.00	**Benefit:** 75% = $126.00	85% = $142.80
	- pituitary tumour (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63075	**Fee:** $179.20	**Benefit:** 75% = $134.40	85% = $152.35
	- toxic or metabolic or ischaemic encephalopathy (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63076	**Fee:** $201.60	**Benefit:** 75% = $151.20	85% = $171.40
	- demyelinating disease of the brain (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63077	**Fee:** $201.60	**Benefit:** 75% = $151.20	85% = $171.40
	- congenital malformation of the brain or meninges (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63078	**Fee:** $201.60	**Benefit:** 75% = $151.20	85% = $171.40
	- venous sinus thrombosis (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63079	**Fee:** $201.60	**Benefit:** 75% = $151.20	85% = $171.40

63080	- head trauma (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60	**Benefit:** 75% = $151.20	85% = $171.40
63081	- epilepsy (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60	**Benefit:** 75% = $151.20	85% = $171.40
63082	- stroke (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60	**Benefit:** 75% = $151.20	85% = $171.40
63083	- carotid or vertebral artery desection (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60	**Benefit:** 75% = $151.20	85% = $171.40
63084	- intracranial aneurysm (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60	**Benefit:** 75% = $151.20	85% = $171.40
63085	- intracranial arteriovenous malformation (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60	**Benefit:** 75% = $151.20	85% = $171.40
	SUBGROUP 3 - SCAN OF HEAD AND NECK VESSELS - FOR SPECIFIED CONDITIONS		
63101	**NOTE: Benefits are payable for each service included by Subgroup 3 on three occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING AND MAGNETIC RESONANCE ANGIOGRAPHY of extra and/or intracranial circulation, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head and neck vessels** for: - stroke (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $492.80	**Benefit:** 75% = $369.60	85% = $418.90
63104	**NOTE: Benefits are payable for each service included by Subgroup 3 on three occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING AND MAGNETIC RESONANCE ANGIOGRAPHY of extra and/or intracranial circulation, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head and neck vessels** for: - stroke (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.40	**Benefit:** 75% = $184.80	85% = $209.45
	SUBGROUP 4 - SCAN OF HEAD AND CERVICAL SPINE - FOR SPECIFIED CONDITIONS		
63111	MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head and cervical spine** for: - tumour of the central nervous system or meninges (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $492.80	**Benefit:** 75% = $369.60	85% = $418.90
63114	- inflammation of the central nervous system or meninges (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $492.80	**Benefit:** 75% = $369.60	85% = $418.90

	SUBGROUP 3 - SCAN OF HEAD AND NECK VESSELS - FOR SPECIFIED CONDITIONS
63117	MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head and cervical spine** for: - tumour of the central nervous system or meninges (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45
63119	- inflammation of the central nervous system or meninges (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45
	SUBGROUP 5 - SCAN OF HEAD AND CERVICAL SPINE - FOR SPECIFIED CONDITIONS
63125	**NOTE: Benefits are payable for each service included by Subgroup 5 on three occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head and cervical spine** for: - demyelinating disease of the central nervous system (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63128	- congenital malformation of the central nervous system or meninges (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63131	- syrinx (congenital or acquired) (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63134	**NOTE: Benefits are payable for each service included by Subgroup 5 on three occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head and cervical spine** for: - demyelinating disease of the central nervous system (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45
63135	- congenital malformation of the central nervous system or meninges (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45
63136	- syrinx (congenital or acquired) (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45
	SUBGROUP 6 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS
63151	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of one region or two contiguous regions of the spine** for: - infection (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63154	- tumour (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65

	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of one region or two contiguous regions of the spine** for: - infection (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63157	**Fee:** $179.20	**Benefit:** 75% = $134.40	85% = $152.35
	- tumour (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63158	**Fee:** $179.20	**Benefit:** 75% = $134.40	85% = $152.35
	SUBGROUP 7 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS		
	NOTE: Benefits are payable for each service included by Subgroup 7 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of one region or two contiguous regions of the spine** for: - demyelinating (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63161	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65
	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63164	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65
	myelopathy (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63167	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65
	- syrinx (congenital or acquired) (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63170	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65
	- cervical radiculopathy (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63173	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65
	- sciatica (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63176	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65
	- spinal canal stenosis (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63179	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65
	- previous spinal surgery (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63182	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65
	- trauma (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63185	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65
	NOTE: Benefits are payable for each service included by Subgroup 7 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of one region or two contiguous regions of the spine** for: - demyelinating (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63186	**Fee:** $179.20	**Benefit:** 75% = $134.40	85% = $152.35

	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63187	**Fee:** $179.20	**Benefit:** 75% = $134.40	85% = $152.35
	- myelopathy (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63188	**Fee:** $179.20	**Benefit:** 75% = $134.40	85% = $152.35
	- syrinx (congenital or acquired) (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63189	**Fee:** $179.20	**Benefit:** 75% = $134.40	85% = $152.35
	- cervical radiculopathy (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63190	**Fee:** $179.20	**Benefit:** 75% = $134.40	85% = $152.35
	- sciatica (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63191	**Fee:** $179.20	**Benefit:** 75% = $134.40	85% = $152.35
	- spinal canal stenosis (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63192	**Fee:** $179.20	**Benefit:** 75% = $134.40	85% = $152.35
	- previous spinal surgery (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63193	**Fee:** $179.20	**Benefit:** 75% = $134.40	85% = $152.35
	- trauma (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63194	**Fee:** $179.20	**Benefit:** 75% = $134.40	85% = $152.35
	SUBGROUP 8 - SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS		
	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of three contiguous regions or two non contiguous regions of the spine** for: - infection (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63201	**Fee:** $448.00	**Benefit:** 75% = $336.00	85% = $380.80
	- tumour (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63204	**Fee:** $448.00	**Benefit:** 75% = $336.00	85% = $380.80
	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of three contiguous regions or two non contiguous regions of the spine** for: - infection (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63207	**Fee:** $224.00	**Benefit:** 75% = $168.00	85% = $190.40
	- tumour (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63208	**Fee:** $224.00	**Benefit:** 75% = $168.00	85% = $190.40

	SUBGROUP 9 - SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 9 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of three contiguous regions or two non contiguous regions of the spine** for: - demyelinating disease (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63219	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63222	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- myelopathy (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63225	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- syrinx (congenital or acquired) (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63228	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- cervical radiculopathy (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63231	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- sciatica (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63234	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- spinal canal stenosis (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63237	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- previous spinal surgery (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63240	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- trauma (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63243	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	NOTE: Benefits are payable for each service included by Subgroup 9 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of three contiguous regions or two non contiguous regions of the spine** for: - demyelinating disease (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63257	**Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63258	**Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
	- myelopathy (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63259	**Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
	- syrinx (congenital or acquired) (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63260	**Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40

	- cervical radiculopathy (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63261	**Fee:** $224.00	**Benefit:** 75% = $168.00	85% = $190.40
	- sciatica (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63262	**Fee:** $224.00	**Benefit:** 75% = $168.00	85% = $190.40
	- spinal canal stenosis (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63263	**Fee:** $224.00	**Benefit:** 75% = $168.00	85% = $190.40
	- previous spinal surgery (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63264	**Fee:** $224.00	**Benefit:** 75% = $168.00	85% = $190.40
	- trauma (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63265	**Fee:** $224.00	**Benefit:** 75% = $168.00	85% = $190.40
	SUBGROUP 10 - SCAN OF CERVICAL SPINE AND BRACHIAL PLEXUS - FOR SPECIFIED CONDITIONS		
	NOTE: Benefits are payable for each service included by Subgroup 10 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of cervical spine and brachial plexus** for: - tumour (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63271	**Fee:** $492.80	**Benefit:** 75% = $369.60	85% = $418.90
	- trauma (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63274	**Fee:** $492.80	**Benefit:** 75% = $369.60	85% = $418.90
	- cervical radiculopathy (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63277	**Fee:** $492.80	**Benefit:** 75% = $369.60	85% = $418.90
	- previous surgery (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63280	**Fee:** $492.80	**Benefit:** 75% = $369.60	85% = $418.90
	NOTE: Benefits are payable for each service included by Subgroup 10 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of cervical spine and brachial plexus** for: - tumour (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63282	**Fee:** $246.40	**Benefit:** 75% = $184.80	85% = $209.45
	- trauma (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63283	**Fee:** $246.40	**Benefit:** 75% = $184.80	85% = $209.45
	- cervical radiculopathy (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63284	**Fee:** $246.40	**Benefit:** 75% = $184.80	85% = $209.45
	- previous surgery (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63285	**Fee:** $246.40	**Benefit:** 75% = $184.80	85% = $209.45

	SUBGROUP 11 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS
63301	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of musculoskeletal system** for: - tumour arising in bone or musculoskeletal system, this excludes tumours arising in breast, prostate or rectum (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70
63304	- infection arising in bone or musculoskeletal system, this excludes infection arising in breast, prostate or rectum (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70
63307	- osteonecrosis (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70
63310	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of musculoskeletal system** for: - tumour arising in bone or musculoskeletal system, this excludes tumours arising in breast, prostate or rectum (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $190.40 **Benefit:** 75% = $142.80 85% = $161.85
63311	- infection arising in bone or musculoskeletal system, this excludes infection arising in breast, prostate or rectum (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $190.40 **Benefit:** 75% = $142.80 85% = $161.85
63313	- osteonecrosis (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $190.40 **Benefit:** 75% = $142.80 85% = $161.85
	SUBGROUP 12 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS
63322	**NOTE: Benefits are payable for each service included by Subgroup 12 on three occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of musculoskeletal system** for: - derangement of hip or its supporting structures (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63325	- derangment of shoulder or its supporting structures (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63328	- derangment of knee or its supporting structures (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63331	- derangment of ankle and/or foot or its supporting structures (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63334	- derangment of one or both temporomandibular joints or their supporting structures (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $336.00 **Benefit:** 75% = $252.00 85% = $285.60
63337	- derangment of wrist and/or hand or its supporting structures (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80

	- derangment of elbow or its supporting structures (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63340	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75
	NOTE: Benefits are payable for each service included by Subgroup 12 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of musculoskeletal system** for: - derangement of hip or its supporting structures (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63341	**Fee:** $201.60	**Benefit:** 75% = $151.20	85% = $171.40
	- derangement of shoulder or its supporting structures (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63342	**Fee:** $201.60	**Benefit:** 75% = $151.20	85% = $171.40
	- derangement of knee or its supporting structures (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63343	**Fee:** $201.60	**Benefit:** 75% = $151.20	85% = $171.40
	- derangement of ankle and/or foot or its supporting structures (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63345	**Fee:** $201.60	**Benefit:** 75% = $151.20	85% = $171.40
	- derangement of one or both temporomandibular joints or their supporting structures (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63346	**Fee:** $168.00	**Benefit:** 75% = $126.00	85% = $142.80
	- derangement of wrist and/or hand or its supporting structures (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63347	**Fee:** $224.00	**Benefit:** 75% = $168.00	85% = $190.40
	- derangement of elbow or its supporting structures (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63348	**Fee:** $201.60	**Benefit:** 75% = $151.20	85% = $171.40
	SUBGROUP 13 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS		
	NOTE: Benefits are payable for each service included by Subgroup 13 on two occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of musculoskeletal system** for: - Gaucher disease (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63361	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75
	NOTE: Benefits are payable for each service included by Subgroup 13 on two occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of musculoskeletal system** for: - Gaucher disease (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63364	**Fee:** $201.60	**Benefit:** 75% = $151.20	85% = $171.40

	SUBGROUP 14 - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS
63385	**NOTE: Benefits are payable for each service included by Subgroup 14 on two occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of cardiovascular system** for: - congenital disease of the heart or a great vessel (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63388	- tumour of the heart or a great vessel (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63391	- abnormality of thoracic aorta (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63392	**NOTE: Benefits are payable for each service included by Subgroup 14 on two occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of cardiovascular system** for: - congenital disease of the heart or a great vessel (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
63393	- tumour of the heart or a great vessel (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
63394	- abnormality of thoracic aorta (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	SUBGROUP 15 - MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS
63401	**NOTE: Benefits are payable for each service included by Subgroup 15 on three occasions only in any 12 month period** MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of cardiovascular system** for: - vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63404	- obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63407	**NOTE: Benefits are payable for each service included by Subgroup 15 on three occasions only in any 12 month period** MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of cardiovascular system** for: - vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

	- obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63408	**Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	SUBGROUP 16 - MAGNETIC RESONANCE ANGIOGRAPHY - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
	NOTE: Benefits are payable for each service included by Subgroup 16 on one occasion only in any 12 month period MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of person under the age of 16** for: - the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63416	**Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	NOTE: Benefits are payable for each service included by Subgroup 16 on one occasion only in any 12 month period MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of person under the age of 16** for: - the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (R) NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63419	**Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	SUBGROUP 17 - MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
	NOTE: Benefits are payable for each service included by Subgroup 17 on two occasions only in any 12 month period, for previously diagnosed conditions MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of person under the age of 16** for: - post-inflammatory or post-traumatic physeal fusion (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63425	**Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	- Gaucher disease (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63428	**Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	NOTE: Benefits are payable for each service included by Subgroup 17 on two occasions only in any 12 month period, for previously diagnosed conditions MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of person under the age of 16** for: - post-inflammatory or post-traumatic physeal fusion (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63432	**Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	- Gaucher disease (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63433	**Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	SUBGROUP 18 - MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of person under the age of 16** for: - pelvic or abdominal mass (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63440	**Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

	- mediastinal mass (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63443	**Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	- congenital uterine or anorectal abnormality (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63446	**Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of person under the age of 16** for: - pelvic or abdominal mass (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63447	**Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	- mediastinal mass (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63448	**Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	- congenital uterine or anorectal abnormality (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63449	**Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	SUBGROUP 19 - SCAN OF BODY - FOR SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 19 on one occasion only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of body** for: - adrenal mass in a patient with malignancy which is otherwise resectable (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63455	**Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35
	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a dedicated breast coil is used; and (b) the request for scan identifies that the person is asymptomatic and is less than 50 years of age; and (c) the request for scan identifies either: (i) that the patient is at high risk of developing breast cancer, due to 1 of the following: (A) 3 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer; (B) 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 following applies to at least 1 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; - is a male relative who has been diagnosed with breast cancer; (C) 1 first or second degree relative diagnosed with breast cancer at age 45 years or younger, plus 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 (ii) that genetic testing has identified the presence of a high risk breast cancer gene mutation. **Scan of both breasts** for: - detection of cancer (R) **NOTE: Benefits are payable on one occasion only in any 12 month period** (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63457	**Fee:** $345.00 **Benefit:** 75% = $258.75 85% = $293.25

<table>
<tr><th colspan="2">MAGNETIC RESONANCE IMAGING MRI</th></tr>
<tr><td></td><td>MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where:
(a) a dedicated breast coil is used; and
(b) the person has had an abnormality detected as a result of a service described in item 63464 or 63457 performed in the previous 12 months

Scan of both breasts for:

- detection of cancer (R)
NOTE 1: Benefits are payable on one occasion only in any 12 month period

NOTE 2: This item is intended for follow-up imaging of abnormalities diagnosed on a scan described by item 63464 or 63457

(NK) (Anaes.)
(See para DIQ of explanatory notes to this Category)</td></tr>
<tr><td>63458</td><td>Fee: $345.00 Benefit: 75% = $258.75 85% = $293.25</td></tr>
<tr><td></td><td>NOTE: Benefits are payable for each service included by Subgroup 19 on one occasion only in any 12 month period

MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - scan of body for:

- adrenal mass in a patient with malignancy which is otherwise resecetable (R) (Anaes.)
(See para DIQ of explanatory notes to this Category)</td></tr>
<tr><td>63461</td><td>Fee: $358.40 Benefit: 75% = $268.80 85% = $304.65</td></tr>
<tr><td></td><td>MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where:
(a) a dedicated breast coil is used; and
(b) the request for scan identifies that the person is asymptomatic and is less than 50 years of age; and
(c) the request for scan identifies either:
(i) that the patient is at high risk of developing breast cancer, due to 1 of the following:
(A) 3 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer;
(B) 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 following applies to at least 1 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;
- is a male relative who has been diagnosed with breast cancer;

(C) 1 first or second degree relative diagnosed with breast cancer at age 45 years or younger, plus 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

(ii) that genetic testing has identified the presence of a high risk breast cancer gene mutation.

Scan of both breasts for:

- detection of cancer (R)

NOTE: Benefits are payable on one occasion only in any 12 month period (Anaes.)
(See para DIQ of explanatory notes to this Category)</td></tr>
<tr><td>63464</td><td>Fee: $690.00 Benefit: 75% = $517.50 85% = $610.50</td></tr>
</table>

MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where:
(a) a dedicated breast coil is used; and
(b) the person has had an abnormality detected as a result of a service described in item 63464 performed in the previous 12 months

Scan of both breasts for:

- detection of cancer (R)

NOTE 1: Benefits are payable on one occasion only in any 12 month period

NOTE 2: This item is intended for follow-up imaging of abnormalities diagnosed on a scan described by item 63464 (Anaes.)
(See para DIQ of explanatory notes to this Category)

63467 **Fee:** $690.00 **Benefit:** 75% = $517.50 85% = $610.50

SUBGROUP 20 - SCAN OF PELVIS AND UPPER ABDOMEN - FOR SPECIFIED CONDITIONS

NOTE: Benefits are payable for a service under items 63470 and 63473 on one occasion only.

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

Scan of:

- Pelvis for the staging of histologically diagnosed cervical cancer at FIGO stages 1B or greater (R) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)

63470 **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

- Pelvis and upper abdomen, in a single examination, for the staging of histologically diagnosed cervical cancer at FIGO stages 1B or greater (R) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)

63473 **Fee:** $627.20 **Benefit:** 75% = $470.40 85% = $547.70

NOTE: benefits are payable for a service under item 63476 on one occasion only.
MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where:
(a) a phased array body coil is used, and
(b) the request for scan identifies that the indication is for the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum).

Scan of:

- Pelvis for the initial staging of rectal cancer (R) (contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)

63476 **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

NOTE: Benefits are payable for a service included by Subgroup 20 on one occasion only.
MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where:
(a) the patient is referred by a specialist or by a consultant physician and
(b) the request for scan identifies that (i) a histological diagnosis of carcinoma of the cervix has been made and (ii) the patient has been diagnosed with cervical cancer at FIGO stage 1B or greater

Scan of:

- Pelvis for the staging of histologically diagnosed cervical cancer at FIGO stages 1B or greater (R) (NK) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)

63479 **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

63481	- Pelvis and upper abdomen, in a single examination, for the staging of histologically diagnosed cervical cancer at FIGO stages 1B or greater (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $313.60 **Benefit:** 75% = $235.20 85% = $266.60
	SUBGROUP 21 - SCAN OF BODY - FOR SPECIFIED CONDITIONS
63482	**NOTE: Benefits are only payable for each service included by Subgroup 21 on three occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of pancreas and biliary tree** for: - suspected biliary or pancreatic pathology (R) (Anaes.) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	SUBGROUP 20 - SCAN OF PELVIS AND UPPER ABDOMEN - FOR SPECIFIED CONDITIONS
63484	**NOTE: benefits are payable for a service included by Subgroup 20 on one occasion only.** MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a phased array body coil is used, and (b) the request for scan identifies that the indication is for the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum). Scan of: - Pelvis for the initial staging of rectal cancer (R) (NK) (contrast) (Anaes.) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	SUBGROUP 21 - SCAN OF BODY - FOR SPECIFIED CONDITIONS
63486	**NOTE: Benefits are only payable for each service included by Subgroup 21 on three occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of pancreas and biliary tree** for: - suspected biliary or pancreatic pathology (R) (NK) (Anaes.) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	SUBGROUP 22 - MODIFYING ITEMS
63491	NOTE: Benefits in Subgroup 22 are only payable for modifying items where claimed simultaneously with MRI services. Modifiers for sedation and anaesthesia may not be claimed for the same service. Modifying items for use with MAGNETIC RESONANCE IMAGING or MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the service requested by a medical practitioner. Scan performed: - involves the use of contrast agent for eligible Magnetic Resonance Imaging items (Note: (Contrast) denotes an item eligible for use with this item) *(See para DIQ of explanatory notes to this Category)* **Fee:** $44.80 **Benefit:** 75% = $33.60 85% = $38.10
63494	- involves use of intravenous or intramuscular sedation on a patient *(See para DIQ of explanatory notes to this Category)* **Fee:** $44.80 **Benefit:** 75% = $33.60 85% = $38.10
63497	- on a patient under anaesthetic in the presence of a medical practitioner qualified to perform an anaesthetic *(See para DIQ 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 DIQ 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 DIQ of explanatory notes to this Category)* **Fee:** $156.80 **Benefit:** 75% = $117.60 85% = $133.30
	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 12 Month Period** *(See para DIQ of explanatory notes to this Category)* **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 12 Month Period** *(See para DIQ 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 DIQ 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 DIQ of explanatory notes to this Category)* **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00
	SUBGROUP 33 - MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16YRS
63507	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of head for a patient under 16 years for any of the following: – unexplained seizure(s) (R) (Contrast) (Anaes.); or – unexplained headache where significant pathology is suspected (R) (Contrast) (Anaes.); or – paranasal sinus pathology which has not responded to conservative therapy (R) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

63508	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of head for a patient under 16 years for any of the following: – unexplained seizure(s) (R) (NK) (Contrast) (Anaes.); or – unexplained headache where significant pathology is suspected (R) (NK) (Contrast) (Anaes.); or – paranasal sinus pathology which has not responded to conservative therapy (R) (NK) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63510	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient under 16 years following radiographic examination for: – significant trauma (R) (Contrast) (Anaes.); or – unexplained neck or back pain with associated neurological signs (R) (Contrast) (Anaes.); or – unexplained back pain where significant pathology is suspected (R) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63511	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient under 16 years following radiographic examination for: – significant trauma (R) (NK) (Contrast) (Anaes.); or – unexplained neck or back pain with associated neurological signs (R) (NK) (Contrast) (Anaes.); or – unexplained back pain where significant pathology is suspected (R) (NK) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
63513	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of knee for a patient under 16 years following radiographic examination for internal joint derangement (R) (Contrast) (Anaes.) **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63514	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of knee for a patient under 16 years following radiographic examination for internal joint derangement (R) (NK) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63516	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of hip for a patient under 16 years following radiographic examination for: – suspected septic arthritis (R) (Contrast) (Anaes.); or – suspected slipped capital femoral epiphysis (R) (Contrast) (Anaes.); or – suspected Perthes disease (R) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63517	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of hip for a patient under 16 years following radiographic examination for: – suspected septic arthritis (R) (NK) (Contrast) (Anaes.); or – suspected slipped capital femoral epiphysis (R) (NK) (Contrast) (Anaes.); or – suspected Perthes disease (R) (NK) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63519	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of elbow for a patient under 16 years following radiographic examination where a significant fracture or avulsion injury is suspected that will change management (R) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63520	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of elbow for a patient under 16 years following radiographic examination where a significant fracture or avulsion injury is suspected that will change management (R) (NK) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

63522	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of wrist for a patient under 16 years following radiographic examination where scaphoid fracture is suspected (R) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
63523	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of wrist for a patient under 16 years following radiographic examination where scaphoid fracture is suspected (R) (NK) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
	SUBGROUP 34 - MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS
63551	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of head for a patient 16 years or older for any of the following: - unexplained seizure(s) (R) (Contrast) (Anaes.) - unexplained chronic headache with suspected intracranial pathology (R) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63552	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of head for a patient 16 years or older for any of the following: - unexplained seizure(s) (R) (NK) (Contrast) (Anaes.) - unexplained chronic headache with suspected intracranial pathology (R) (NK) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
63554	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient 16 years or older for suspected: - cervical radiculopathy (R) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63555	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient 16 years or older for suspected: - cervical radiculopathy (R) (NK) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35
63557	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient 16 years or older for suspected: - cervical spine trauma (R) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $418.90
63558	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of spine for a patient 16 years or older for suspected: - cervical spine trauma (R) (NK) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45
63560	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of knee following acute knee trauma for a patient 16 years or older with: - inability to extend the knee suggesting the possibility of acute meniscal tear (R) (Contrast) (Anaes.); or - clinical findings suggesting acute anterior cruciate ligament tear. (R) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

	referral by a medical practitioner (excluding a specialist or consultant physician) for a scan of knee following acute knee trauma for a patient 16 years or older with: - inability to extend the knee suggesting the possibility of acute meniscal tear (R) (NK) (Contrast) (Anaes.); or - clinical findings suggesting acute anterior cruciate ligament tear. (R) (NK) (Contrast) (Anaes.) *(See para DIO of explanatory notes to this Category)*
63561	**Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	SUBGROUP 20 - SCAN OF PELVIS AND UPPER ABDOMEN - FOR SPECIFIED CONDITIONS
	MRI to evaluate small bowel Crohn's disease. Medicare benefits are only payable for this item if the service is provided to patients: (a) Evaluation of disease extent at time of initial diagnosis of Crohn's disease (b) Evaluation of exacerbation/suspected complications of known Crohn's disease (c) Evaluation of known or suspected Crohn's disease in pregnancy (d) Assessment of change to therapy in patients with small bowel Crohn's disease Assessment of change to therapy can only be claimed once in a 12 month period. (R) (K) (Contrast)
63740	**Fee:** $457.20 **Benefit:** 75% = $342.90 85% = $388.65
	MRI enteroclysis for Crohn's disease. Medicare benefits are only payable for this item if the service is related to item 63740. (R) (K)
63741	**Fee:** $265.25 **Benefit:** 75% = $198.95 85% = $225.50
	MRI for fistulising perianal Crohn's disease. Medicare benefits are only payable for this item if the service is provided to patients for: - Evaluation of pelvic sepsis and fistulas associated with established or suspected Crohn's disease - Assessment of change to therapy of pelvis sepsis and fistulas from Crohn's disease Assessment of change to therapy can only be claimed once in a 12 month period. (R) (K) (Contrast)
63743	**Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	MRI to evaluate small bowel Crohn's disease. Medicare benefits are only payable for this item if the service is provided to patients: (a) Evaluation of disease extent at time of initial diagnosis of Crohn's disease (b) Evaluation of exacerbation/suspected complications of known Crohn's disease (c) Evaluation of known or suspected Crohn's disease in pregnancy (d) Assessment of change to therapy in patients with small bowel Crohn's disease Assessment of change to therapy can only be claimed once in a 12 month period. (R) (NK) (Contrast)
63744	**Fee:** $228.60 **Benefit:** 75% = $171.45 85% = $194.35
	MRI enteroclysis for Crohn's disease. Medicare benefits are only payable for this item if the service is related to item 63744. (R) (NK)
63746	**Fee:** $132.65 **Benefit:** 75% = $99.50 85% = $112.80
	MRI for fistulising perianal Crohn's disease. Medicare benefits are only payable for this item if the service is provided to patients for: - Evaluation of pelvic sepsis and fistulas associated with established or suspected Crohn's disease - Assessment of change to therapy of pelvis sepsis and fistulas from Crohn's disease Assessment of change to therapy can only be claimed once in a 12 month period. (R) (NK) (Contrast)
63747	**Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

GROUP I6 - MANAGEMENT OF BULK-BILLED SERVICES

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 DIP and DIQ of explanatory notes to this Category)

64990 **Fee:** $7.05 **Benefit:** 85% = $6.00

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
(d) the service is bulk-billed in respect of the fees for:
(i) this item; and
(ii) the other item in this table applying to the service; and
(e) the service is provided at, or from, a practice location in:
(i) a regional, rural or remote area; or
(ii) Tasmania; or
(iii) A geographical area included in any of the following SSD spatial units:
(A) Beaudesert Shire Part A
(B) Belconnen
(C) Darwin City
(D) Eastern Outer Melbourne
(E) East Metropolitan, Perth
(F) Frankston City
(G) Gosford-Wyong
(H) Greater Geelong City Part A
(I) Gungahlin-Hall
(J) Ipswich City (part in BSD)
(K) Litchfield Shire
(L) Melton-Wyndham
(M) Mornington Peninsula Shire
(N) Newcastle
(O) North Canberra
(P) Palmerston-East Arm
(Q) Pine Rivers Shire
(R) Queanbeyan
(S) South Canberra
(T) South Eastern Outer Melbourne
(U) Southern Adelaide
(V) South West Metropolitan, Perth
(W) Thuringowa City Part A
(X) Townsville City Part A
(Y) Tuggeranong
(Z) Weston Creek-Stromlo
(ZA) Woden Valley
(ZB) Yarra Ranges Shire Part A; or
(iv) the geographical area included in the SLA spatial unit of Palm Island (AC)

(See para DIP and DIQ of explanatory notes to this Category)

64991 **Fee:** $10.65 **Benefit:** 85% = $9.10

INDEX

A

Abdomen, barium X-ray 58909
Abdominal x-ray, plain 58903
Abdominal x-ray, plain 58900
Air contrast study, with opaque enema 58921
Air insufflation 59763
Alimentary tract, x-ray of 58900
Alimentary tract, x-ray of 58903
Alimentary tract, x-ray of 58909
Alimentary tract, x-ray of 58912
Alimentary tract, x-ray of 58915
Alimentary tract, x-ray of 58916
Alimentary tract, x-ray of 58921
Angiocardiography 59903
Angiography, cerebral, preparation for 60918
Angiography, coronary 59912
Angiography, digital subtraction (DSA) 60036
Angiography, digital subtraction (DSA) 60033
Angiography, digital subtraction (DSA) 60030
Angiography, digital subtraction (DSA) 60027
Angiography, digital subtraction (DSA) 60024
Angiography, digital subtraction (DSA) 60021
Angiography, digital subtraction (DSA) 60018
Angiography, digital subtraction (DSA) 60015
Angiography, digital subtraction (DSA) 60012
Angiography, digital subtraction (DSA) 60009
Angiography, digital subtraction (DSA) 60006
Angiography, digital subtraction (DSA) 60003
Angiography, digital subtraction (DSA) 60000
Angiography, digital subtraction (DSA) 60039
Angiography, digital subtraction (DSA) 60001,60004,60007 60010,60013,60016,60019,60022,60025,60028,60031 60034,60037,60040,60043,60046,60049,60052,60055 60058,60061,60064,60067,60069,60070
Angiography, digital subtraction (DSA) 60066
Angiography, digital subtraction (DSA) 60063
Angiography, digital subtraction (DSA) 60060
Angiography, digital subtraction (DSA) 60057
Angiography, digital subtraction (DSA) 60054
Angiography, digital subtraction (DSA) 60051
Angiography, digital subtraction (DSA) 60048
Angiography, digital subtraction (DSA) 60045
Angiography, digital subtraction (DSA) 60042
Angiography, with mobile image intensification 59970
Ankle, x-ray of 57518
Ankle, x-ray of 57521
Ankle, x-ray of 57524
Ankle, x-ray of 57527
Antegrade pyelography 58715
Arm, x-ray of 57506
Arm, x-ray of 57509
Arm, x-ray of 57512
Arm, x-ray of 57515
Arteriogram - selective, preparation 60927
Arteriography 59912
Arteriography or venography, selective 60072
Arteriography or venography, selective 60075
Arteriography or venography, selective 60073,60076,60078 60079
Arteriography, preparation for 60918
Arteriography, selective 59912
Arthrography 59751

B

Barium, alimentary tract 58909
Barium, alimentary tract 58912
Barium, alimentary tract 58915
Biliary system, x-ray of 58924
Biliary system, x-ray of 58927
Biliary system, x-ray of 58933
Biliary system, x-ray of 58936
Bone, age study 58300
Bowel - small, barium x-ray of 58912
Bowel - small, barium x-ray of 58915
Bowel - small, enema 58916
Breast x-ray, excised tissue 59318
Breast x-ray, restriction applies 59300
Breast x-ray, restriction applies 59303
Breast x-ray, with surgical procedure 59312
Breast x-ray, with surgical procedure 59314
Bronchography 59715
Bulk-billing 64990
Bulk-billing 64991

C

Calculus, salivary, x-ray of 57918
CBCT dental imaging 57362,57363
Cephalometry, x-ray 57902
Cerebral angiography, preparation for 60918
Cervical spine, x-ray of 58100
Chest, x-ray of 58503
Chest, x-ray of 58509
Chest, x-ray of 58500
Chest, x-ray of 58506
Cholecystography 58924
Cholegraphy 58936
Cholegraphy 58933
Cholegraphy 58927
Clavicle, x-ray of 57709
Clavicle, x-ray of 57706
Coccyx, x-ray of 58109
Colon, x-ray of 58912
Colon, x-ray of 58921
Computed Tomography of the colon 56553,56555
Computerised tomography, brain, chest and upper abdomen 57007
Computerised tomography, brain, chest and upper abdomen 57001
Computerised tomography, brain, chest and upper abdomen 57047
Computerised tomography, brain, chest and upper abdomen 57041
Computerised tomography, chest and upper abdomen 56301
Computerised tomography, chest and upper abdomen 56347
Computerised tomography, chest and upper abdomen 56341
Computerised tomography, chest and upper abdomen 56307
Computerised tomography, coronary arteries 57360,57361
Computerised tomography, extremities 56619
Computerised tomography, extremities 56625
Computerised tomography, extremities 56659
Computerised tomography, extremities 56665
Computerised tomography, facial bones 56062
Computerised tomography, facial bones 56022
Computerised tomography, facial bones 56028
Computerised tomography, facial bones 56068
Computerised tomography, head, brain 56001
Computerised tomography, head, brain 56047
Computerised tomography, head, brain 56041
Computerised tomography, head, brain 56007
Computerised tomography, interventional technique 57341
Computerised tomography, interventional technique 57345
Computerised tomography, middle ear 56056
Computerised tomography, middle ear 56016
Computerised tomography, neck 56141
Computerised tomography, neck 56107

Computerised tomography, neck 56101
Computerised tomography, neck 56147
Computerised tomography, orbits 56013
Computerised tomography, orbits 56053
Computerised tomography, pelvimetry 57247
Computerised tomography, pelvimetry 57201
Computerised tomography, pelvis 56409
Computerised tomography, pelvis 56412
Computerised tomography, pelvis 56449
Computerised tomography, pelvis 56452
Computerised tomography, pituitary fossa 56010
Computerised tomography, pituitary fossa 56050
Computerised tomography, spine 56227
Computerised tomography, spine 56228
Computerised tomography, spine 56229
Computerised tomography, spine 56230
Computerised tomography, spine 56231
Computerised tomography, spine 56232
Computerised tomography, spine 56233
Computerised tomography, spine 56234
Computerised tomography, spine 56235
Computerised tomography, spine 56236
Computerised tomography, spine 56237
Computerised tomography, spine 56238
Computerised tomography, spine 56239
Computerised tomography, spine 56240
Computerised tomography, spine 56259
Computerised tomography, spine 56226
Computerised tomography, spine 56225
Computerised tomography, spine 56224
Computerised tomography, spine 56223
Computerised tomography, spine 56221
Computerised tomography, spine 56219
Computerised tomography, spine 56220
Computerised tomography, spiral angiography 57356
Computerised tomography, spiral angiography 57351
Computerised tomography, spiral angiography 57350
Computerised tomography, spiral angiography 57355
Computerised tomography, upper abdomen 56407
Computerised tomography, upper abdomen 56441
Computerised tomography, upper abdomen 56447
Computerised tomography, upper abdomen 56401
Computerised tomography, upper abdomen & pelvis 56501
Computerised tomography, upper abdomen & pelvis 56547
Computerised tomography, upper abdomen & pelvis 56507
Computerised tomography, upper abdomen & pelvis 56541
Computerised tomography,chest, abdomen, pelvis, neck 56841
Computerised tomography,chest, abdomen, pelvis, neck 56807
Computerised tomography,chest, abdomen, pelvis, neck 56801
Computerised tomography,chest, abdomen, pelvis, neck 56847
Contrast media, intro for radiology 60918
Coronary arteriography, selective 59912
Cysto-urethrography, retrograde micturating 58721
Cystography, retrograde 58718

D

Dacryocystography 59703
Defaecogram 58939
Digits & phalanges 57512
Digits & phalanges 57509
Digits & phalanges 57506
Digits & phalanges 57515
Digits & phalanges 57518
Digits & phalanges 57521
Digits & phalanges 57524
Digits & phalanges 57527
Discography 59700
Duodenum, barium x-ray of 58909
Duodenum, barium x-ray of 58912
Duplex scanning, carotid and vertebral vessels 55274
Duplex scanning, of abdominal aorta, arteries, iliac arteries and veins 55276
Duplex scanning, of arteries/grafts lower limb 55238
Duplex scanning, of arteries/grafts upper limb 55248
Duplex scanning, of intra-cranial vessels 55280
Duplex scanning, of penis, cavernosal artery 55282
Duplex scanning, of penis, cavernosal tissue 55284
Duplex scanning, of renal/visceral vessels 55278
Duplex scanning, of veins lower limb, venous disease 55246
Duplex scanning, of veins lower limb, venous thrombrosis 55244
Duplex scanning, veins upper limb 55252

E

Echocardiographic, exam of heart 55114
Echocardiographic, exam of heart 55113
Echocardiographic, exam of heart 55135
Echocardiographic, exam of heart 55130
Echocardiographic, exam of heart 55118
Echocardiographic, exam of heart 55117
Echocardiographic, exam of heart 55116
Echocardiographic, exam of heart 55115
Echography, ultrasonic 55038
Echography, ultrasonic 55039
Echography, ultrasonic 55037
Echography, ultrasonic 55036
Echography, ultrasonic 55033
Echography, ultrasonic 55032
Echography, ultrasonic 55031
Echography, ultrasonic 55030
Echography, ultrasonic 55029
Echography, ultrasonic 55028
Echography, ultrasonic 55048
Echography, ultrasonic 55118
Echography, ultrasonic 55117
Echography, ultrasonic 55116
Echography, ultrasonic 55049
Echography, ultrasonic 55054
Echography, ultrasonic 55070
Echography, ultrasonic 55073
Echography, ultrasonic 55076
Echography, ultrasonic 55079
Echography, ultrasonic 55084
Echography, ultrasonic 55085
Echography, ultrasonic 55113
Echography, ultrasonic 55114
Echography, ultrasonic 55115
Elbow, x-ray 57506
Elbow, x-ray 57509
Enema, opaque x-ray 58921
Eye, x-ray of 57924

F

Facial bones, x-ray of 57912
Femur, x-ray of 57527
Femur, x-ray of 57518
Femur, x-ray of 57721
Fistulogram 59739
Fluroscopic exam 60506
Fluroscopic exam 60503
Fluroscopic exam 60500
Fluroscopic exam 60509
Fluroscopic exam 61109
Foot, x-ray of 57518
Foot, x-ray of 57521
Foot, x-ray of 57524
Foot, x-ray of 57527
Forearm, x-ray of 57506
Forearm, x-ray of 57515

Foreign body, localisation of and report 59103

G

Gallbladder, x-ray of 58924
Gallbladder, x-ray of 58927
Gallbladder, x-ray of 58933
Gallbladder, x-ray of 58936
Graham's test 58924

H

Hand/wrist/forearm/elbow 57506
Hand/wrist/forearm/elbow 57509
Hand/wrist/forearm/elbow 57512
Hand/wrist/forearm/elbow 57515
Hip joint, x-ray of 57712
Humerus, x-ray of 57506
Humerus, x-ray of 57509
Humerus, x-ray of 57512
Humerus, x-ray of 57515
Hysterosalpingography 59712

I

Intravenous pyelogram 58706

K

Knee/foot/ankle/leg/femur x-ray 57518
Knee/foot/ankle/leg/femur x-ray 57527
Knee/foot/ankle/leg/femur x-ray 57524
Knee/foot/ankle/leg/femur x-ray 57521

L

Larynx, neck tissues, x-ray of 57945
Leg, x-ray of 57521
Leg, x-ray of 57524
Leg, x-ray of 57518
Leg, x-ray of 57527
Lumbo-sacral spine, x-ray of 58106
Lung fields, x-ray of 58500
Lung fields, x-ray of 58503
Lung fields, x-ray of 58506
Lymphangiography 59754

M

Magnetic Resonance Angiography, cardiovascular system 63404
Magnetic Resonance Angiography, cardiovascular system 63401
Magnetic Resonance Angiography, persons under 16 years 63416
Magnetic Resonance Imaging, body 63461
Magnetic Resonance Imaging, cardiovascular system 63391
Magnetic Resonance Imaging, cardiovascular system 63388
Magnetic Resonance Imaging, cardiovascular system 63385
Magnetic Resonance Imaging, cervical spine and brachial plexus 63274
Magnetic Resonance Imaging, cervical spine and brachial plexus 63280
Magnetic Resonance Imaging, cervical spine and brachial plexus 63277
Magnetic Resonance Imaging, cervical spine and brachial plexus 63271
Magnetic Resonance Imaging, head 63046
Magnetic Resonance Imaging, head 63043
Magnetic Resonance Imaging, head 63040
Magnetic Resonance Imaging, head 63010
Magnetic Resonance Imaging, head 63007
Magnetic Resonance Imaging, head 63004
Magnetic Resonance Imaging, Head 63001
Magnetic Resonance Imaging, head 63049
Magnetic Resonance Imaging, head 63055
Magnetic Resonance Imaging, head 63058
Magnetic Resonance Imaging, head 63061
Magnetic Resonance Imaging, head 63064
Magnetic Resonance Imaging, head 63067
Magnetic Resonance Imaging, head 63070
Magnetic Resonance Imaging, head 63073
Magnetic Resonance Imaging, head 63052
Magnetic Resonance Imaging, head and cervical spine 63131
Magnetic Resonance Imaging, head and cervical spine 63128
Magnetic Resonance Imaging, head and cervical spine 63125
Magnetic Resonance Imaging, head and neck vessels 63101
Magnetic Resonance Imaging, modifying items 63491,63494, 63497-63499
Magnetic Resonance Imaging, musculoskeletal system 63328
Magnetic Resonance Imaging, musculoskeletal system 63361
Magnetic Resonance Imaging, musculoskeletal system 63331
Magnetic Resonance Imaging, musculoskeletal system 63307
Magnetic Resonance Imaging, musculoskeletal system 63304
Magnetic Resonance Imaging, musculoskeletal system 63340
Magnetic Resonance Imaging, musculoskeletal system 63337
Magnetic Resonance Imaging, musculoskeletal system 63334
Magnetic Resonance Imaging, musculoskeletal system 63325
Magnetic Resonance Imaging, musculoskeletal system 63301
Magnetic Resonance Imaging, musculoskeletal system 63322
Magnetic Resonance Imaging, pelvis and upper abdomen 63470
Magnetic Resonance Imaging, pelvis and upper abdomen 63473
Magnetic Resonance Imaging, person under 16 years 63440
Magnetic Resonance Imaging, person under 16 years 63443
Magnetic Resonance Imaging, person under 16 years 63446
Magnetic Resonance Imaging, person under 16 years 63428
Magnetic Resonance Imaging, person under 16 years 63425
Magnetic Resonance Imaging, PIP Breast Implant 63501,63502, 63504, 63505
Magnetic Resonance Imaging, spine - one region or two contiguous regions 63185
Magnetic Resonance Imaging, spine - one region or two contiguous regions 63151
Magnetic Resonance Imaging, spine - one region or two contiguous regions 63154
Magnetic Resonance Imaging, spine - one region or two contiguous regions 63161
Magnetic Resonance Imaging, spine - one region or two contiguous regions 63164
Magnetic Resonance Imaging, spine - one region or two contiguous regions 63167
Magnetic Resonance Imaging, spine - one region or two contiguous regions 63170
Magnetic Resonance Imaging, spine - one region or two contiguous regions 63173
Magnetic Resonance Imaging, spine - one region or two contiguous regions 63176
Magnetic Resonance Imaging, spine - one region or two contiguous regions 63179
Magnetic Resonance Imaging, spine - one region or two contiguous regions 63182
Magnetic Resonance Imaging, spine - three contiguous or two non contiguous regio 63201
Magnetic Resonance Imaging, spine - three contiguous or two non contiguous regio 63204
Magnetic Resonance Imaging, spine - three contiguous or two non contiguous regio 63237
Magnetic Resonance Imaging, spine - three contiguous or two non contiguous regio 63234
Magnetic Resonance Imaging, spine - three contiguous or two non contiguous regio 63231
Magnetic Resonance Imaging, spine - three contiguous or two non contiguous regio 63228
Magnetic Resonance Imaging, spine - three contiguous or two non contiguous regio 63225

Magnetic Resonance Imaging, spine - three contiguous or two non contiguous regio 63222
Magnetic Resonance Imaging, spine - three contiguous or two non contiguous regio 63219
Malar bones, x-ray of 57912
Mammary ductogram 59306
Mammary ductogram 59309
Mammography, (restriction applies) 59303
Mammography, (restriction applies) 59300
Mandible, X-ray of 57915
Mastoids, X-ray of 57906
Maxilla, X-ray of 57912
Myelography 59724

N

Nephography 58700
Nephography 58715
Nose, X-ray of 57921
Nuclear Medicine Imaging, brain study 61405
Nuclear Medicine Imaging, brain study 61402
Nuclear medicine imaging, cardiovascular, cardiac blood flow, shunt/output study 61320
Nuclear medicine imaging, cardiovascular, gated cardiac study - 1st pass/cardiac 61314
Nuclear medicine imaging, cardiovascular, gated cardiac study - intervention 61316
Nuclear medicine imaging, cardiovascular, gated cardiac study-planar or spect 61313
Nuclear Medicine Imaging, cerebro spinal fluid study 61409
Nuclear Medicine Imaging, cerebro spinal fluid study 61413
Nuclear Medicine Imaging, endocrine, adrenal study 61484
Nuclear Medicine Imaging, endocrine, adrenal study 61485
Nuclear Medicine Imaging, endocrine, parathyroid study 61480
Nuclear Medicine Imaging, endocrine, thyroid study 61473
Nuclear Medicine Imaging, gastrointestinal, bowel haemorrhage study 61364
Nuclear Medicine Imaging, gastrointestinal, colonic transit study 61384
Nuclear Medicine Imaging, gastrointestinal, gastric emptying 61383
Nuclear Medicine Imaging, gastrointestinal, gastric emptying 61381
Nuclear Medicine Imaging, gastrointestinal, gastro-oesophageal reflux study 61373
Nuclear Medicine Imaging, gastrointestinal, hepatobiliary study 61360
Nuclear Medicine Imaging, gastrointestinal, hepatobiliary study 61361
Nuclear Medicine Imaging, gastrointestinal, oesophageal clearance study 61376
Nuclear Medicine Imaging, genitourinary, cystoureterogram 61397
Nuclear Medicine Imaging, genitourinary, renal cortical study 61387
Nuclear Medicine Imaging, genitourinary, renal study 61393
Nuclear Medicine Imaging, genitourinary, renal study 61389
Nuclear Medicine Imaging, genitourinary, renal study 61386
Nuclear Medicine Imaging, genitourinary, renal study 61390
Nuclear Medicine Imaging, genitourinary, renal study including renogram or plana 61386
Nuclear Medicine Imaging, genitourinary, testicular study 61401
Nuclear Medicine Imaging, Indium, labelled octreotide study 61369
Nuclear Medicine Imaging, Indium, Meckel's diverticulum study 61368
Nuclear Medicine Imaging, Indium, red blood cell spleen/liver SPECT 61356
Nuclear Medicine Imaging, Indium, salivary study 61372
Nuclear Medicine Imaging, liver and spleen study 61353
Nuclear Medicine Imaging, liver and spleen study 61352
Nuclear Medicine Imaging, localised study, gallium 61450
Nuclear Medicine Imaging, localised study, gallium 61453
Nuclear Medicine Imaging, localised study, technetium 61457
Nuclear Medicine Imaging, localised study, technetium 61454
Nuclear Medicine Imaging, localised study, thallium 61461
Nuclear Medicine Imaging, localised study,thallium 61458
Nuclear Medicine Imaging, lymphoscintigraphy 61469
Nuclear Medicine Imaging, myocardial infarct-avid imaging 61310
Nuclear Medicine Imaging, myocardial perfusion central nervous 61306
Nuclear Medicine Imaging, myocardial perfusion central nervous 61303
Nuclear Medicine Imaging, myocardial perfusion central nervous 61302
Nuclear Medicine Imaging, myocardial perfusion central nervous 61307
Nuclear Medicine Imaging, positron emission tomography 61523, 61529,61541, 61553,61559, 61565,61575, 61577,61598, 61604,61610, 61620,61632
Nuclear Medicine Imaging, pulmonary, lung perfusion & ventilation 61348
Nuclear Medicine Imaging, pulmonary, lung perfusion study 61328
Nuclear Medicine Imaging, pulmonary, lung ventilation study 61340
Nuclear Medicine Imaging, repeat planar or SPECT 61462
Nuclear Medicine Imaging, skeletal, bone marrow study 61441
Nuclear Medicine Imaging, skeletal, bone marrow study 61445
Nuclear Medicine Imaging, skeletal, bone study 61421
Nuclear Medicine Imaging, skeletal, bone study 61425
Nuclear Medicine Imaging, skeletal, bone/joint localised 61446
Nuclear Medicine Imaging, tear duct study 61495
Nuclear Medicine Imaging, vascular, dynamic flow/volume study 61417
Nuclear Medicine Imaging, vascular, particle perfusion or Le Veen 61499
Nuclear Medicine Imaging, vascular, venography 61465
Nuclear Medicine Imaging, whole body study, gallium 61442
Nuclear Medicine Imaging, whole body study, gallium 61429
Nuclear Medicine Imaging, whole body study, gallium 61430
Nuclear Medicine Imaging, whole body study, iodine 61426
Nuclear Medicine Imaging, whole body study, technetium 61433
Nuclear Medicine Imaging, whole body study, technetium 61434
Nuclear Medicine Imaging, whole body study, thallium 61437
Nuclear Medicine Imaging, whole body study, thallium 61438

O

Oesophagus, barium X-ray of 58909
Oesophagus, barium X-ray of 58912
Opaque enema 58921
Opaque enema, meal 58909
Opaque enema, meal 58912
Opaque enema, meal 58915
Opaque enema, media, radiology prep 60918
Opaque enema, media, radiology prep 60927
Orbit, facial bones, X-ray of 57912
Orthopantomography 57960
Orthopantomography 57963
Orthopantomography 57966
Orthopantomography 57969

P

Palato-pharyngeal studies 57942
Paloat-pharyngeal studies 57939
Pelvic girdle, X-ray of 57715
Pelvimetry 59503

Pelvis, X-ray of 57715
Peritoneogram 59760
Petrous temporal bones, X-ray of 57909
Phalanges & digits 57524
Phalanges & digits 57521
Phalanges & digits 57518
Phalanges & digits 57515
Phalanges & digits 57512
Phalanges & digits 57509
Phalanges & digits 57506
Phalanges & digits 57527
Pharynx, barium X-ray of 58909
Phlebogram, preparation 60927
Phlebography 59718
Phlebography, preparation for 60918
Plain abdominal X-ray 58900
Plain, abdominal X-ray 58903
Plain, renal X-ray 58700
Pleura, X-ray of 58503
Pleura, X-ray of 58500
Positron emission tomography 61523,61529,61538
61541,61553,61559,61565,61571,61575,61577,61598
61604,61610,61616,61620,61622,61628,61632,61640
61646
Prep, for radiological procedure 60918
Prep, for radiological procedure 60927
Pyelography - intravenous 58706
Pyelography - intravenous, retrograde/antegrade 58715

R

Renal, plain X-ray 58700
Retrograde - pyelography 58715
Retrograde - pyelography, cysto-urethography 58721
Retrograde - pyelography, cystography 58718
Ribs, X-ray of 58527
Ribs, X-ray of 58521
Ribs, X-ray of 58524

S

Sacro-coccygeal spine, X-ray of 58109
Salivary calculus, X-ray of 57918
Scapula, X-ray of 57703
Scapula, X-ray of 57700
Screening with x-ray of chest 58506
Screening, palate/pharynx, x-ray 57939
Serial, angiocardiography 59903
Shoulder or scapula, X-ray of 57700
Shoulder or scapula, X-ray of 57703
Sialography 59733
Sinogram, or fistulogram 59739
Sinus, X-ray of 57903
Skeletal survey 58306
Skull, X-ray 57901
Small bowel series, barium, X-ray 58915
Small bowel series, barium, X-ray 58912
Spine, X-ray of 58106
Spine, X-ray of 58108
Spine, X-ray of 58103
Spine, X-ray of 58100
Spine, X-ray of 58109
Spine, X-ray of 58115
Spine, X-ray of 58112
Sternum, X-ray of 58521
Sternum, X-ray of 58524
Sternum, X-ray of 58527
Stomach, barium X-ray 58909
Stomach, barium X-ray 58912

T

Teeth, orthopantomography 57960
Teeth, orthopantomography 57963
Teeth, orthopantomography 57966
Teeth, orthopantomography 57969
Teeth, X-ray of 57930
Teeth, X-ray of 57933
Temporo-mandibular joints, X-ray of 57927
Thigh (femur), X-ray of 57518
Thigh (femur), X-ray of 57521
Thoracic inlet, spine, X-ray of 58103
Thoracic inlet, X-ray of 58509
Tomography, any region 60100
Trachea, X-ray of 58509

U

Ultrasound, cardiac examination 55116
Ultrasound, cardiac examination 55117
Ultrasound, cardiac examination 55118
Ultrasound, cardiac examination 55130
Ultrasound, cardiac examination 55135
Ultrasound, cardiac examination 55113
Ultrasound, cardiac examination 55114
Ultrasound, cardiac examination 55115
Ultrasound, general 55029
Ultrasound, general 55039
Ultrasound, general 55028
Ultrasound, general 55038
Ultrasound, general 55048
Ultrasound, general 55049
Ultrasound, general 55054
Ultrasound, general 55070
Ultrasound, general 55073
Ultrasound, general 55076
Ultrasound, general 55079
Ultrasound, general 55084
Ultrasound, general 55030
Ultrasound, general 55031
Ultrasound, general 55085
Ultrasound, general 55032
Ultrasound, general 55033
Ultrasound, general 55036,55065,55067
Ultrasound, general 55037
Ultrasound, musculoskeletal 55800
Ultrasound, musculoskeletal 55854
Ultrasound, obstetric and gynaecological 55770
Ultrasound, obstetric and gynaecological 55772
Ultrasound, obstetric and gynaecological 55774
Ultrasound, obstetric and gynaecological 55768
Ultrasound, obstetric and gynaecological 55766
Ultrasound, obstetric and gynaecological 55764
Ultrasound, obstetric and gynaecological 55762
Ultrasound, obstetric and gynaecological 55759
Ultrasound, obstetric and gynaecological 55739
Ultrasound, obstetric and gynaecological 55736
Ultrasound, obstetric and gynaecological 55725
Ultrasound, obstetric and gynaecological 55723
Ultrasound, obstetric and gynaecological 55721
Ultrasound, obstetric and gynaecological 55718
Ultrasound, obstetric and gynaecological 55715
Ultrasound, obstetric and gynaecological 55712
Ultrasound, obstetric and gynaecological 55709
Ultrasound, obstetric and gynaecological 55708
Ultrasound, obstetric and gynaecological 55707
Ultrasound, obstetric and gynaecological 55706
Ultrasound, obstetric and gynaecological 55705
Ultrasound, obstetric and gynaecological 55704
Ultrasound, obstetric and gynaecological 55703
Ultrasound, obstetric and gynaecological 55700

Ultrasound, obstetric and gynaecological 55729
Ultrasound, urological
Prostate, bladder base and urethra, ultrasound scan of 55600
Ultrasound, urological 55603
Ultrasound, vascular 55284
Ultrasound, vascular 55282
Ultrasound, vascular 55280
Ultrasound, vascular 55278
Ultrasound, vascular 55276
Ultrasound, vascular 55274
Ultrasound, vascular 55252
Ultrasound, vascular 55248
Ultrasound, vascular 55246
Ultrasound, vascular 55244
Ultrasound, vascular 55238
Ultrasound, vascular 55292
Ultrasound, vascular 55296
Ultrasound, vascular 55294
Upper forearm & elbow, leg and knee, X-ray of 57524
Upper forearm & elbow, leg and knee, X-ray of 57527
Upper forearm & elbow, X-ray 57512
Upper forearm & elbow, X-ray 57515
Urethrography, retrograde 58718
Urinary tract, X-ray of 58721
Urinary tract, X-ray of 58715
Urinary tract, X-ray of 58718
Urinary tract, X-ray of 58700
Urinary tract, X-ray of 58706

V

Vasoepididymography 59736
Venography, selective 60075
Venography, selective 60078
Venography, selective 60072,60073,60076
60079

W

Wrist/hand/forearm/elbow/humerus X-ray of 57506
Wrist/hand/forearm/elbow/humerus X-ray of 57515
Wrist/hand/forearm/elbow/humerus X-ray of 57512
Wrist/hand/forearm/elbow/humerus X-ray of 57509

X

X-ray, alimentary tract and biliary system 58927
X-ray, alimentary tract and biliary system 58933
X-ray, alimentary tract and biliary system 58936
X-ray, alimentary tract and biliary system 58939
X-ray, alimentary tract and biliary system 58900
X-ray, alimentary tract and biliary system 58903
X-ray, alimentary tract and biliary system 58909
X-ray, alimentary tract and biliary system 58912
X-ray, alimentary tract and biliary system 58915
X-ray, alimentary tract and biliary system 58916
X-ray, alimentary tract and biliary system 58921
X-ray, alimentary tract and biliary system 58924
X-ray, bone age study and skeletal surveys 58306
X-ray, bone age study and skeletal surveys 58300
X-ray, breasts 59303
X-ray, breasts 59300
X-ray, breasts - mammary ductogram 59306
X-ray, breasts - mammary ductogram 59309
X-ray, breasts, in conjunction with a surgical procedure 59312
X-ray, breasts, in conjunction with a surgical procedure 59314
X-ray, extremeties 57515
X-ray, extremeties 57509
X-ray, extremeties 57512
X-ray, extremeties 57527
X-ray, extremeties 57518
X-ray, extremeties 57521
X-ray, extremeties 57524
X-ray, extremities 57506
X-ray, head 57901
X-ray, head 57969
X-ray, head 57903
X-ray, head 57906
X-ray, head 57909
X-ray, head 57912
X-ray, head 57915
X-ray, head 57918
X-ray, head 57921
X-ray, head 57924
X-ray, head 57927
X-ray, head 57930
X-ray, head 57933
X-ray, head 57939
X-ray, head 57942
X-ray, head 57945
X-ray, head 57960
X-ray, head 57963
X-ray, head 57966
X-ray, head 57902
X-ray, image intensification 60500
X-ray, image intensification 60503
X-ray, in connection with pregnancy 59503
X-ray, of excised breast tissue 59318
X-ray, shoulder or pelvis 57700
X-ray, shoulder or pelvis 57703
X-ray, shoulder or pelvis 57706
X-ray, shoulder or pelvis 57709
X-ray, shoulder or pelvis 57712
X-ray, shoulder or pelvis 57715
X-ray, shoulder or pelvis 57721
X-ray, spine 58100
X-ray, spine 58103
X-ray, spine 58106
X-ray, spine 58108
X-ray, spine 58109
X-ray, spine 58112
X-ray, spine 58115
X-ray, thoracic region 58500
X-ray, thoracic region 58503
X-ray, thoracic region 58506
X-ray, thoracic region 58509
X-ray, thoracic region 58521
X-ray, thoracic region 58721
X-ray, thoracic region 58527
X-ray, thoracic region 58706
X-ray, thoracic region 58715
X-ray, thoracic region 58718
X-ray, thoracic region 58524
X-ray, Urinary tract 58700
X-ray, with opaque or contrast media 59700
X-ray, with opaque or contrast media 59703
X-ray, with opaque or contrast media 59712
X-ray, with opaque or contrast media 59715
X-ray, with opaque or contrast media 59718
X-ray, with opaque or contrast media 59724
X-ray, with opaque or contrast media 59763
X-ray, with opaque or contrast media 59736
X-ray, with opaque or contrast media 59739
X-ray, with opaque or contrast media 59751
X-ray, with opaque or contrast media 59754
X-ray, with opaque or contrast media 59760
X-ray, with opaque or contrast media 59733

PATHOLOGY SERVICES

CATEGORY 6

SUMMARY OF CHANGES FROM 1/1/2016

The 1/1/2016 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

New items

73342

P.1.1. PATHOLOGY SERVICES IN RELATION TO MEDICARE BENEFITS - OUTLINE OF ARRANGEMENTS

Basic Requirements

Determination of Necessity of Service
The treating practitioner must determine that the pathology service is necessary.

Request for Service
The service may only be provided:
(i) in response to a request from the treating practitioner, including a participating midwife or a participating nurse practitioner, or from another Approved Pathology Practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days); or
(ii) if determined to be necessary by an Approved Pathology Practitioner who is treating the patient.

Services requested by participating midwives and participating nurse practitioners:
(i) A participating midwife can request the following services:
Items 65060, 65070, 65090 to 65099 (inclusive), 65114, 66500 to 66512 (inclusive), 66545, 66548, 66566, 66743, 66750, 66751, 69303 to 69317 (inclusive), 69324, 69384 to 69415 (inclusive), 73053 and 73529.

(ii) A participating nurse practitioner can request items in the range 65060 to 73529 (inclusive).

Provision of Service
The following conditions relate to provision of services:
(i) the service has to be provided by or on behalf of an Approved Pathology Practitioner;
(ii) the service has to be provided in a pathology laboratory accredited for that kind of service;
(iii) the proprietor of the laboratory where the service is performed must be an Approved Pathology Authority;
(iv) the Approved Pathology Practitioner providing the service must either be the proprietor of the laboratory or party to an agreement, either by way of contract of employment or otherwise, with the proprietor of the laboratory in which the service is provided; and
(v) no benefit will be payable for services provided by an Approved Pathology Practitioner on behalf of an Approved Pathology Authority if they are not performed in the laboratories of that particular Approved Pathology Authority.

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

P.1.2. EXEMPTIONS TO BASIC REQUIREMENTS

Satisfying requirements described in pathology service

Unless the contrary intention appears, a requirement contained in the description of a pathology service in Part 2 is satisfied if:

(a) for a requirement for information — the information:
  (i) is included in the request for the service; or
  (ii) was supplied in writing on an earlier occasion to the approved pathology authority that rendered the service, and has been kept by the approved pathology authority; or
(b) for a requirement for laboratory test results — the results are:
  (i) included in the request for the service; or
  (ii) obtained from another laboratory test performed in the same patient episode; or
  (iii) included in results from an earlier laboratory test that have been kept by the approved pathology authority.

Services Where Request Not Required

(i) a pathologist determinable service. A pathologist-determinable service is a pathology service:

(a) that is rendered by or on behalf of an approved pathology practitioner for a person who is a patient of that approved pathology practitioner who has determined that the service is necessary; or

(b) that is specified in item 73332, 73336, 73337, or only one immunohistochemistry items 72846, 72847, 72848, 72849 and 72850, or electronmicroscopy items 72851 and 72852 or immunocytochemistry items 73059, 73060 or 73061 and is considered necessary by the approved pathology practitioner as a consequence of information

resulting from a pathology service contained in tissue examination items 72813 – 72838 or cytology items 73045 – 73051 respectively.

Please note: a written request is required for a service contained in items 72813 to 72838 and items 73045 to 73051.

(c) that is specified in one of the antigen detection items 69494, 69495 or 69496 is considered necessary by the approved pathology practitioner as a consequence of information provided by the requesting practitioner or by the nature or appearance of the specimen or as a consequence of information resulting from a pathology service contained in items 69303, 69306, 69312, 69318, 69321 and 69345.

Please note: a written request is required for a service contained in items 69303, 69306, 69312, 69318, 69321 and 69345.

(d) that is specified in item 73320, HLA-B27 typing by nucleic acid amplification, and is considered necessary by the approved pathology practitioner because the results of HLA-B27 typing described in item 71147 are unsatisfactory.

(e) that is specified in item 73305, detection of mutation of the FMRI gene by Southern Blot analysis where the results in item 73300 are inconclusive.

P.1.3. CIRCUMSTANCES WHERE MEDICARE BENEFITS NOT ATTRACTED

Services Rendered by Disqualified Practitioner

Medicare benefits are not payable for pathology services if at the time the service is rendered, the person, by or on whose behalf the service is rendered, is a person in relation to whom a determination is in force in relation to that class of services. That is, where an Approved Pathology Practitioner has breached an undertaking, and a determination has been made that Medicare benefits should not be paid during a specified period (of up to five years) in respect of specified pathology services rendered by the practitioner.

Note: An Approved Pathology Practitioner may be disqualified for reasons other than a breach of undertaking.

Certain Pathology Tests Do Not Attract Medicare Benefits

Certain tests of public health significance do not qualify for payment of Medicare benefits. Examples of services in this category are:

- examination by animal inoculation;
- Guthrie test for phenylketonuria;
- neonatal screening for hypothyroidism (T4/TSH estimation);
- neonatal screening for Cystic Fibrosis;
- neonatal screening for Galactosemia;
- pathology services used with the intention of monitoring the performance enhancing effects of any substance;
- pathology tests carried out on specimens collected from persons occupationally exposed to sexual transmission of disease where the purpose of the collection of specimens is for testing in accordance with conditions determined by the health authority of the State or Territory in which the service is performed.

In addition to the above, certain other tests do not qualify for payment of Medicare benefits. These include:

- cytotoxic food testing;
- pathology services performed for the purposes of control estimation, repeat tests (eg. for confirmation of earlier tests on the same specimen, etc);
- preparation of autogenous vaccines;
- tissue banking and preparation procedures;
- pathology services performed on stillborn babies or cadavers;
- pathology services which are performed routinely in association with the termination of pregnancy without there being any indication for the necessity of the services.

However, benefits will be paid for the following pathology tests:

- item 65060 - haemoglobin estimation;
- item 65090 - blood grouping ABO and Rh (D antigen);
- item 65096 - examination of serum for Rh and other blood group antibodies.

P.2.1. RESPONSIBILITIES OF TREATING/REQUESTING PRACTITIONERS

Form of Request

A treating practitioner may request a pathology service either orally or in writing but oral requests must be confirmed in writing within fourteen days from the day when the oral request was made.

Pathology request forms and combined pathology request/offer to assign forms which are prepared by the pathologists and distributed to requesting practitioners on or after 1 August 2012 must include the minimum information detailed under P.2.2.

All written requests for pathology services should contain the following particulars:

(i) a description of the individual pathology services, or recognised groups of pathology tests to be rendered (see P.17.4 and the Index for acceptable terms and abbreviations). The description must be sufficient to enable the item in which the service is specified to be identified;

(ii) the date of request;

(iii) the surname, initials of given names, practice address and provider number of the requesting practitioner;

(iv) the patient's name and address;

(v) details of the hospital status of the patient, as follows (for benefit rate assessment). That is, whether the patient was or will be, at the time of the service and when the specimen is obtained:

(a) a private patient in a private hospital, or approved day hospital facility;

(b) a private patient in a recognised hospital;

(c) a public patient in a recognised hospital;

(d) an outpatient of a recognised hospital;

Offence Not to Confirm an Oral Request

A requesting practitioner who, without reasonable excuse, does not confirm in writing an oral request within fourteen days of making the oral request is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding $1,100 (10 Penalty Units in accordance with the Crimes Act 1914), and the request is deemed never to have been made.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline to substantiate that a valid request existed (pathology or diagnostic imaging) which is located on the DHS website.

P.2.2. RESPONSIBILITIES OF APPROVED PATHOLOGY PRACTIONERS

Form of Request

There is no official "request in writing" form, and the requesting practitioner's own stationery, or pre-printed forms supplied by Approved Pathology Practitioners/Authorities are acceptable.

For the purposes of Medicare eligible services, the minimum information requirements for a pre –printed pathology request and combined pathology request/offer to assign are detailed within the: *Health Insurance Act 1973*; *Health Insurance Regulations 1975*; *Health Insurance (Pathology Services) Regulations 1989*; and the *Privacy Act 1988*.

The following table presents the minimum details that pre-printed pathology request forms and combined pathology request/offer to assign forms must contain for the purposes of a subsequent Medicare claim:

Requesting Practitioner
a) surname and initials
b) address
c) provider number
d) date of request

Patient Details
a) name – surname, first name
b) address
c) date of birth
d) sex

e) Medicare card number
f) hospital status Two acceptable versions are as follows: State the patient's status at the time of the service or when the specimen was collected: OR cross out the statements that do not apply Was or will the patient be, at the time of the service or when the specimen is obtained: (a) a private patient in a private hospital or approved day hospital facility (b) a private patient in a recognised hospital (c) a public patient in a recognised hospital (d) an outpatient of a recognised hospital

Tests Requested
a) an area titled "Tests Requested"

Self Determined (SD)
A tick box is required for SD. This is used when the APP determines that pathologist-determinable tests are necessary. This tick box can be put in the Clinical Notes area.

Mandatory patient advisory statement
One of the following statements: 'Your doctor has recommended that you use (insert name of pathology provider). You are free to choose your own pathology provider. However, if your doctor has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor.' 'Your treating practitioner has recommended that you use (insert name of pathology provider). You are free to choose your own pathology provider. However, if your treating practitioner has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your treating practitioner.'

Privacy Note
The wording of the note must be: "Privacy Note: The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of government health programs, and may be used to update enrolment records. Its collection is authorised by the provisions of the *Health Insurance Act 1973*. The information may be disclosed to the Department of Health or to a person in the medical practice associated with this claim, or as authorised/required by law." The placement of the note is only necessary on the patient's copy and could be incorporated into the clinical notes area. Alternatively, the back of the patient copy could be used if that is more practicable.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline to substantiate that a valid request existed (pathology or diagnostic imaging) which is located on the DHS website.

Combined Request/Assignment form only
Offer to Assign and Reference to Section 20A
An example of a Section 20A Offer to Assign is as follows: "Medicare Agreement (Section 20A of the Health Insurance Act 1973) I offer to assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner. Patient signature _____ Date / / /"
Practitioners Use Only
A text box is also required for 'Practitioner's Use Only' this section is used where the patient is unable to sign and an appropriate person endorses on behalf of patient, eg. Practitioner's Use Only _____ (Reason patient cannot sign)

An Approved Pathology Practitioner or Approved Pathology Authority who, without reasonable excuse, provides to practitioners (directly or indirectly) combined request/assignment forms which are not in accordance with the legislation is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding $1,100 (10 Penalty Units in accordance with the Crimes Act 1914).

Patient Copy

Assignment of benefits requires the patient to receive a copy of the request. The doctor must cause the particulars relating to the professional service (tests requested) to be set out on the assignment form, before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it.

Authority to lodge a Patient Claim electronically

Where an Approved Pathology Practitioner or Approved Pathology Authority renders a service and the patient has not assigned the benefit the Approved Pathology Practitioner or Approved Pathology Authority can lodge a claim electronically to the Department of Human Services on behalf of the patient where consent is provided. This consent can be provided verbally.

Combined Online Patient Claiming Authority

Authority for APP/APA to submit an electronic patient claim on behalf of the claimant

An example of wording that could be used is:

'I authorise the approved pathology practitioner who will render the requested pathology services, and any further pathology services which the practitioner determines to be necessary, to submit my unpaid account to Medicare, so that Medicare can assess my claim and issue me a cheque made payable to the practitioner, for the Medicare benefit.'

Patient Signature_____ Date_____/_____/_____

_____

Verbal consent was provided by patient to submit unpaid account to Medicare. No signature available.

Request to Approved Pathology Authority

It is acceptable for a request to be made to an Approved Pathology Authority who is the proprietor or one of the proprietors of a laboratory instead of making the request to the Approved Pathology Practitioner who renders the service or on whose behalf the service is rendered.

Holding, Retention, Recording and Production of Request Forms

Approved Pathology Practitioners must hold a request in writing for all services requested by any other practitioner before billing patients. An Approved Pathology Practitioner is required to retain written requests/confirmation of requests for pathology services for 18 months from the day when the service was rendered. This also applies to requests which an Approved Pathology Practitioner receives of which only some tests are referred to another Approved Pathology Practitioner (the first Approved Pathology Practitioner would retain the request for 18 months). If all tests were referred, the second pathologist would retain the original request.

If the written request or written confirmation has been recorded on film or other magnetic medium approved by the Minister for Health and Ageing, for the purposes of storage and subsequent retrieval, the record so made shall be deemed to be a retention of the request or confirmation. The production or reproduction of such a record shall be deemed to be a production of the written request or written confirmation.

An Approved Pathology Practitioner or an Approved Pathology Authority is required to produce, on request from the Department of Human Services CEO, no later than the end of the day following the request from the CEO, a written request or written confirmation retained pursuant to the above paragraphs. An employee of the Department of Human Services is authorised to make and retain copies of or take and retain extracts from written requests or written confirmations.

Offences in Relation to Retaining and Producing Request Forms

The following offences are punishable upon conviction by a fine not exceeding $1000:

(i) an Approved Pathology Practitioner who, without reasonable excuse, does not keep request forms for 18 months;

(ii) an Approved Pathology Practitioner who, without reasonable excuse, does not produce a request form to an employee of the Department of Human Services before the end of the day following the day of the Department of Human Services CEO's request.

Referral From An Approved Pathology Practitioner To Another Approved Pathology Practitioner

Where an Approved Pathology Practitioner refers some or all services requested to another Approved Pathology Practitioner not associated with the same Approved Pathology Authority the following apply:

(i) where all the services are referred, the first Approved Pathology Practitioner should forward the original request to the second Approved Pathology Practitioner, and the document bearing the patient's assignment voucher so that the second Approved Pathology Authority can direct-bill Medicare;

(ii) where some of the services which are listed in different items in the Schedule are referred, the first Approved Pathology Practitioner must issue his/her own request in writing listing the tests to be performed, and when necessary, forward a photocopy of the patient's assignment voucher so that the second Approved Pathology Authority can direct-bill Medicare;

in addition to the details of the first Approved Pathology Practitioner, the second Approved Pathology Practitioner must show on the account/receipt/assignment form:

(a) name and provider number of the original requesting practitioner; and

(b) date of original request;

(iii) under the item coning rules (which limit benefits for multiple services) only one Medicare benefit is payable for services included in coned items except for estimations covered by Rule 6 entitled "designated pathology services". The exemption allows payment of more than one Medicare benefit where various components of the one item number from the same request e.g. drug assays (items 66800 and 66812) are performed by two Approved Pathology Authorities.

Although the provisions concerning designated pathology services in Rule 6 permit similar services (e.g. hormone estimations) to be performed by 2 or more laboratories, with different Approved Pathology Authorities, the sum of the Medicare benefit payable for services provided by the laboratories concerned will not exceed the maximum amount payable under the item coning rules when a single laboratory performs all the estimations.

Notes:
(i) the patient should be billed by each Approved Pathology Practitioner only for those services rendered by or on his/her behalf;
(ii) photocopies of requests are not acceptable;
(iii) in the case of "designated pathology services" 65150, 65175, 66650, 66695, 66711, 66722, 66785, 66800,66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165 a patient episode initiation fee (PEI) is payable for the services provided by the laboratory which receives the original request and performs one or more of the estimations. However, no PEI is payable for services provided by the other laboratory which performs the remainder of the estimations. A "specimen referred fee" is payable instead. One Approved Pathology Practitioner cannot claim both a PEI and a "specimen referred fee" in relation to the same patient episode.

Offence Not To Confirm An Oral Request
An Approved Pathology Practitioner who, without reasonable excuse, does not confirm in writing an oral request to another Approved Pathology Practitioner within fourteen days of making the oral request is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding $1000, and the request is deemed never to have been made.

P.2.3. PATHOLOGY TESTS NOT COVERED BY REQUEST

An Approved Pathology Practitioner, who has been requested to perform one or more pathology services, may consider it necessary, in the interest of the patient, that additional tests to those requested be carried out. The Approved Pathology Practitioner must discuss this need with the requesting practitioner, and if the requesting practitioner determines that additional tests are necessary, the Approved Pathology Practitioner must arrange with the requesting practitioner to forward an amended or second request for those services. The account will then be issued in the ordinary way and the additional services will attract benefits providing the Approved Pathology Practitioner is a recognised specialist pathologist.

P.3.1. DETAILS REQUIRED ON ACCOUNTS, RECEIPTS OR ASSIGNMENT FORMS

General
Medicare benefit is not payable in respect of a pathology service unless specified details are provided, by the practitioner rendering the service, on his or her account, receipt or assignment form.

P.3.2. APPROVED PATHOLOGY PRACTITIONERS

In addition to holding a request in writing from the treating medical or dental practitioner or from another Approved Pathology Practitioner, the following additional details must be recorded on the account, receipt or assignment form of the Approved Pathology Practitioner providing the service:

(i) the surname and initials of the Approved Pathology Practitioner who performed the service and either his/her practice address or the provider number for the address;
(ii) the name of the person to whom the service was rendered;
(iii) the date on which the service was rendered;
(iv) the name of the requesting practitioner; or in the case of a referred test, the name of the original requesting practitioner;
(v) the date on which the request was made; or in the case of a referred test, the date on which the original request was made;
(vi) the requesting practitioner's provider number;
(vii) a description of the pathology service in words which are derived from the item description in the Schedule and are of sufficient detail to identify the specific test in the Schedule that was rendered. Instead of such a full description, the abbreviations contained in the index and the group abbreviations listed at PQ.4 are acceptable alternatives (see PQ.1);
(viii) where the Approved Pathology Practitioner determines or provides a pathology service on his/her own patient, the account must be endorsed "sd"; and

(ix) provide collection centre identification number if the specimen was collected in a licensed collection centre (or approved pathology collection centre).

Where some services are referred from one Approved Pathology Practitioner to another Approved Pathology Practitioner, the request details to be shown on the second Approved Pathology Practitioner's account, receipt or assignment form must be identical to those of the original requesting practitioner including the date of request.

P.3.3. PRESCRIBED PATHOLOGY SERVICES

For Prescribed Pathology Services (that is, pathology items in Group P9) the medical practitioner who renders the service must ensure his or her account, receipt or assignment form includes his or her name, address or provider number, the date of the service, and a description to clearly identify the service in the Schedule that was rendered.

If the service was determined necessary by another medical practitioner who is a member of the same group practice as the practitioner who rendered the service, the name of the requesting practitioner, sufficient to identify the practitioner from other practitioners in the same group practice with the same surname, must also be included together with the date on which the request was made.

P.4.1. INBUILT MULTIPLE SERVICES RULE

The term "Multiple Services Rule" (Rule 3 of the Pathology Services Table) describes an arrangement which places limits on the benefits payable for items in the Pathology Services Table depending on the range of services performed during a single patient episode. A patient episode is defined in PO.4 of these notes.

P.4.2. EXEMPTIONS

Under Rule 4 of the Pathology Services Table, exemptions to the multiple services rule have been granted for certain specified tests. In some circumstances tests which are repeated up to 6 times over a 24 hour period, or tests which are requested up to 6 times on a single request form and are performed within 6 months of the date of request may be eligible for separate Medicare benefits. The services to which the exemptions apply are listed under Rule 4.(1 and 2) and cover seriously or chronically ill patients who require particular tests under specified circumstances. In order to claim the exemptions, accounts should be endorsed "Rule 3 Exemption".

Where a practitioner seeks an exemption to the multiple services rule for a patient whose condition requires a series of pathology investigations at various times throughout any one day or over a longer period of time, and the services required are not exempted under Rule 4, an application for exemption can be made which is endorsed "S4B(3)". Some factors that the delegate of the Minister may take into consideration in approving an exemption are: the patient is seriously ill; there are distinct and separate collections and performances of tests; and the services involve substantial additional expenses for the Approved Pathology Practitioner. These, and other clinical details, should be supplied by the practitioner when seeking an S4B(3) exemption.

If Rule 3 exemptions are endorsed "S4B(3)", claim assessment could take longer as all S4B(3) claims are passed to the delegate for assessment. S4B(3) covers all exemptions to the multiple services rule but, where applicable, specific "Rule 3 exemption" endorsements will speed up the payment of claims. Rule 3 and S4B(3) exemptions cannot be used to overcome time based restrictions within items e.g. "…. each test to a maximum of 4 tests in a 12 month period".

P.5.1. EPISODE CONE

Description of Rule 18

The term "Episode Cone" describes an arrangement under which Medicare benefits payable in a patient episode for a set of pathology services, containing more than three items, ordered by a general practitioner for a non-hospitalised patient, will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. Further information on the episode coning arrangements is provided in PO.5 of these notes.

P.5.2. EXEMPTIONS

Some items are not included in the count of the items performed when applying episode coning. The items which have been exempted from the cone include all the items identified in Rule 18.(1)(d) and (e).

P.6.1. BULK BILLING INCENTIVES FOR EPISODES CONSISTING OF A P10 SERVICE

The Fees for items in Group P13 are additional payments for bulk billing a patient episode consisting of a pathology service to which a Group P10 item (Pathology Episode Initiation fee) applies.

P.6.2. PATIENT EPISODE INITIATION FEES (PEIs)

Items in Groups P10 of the Pathology Services Table are only applicable to services performed:
(i) by or on behalf of an Approved Pathology Practitioner who is a recognised specialist pathologist; and
(ii) in private practice.

Accordingly, these fees are not payable for pathology services rendered by an Approved Pathology Practitioner, being a specialist pathologist when requested for a privately referred out-patient of a recognised hospital.

The patient episode initiation fees (PEIs) will be applicable on an episodic basis i.e. a claim may be made for the provision of pathology services requested by a practitioner in respect of one individual on the same day. For example, if a practitioner orders three pathology tests for a person on the one day, Medicare benefits will be payable for each of those tests but only one PEI will be applicable.

This Rule applies even when the treating practitioner has requested pathology tests from two or more Approved Pathology Practitioners. Thus a PEI will only be paid for the first account submitted unless an exemption listed in Rule 4 or 14.(7) applies or an exemption has been granted under "S4B(3)".

Under Rule 14.(7) two PEIs are payable in relation to the same patient episode where a referring practitioner refers two different specimens to two different Approved Pathology Authorities in the following circumstances:
- a tissue pathology specimen and any other non-tissue pathology specimen; or
- a cytopathology specimen and any other non-cytopathology specimen.

Rule 14.(8) also provides that only one PEI will be paid for the collection of specimens from a patient on one day in or by a single Approved Pathology Authority.

The patient episode initiation benefits are two-tiered. Higher benefits are paid for the collection of specimens from patients who are not private inpatients or private outpatients of a recognised hospital where the specimens are tested in a private laboratory.

A lower and uniform PEI benefit is paid where patients are private patients associated with a recognised hospital and the specimens are tested in a private laboratory or where the testing is performed by a prescribed laboratory on specimen collected from a patient eligible to claim Medicare benefits.

P.6.3. PATIENT EPISODE INITIATION FEES FOR CERTAIN TISSUE PATHOLOGY AND CYTOLOGY ITEMS

Tissue Pathology items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830 and 72836 and Cytology items 73053, 73055 and 73057 will be subject to a different patient episode initiation fee structure - items 73922 to 73939 refer.

P.6.4. HOSPITAL, GOVERNMENT ETC LABORATORIES

The following laboratories have been prescribed for the purposes of payment of Medicare benefits as outlined in paragraphs PF.2 and PF.3:
(i) laboratories operated by the Australian Government (these include health laboratories operated by the Australian Government Department of Health as well as the laboratories operated by other Departments, e.g. the Departments of Defence and Veterans' Affairs operate laboratories from which pathology services are provided);
(ii) laboratories operated by a State Government or authority of a State (laboratories operated or associated with recognised hospitals are also included);
(iii) laboratories operated by the Northern Territory and the Australian Capital Territory; and
(iv) laboratories operated by Australian tertiary education institutions eg Universities.

P.7.1. ASSIGNMENT OF MEDICARE BENEFITS - PATIENT ASSIGNMENT

In addition to the general arrangements relating to the assignment of benefits, as outlined at paragraph 7 of the "General Explanatory Notes" in Section 1 of this book, it should be noted that, where the treating practitioner requests pathology services but the patient does not physically attend the Approved Pathology Practitioner, the patient may complete an assignment voucher at the time of the visit to the requesting doctor offering to assign benefits for the Approved Pathology Practitioner's services.

If an Approved Pathology Practitioner refers some of the tests requested by the treating practitioner to another Approved Pathology Authority, he/she should provide the second Approved Pathology Authority with a photocopy of the patient's assignment voucher so that the second Approved Pathology Authority can also direct-bill Medicare.

P.7.2. APPROVED PATHOLOGY PRACTITIONER ELIGIBILITY

If a practitioner requests an Approved Pathology Practitioner to perform a necessary pathology service, that Approved Pathology Practitioner must personally perform the service or have it performed on his/her behalf in order to be eligible to receive benefits by way of assignment. If, however, the first Approved Pathology Practitioner arranges for the service to be rendered by a second Approved Pathology Practitioner with the same Approved Pathology Authority, the second Approved Pathology Practitioner and not the first, is eligible to receive an assignment of the Medicare benefit for the service in question.

P.8.1. ACCREDITED PATHOLOGY LABORATORIES - NEED FOR ACCREDITATION

A pathology service will not attract Medicare benefits unless that service is provided in a pathology laboratory which is accredited for that kind of service. Details of the administration of the pathology laboratory accreditation arrangements are set out below.

P.8.2. APPLYING FOR ACCREDITATION

To become an Accredited Pathology Laboratory it is necessary to lodge a completed application form with the Manager, Pathology Section, the Department of Human Services, PO Box 1001, TUGGERANONG ACT 2901. The prescribed fees for Approved Pathology Laboratories are:

- $2500 for Category GX labs
- $2000 for Category GY labs
- $1500 for Category B labs
- $ 750 for Category M & S labs.

It is necessary for an application for inspection be made to the National Association of Testing Authorities (NATA) NATA is the independent body chosen to act on the Australian Government's behalf as the primary inspection agency. The Royal Australian College of General Practitioners (RACGP) has also been appointed to inspect laboratories in Category M (general practitioner) in Victoria only.

Details of laboratory categories and associated supervisory requirements can be found on the Department’s internet site (www.health.gov.au/pathology).

P.8.3. EFFECTIVE PERIOD OF ACCREDITATION

Accreditation takes effect from the date of approval by the Minister for Health and Ageing. The Minister has no power to backdate an approval. Transitional accreditation may be given pending full accreditation. An application and fee are required annually.

P.8.4. ASSESSMENT OF APPLICATIONS FOR ACCREDITATION

The principles of accreditation for pathology laboratories as determined by the Minister are used to assess applications for accreditation. These principles also require pathology laboratories to address National Pathology Accreditation Advisory Council standards. Copies of the principles and standards are available from the Secretariat, National Pathology Accreditation Advisory Council (see PH.6) on (02) 6289 4017 or email npaac@health.gov.au .

P.8.5. REFUSAL OF ACCREDITATION AND RIGHT OF REVIEW

An applicant who has been notified of the intention to refuse accreditation may, within 28 days of being notified, provide further information to the Minister which may be taken into consideration prior to a final decision being made.

Applicants refused accreditation or any person affected by the decision have the right to appeal to the Administrative Appeals Tribunal.

P.8.6. NATIONAL PATHOLOGY ACCREDITATION ADVISORY COUNCIL (NPAAC)

NPAAC was established in 1979. Its functions are to develop policy for accreditation of pathology laboratories, introduce and maintain uniform standards of practice in pathology services throughout Australia and initiate and coordinate educational programs in relation to pathology practice. The agencies used to inspect laboratories on the Australian Government's behalf are required to conduct inspections using the standards set down by NPAAC. For further information the NPAAC Secretariat can be contacted on (02) 6289 4017 or email npaac@health.gov.au.

P.8.7. CHANGE OF ADDRESS/LOCATION

Laboratories are accredited for the particular premises given on the application form. Where a laboratory is relocated to other premises, any previously issued approvals for that Accredited Pathology Laboratory lapse. Medicare benefits are not

payable for any pathology services performed at the new location until a new application has been approved by the Minister for Health and Ageing. Paragraph PH.2 sets out the method for applying for accreditation.

P.8.8. CHANGE OF OWNERSHIP OF A LABORATORY

Part of the assessment of an application for an Accredited Pathology Laboratory relates to the Approved Pathology Authority status. Where the ownership, or some other material change occurs affecting the laboratory, the Minister for Health and Ageing must be provided with those changed details. Medicare benefits will not be payable for any pathology services performed on any premises other than those premises for which approval has been given.

P.8.9. APPROVED COLLECTION CENTRES (ACC)

New arrangements for specimen collection centres commenced on 1 December 2001 and replaced the Licensed Collection Centre (LCC) Scheme.

To enable the payment of Medicare benefits for pathology services performed on pathology specimens collected in a collection centre, the centre must first be approved. The exception to this rule is collection centres on the premises of recognised hospitals (recognised hospital in this context means the same as "recognized hospital" in Part 1 Section 3 of the Health Insurance Act 1973) as they do not need approval.

In order for a collection centre to be approved, a public or private Approved Pathology Authority must submit a completed application form to the Department of Human Services including details of the type of application (renewal, new or cancellation of collection centre), the location of the premises, the owner, and any leasing arrangements.

Application forms can be accessed by going to the Department of Human Services website. Completed application forms and any enquiries should be forwarded to Pathology Registration, PO Box 9822 MELBOURNE VIC 3001.

P.9.1. APPROVED PATHOLOGY PRACTITIONERS

Introduction

A pathology service will not attract Medicare benefits unless that service is provided by or on behalf of an Approved Pathology Practitioner. (Approved Pathology Practitioners must be registered medical practitioners.) Set out below is information which relates to Approved Pathology Practitioner requirements.

P.9.2. APPLYING FOR ACCEPTANCE OF THE APPROVED PATHOLOGY PRACTITIONER UNDERTAKING

To apply for acceptance of an Approved Pathology Practitioner Undertaking, it is necessary to send:

(i) a completed application for acceptance of an Approved Pathology Practitioner Undertaking; and

(ii) a signed Approved Pathology Practitioner Undertaking to the Pathology Registration, the Department of Human Services,
PO Box 9822, Melbourne Victoria 3001.

An application form, undertaking and associated literature can be obtained from the Pathology Registration Coordinator.

Payment of Acceptance Fee

On receipt of advice that the Minister has accepted an undertaking, a cheque for $500 should be sent to the Pathology Registration Coordinator. Applicants are required to pay this fee within 14 days of the notice being given. As there is no discretion under the *Health Insurance Act 1973* to accept late payments, failure to pay the fee within the required time means that:

(i) acceptance of the undertaking will be revoked;

(ii) a new application must be completed;

(iii) acceptance of the new undertaking cannot be backdated; and

(iv) there will therefore be a period during which Medicare benefits cannot be paid.

P.9.3. UNDERTAKINGS

Consideration of Undertakings

The Minister is unable to accept an undertaking from a person in respect of whom there is a determination in force that the person has breached the undertaking, or from a person who, if the undertaking were accepted, would be likely to carry on the business of a prescribed person or would enable a person to avoid the financial consequences of the disqualification (or likely disqualification) of that prescribed person. A 'prescribed person' includes, amongst other things, fully or partially disqualified persons (or persons likely to be so disqualified).

Similarly an undertaking cannot be accepted unless the Minister is satisfied that the person giving such undertaking is a fit and proper person to be an Approved Pathology Practitioner.

When an undertaking has been given, the Minister may require the person giving the undertaking to provide additional information within a fixed period of time and if the person does not comply the Minister may refuse to accept the undertaking.

Refusal of Undertaking and Rights of Review
Where the Minister refuses to accept an undertaking, for any of the reasons shown above, the Minister must notify the person of the decision. The notification must include advice of a right of internal review of the decision and a right of further appeal to the Administrative Appeals Tribunal if the internal review upholds the original decision to refuse the undertaking.

Effective Period of Undertaking
The following applies:
(i) Date of Effect the earliest day from which the Minister or delegate can accept an undertaking is the day of the decision in respect of the undertaking. The day the undertaking is signed is to be the day it is actually signed and must not be backdated;
(ii) Period of Effect in determining the period of effect of the undertaking the Minister shall, unless the Minister considers that special circumstances exist, determine that the period of effect shall be twelve months from the day on which the undertaking comes into force. There is a requirement for the Minister to notify persons giving undertakings of the period of time for which the undertaking is to have effect, and the notice is to advise persons whose interests are affected by the decision of their rights of appeal to the Administrative Appeals Tribunal against the Minister's decision;
(iii) Renewals when an undertaking is given and accepted by the Minister while a former undertaking is current, the new undertaking does not take effect until the former undertaking ceases to be in force. When an undertaking is given while a former undertaking is current and the date on which the former undertaking is to expire passes without the Minister giving notice to accept or reject the new undertaking, the former undertaking remains in force until the Minister gives such notification. This provision does not apply when the renewal application is not received by the Department of Human Services until after the expiry of the existing undertaking. Under these circumstances there will be a period during which Medicare benefits cannot be paid unless the new application can be backdated to the expiry of the previous undertaking. This is a limited discretion for periods up to one month and special conditions apply; and
(iv) Cessation of Undertaking the undertaking ceases to be in force if it is terminated, if the Minister revokes acceptance of the undertaking, or if the period of effect for the undertaking expires whichever event first occurs.

An Approved Pathology Practitioner may terminate an undertaking at any time providing that the practitioner gives at least 30 days notice of his/her intention to do so.

P.9.4. OBLIGATIONS AND RESPONSIBILITIES OF APPROVED PATHOLOGY PRACTITIONERS

The requirements of the legislation and the undertaking impose a number of obligations and responsibilities on Approved Pathology Practitioners and the Minister. The more complex of these not already dealt with are considered in PK, PL and PM dealing with Breaches of Undertakings, Excessive Pathology Services and Personal Supervision.

P.10.1. APPROVED PATHOLOGY AUTHORITIES

Introduction
A pathology service will not attract Medicare benefits unless the proprietor of the laboratory in which the pathology service is performed is an Approved Pathology Authority. Following is information which relates to Approved Pathology Authority requirements.

P.10.2. APPLYING FOR ACCEPTANCE OF AN APPROVED PATHOLOGY AUTHORITY UNDERTAKING

To apply for acceptance of an Approved Pathology Authority Undertaking, it is necessary to send:
(i) a completed application for acceptance of an Approved Pathology Authority Undertaking; and
(ii) a signed Approved Pathology Authority Undertaking to the Pathology Registration, the Department of Human Services,
PO Box 9822, Melbourne Victoria 3001.

An application form, undertaking and associated literature can be obtained from the Pathology Registration Coordinator.

Payment of Acceptance Fee

On receipt of advice that the Minister has accepted an undertaking, a cheque for $1,500 should be sent to the Pathology Registration Coordinator. Applicants are required to pay this fee within 14 days of the notice being given. As there is no

discretion under the *Health Insurance Act 1973* to accept late payments, failure to pay the fee within the required time means that:

(i) acceptance of the undertaking will be revoked;
(ii) a new application must be completed;
(iii) acceptance of the new undertaking cannot be backdated; and
(iv) there will therefore be a period during which Medicare benefits cannot be paid.

P.10.3. UNDERTAKINGS

Consideration of Undertakings

The Minister is unable to accept undertakings from a person in respect of whom there is a determination in force that the person has breached the undertaking, or from a person who, if the undertaking were accepted, would be likely to carry on the business of a prescribed person or would enable a person to avoid the financial consequences of the disqualification (or likely disqualification) of that prescribed person. A 'prescribed person' includes, inter alia, fully or partially disqualified persons (or persons likely to be so disqualified).

Similarly an undertaking cannot be accepted unless the Minister is satisfied that the person giving such undertaking is a fit and proper person to be an Approved Pathology Authority.

When an undertaking has been given the Minister may require the person giving the undertaking to provide additional information within a specified period of time and if the person does not comply the Minister may refuse to accept the undertaking.

Refusal of Undertaking and Rights of Review

Where the Minister refuses to accept an undertaking, the Minister must notify the person of the decision. The notification must include advice of a right of internal review of the decision and a right of further appeal to the Administrative Appeals Tribunal if the internal review upholds the original decision to refuse the undertaking.

Effective Period of Undertaking

The following applies:

(i) Date of Effect the earliest day from which the Minister or delegate can accept an undertaking is the day of the decision in respect of the undertaking. The day the undertaking is signed is to be the day it is actually signed and must not be backdated;

(ii) Period of Effect in determining the period of effect of the undertaking the Minister shall, unless the Minister considers that special circumstances exist, determine that the period of effect shall be twelve months from the day on which the undertaking comes into force. There is a requirement for the Minister to notify persons giving an undertaking of the period of time for which the undertaking is to have effect, and the notice is to advise persons whose interests are affected by the decision of their rights of appeal to the Administrative Appeals Tribunal against the Minister's decision;

(iii) Renewals when an undertaking is given and accepted by the Minister while a former undertaking is current, the new undertaking does not take effect until the former undertaking ceases to be in force. When an undertaking is given while a former undertaking is current and the date on which the former undertaking is to expire passes without the Minister giving notice to accept or reject the new undertaking, the former undertaking remains in force until the Minister gives such notification. This provision does not apply when the renewal application is not received by the Department of Human Services until after the expiry of the existing undertaking. Under these circumstances there will be a period during which Medicare benefits cannot be paid unless the new application can be backdated to the expiry of the previous undertaking. This is a limited discretion for periods up to one month and special conditions apply; and

(iv) Cessation of Undertaking the undertaking ceases to be in force if it is terminated, if the Minister revokes acceptance of the undertaking, or if the period of effect for the undertaking expires whichever event first occurs.

An Approved Pathology Authority may terminate an undertaking at any time providing that at least 30 days notice of the intention to terminate the undertaking is given.

P.10.4. OBLIGATIONS AND RESPONSIBILITIES OF APPROVED PATHOLOGY AUTHORITIES

The requirements of the legislation and the undertaking impose a number of obligations and responsibilities on Approved Pathology Authorities and the Minister. The more complex of these which have not already been covered are considered in paragraphs PK and PL dealing with Breaches of Undertakings and Excessive Pathology Services.

P.11.1. BREACHES OF UNDERTAKINGS

Notice Required

Where the Minister has reasonable grounds for believing that an Approved Pathology Practitioner or an Approved Pathology Authority has breached the undertaking, the Minister is required to give notice in writing to the person explaining the grounds for that belief and inviting the person to put a submission to the Minister to show cause why no further action should be taken in the matter.

P.11.2. DECISIONS BY MINISTER

Where a person provides a submission, the Minister may decide to take no further action against the person. Alternatively the Minister may refer the matter to a Medicare Participation Review Committee, notifying the grounds for believing that the undertaking has been breached. If after 28 days no submission has been received from the person, the Minister must refer that matter to the Committee.

P.11.3. APPEALS

The Minister is empowered to suspend an undertaking where notice has been given to a Medicare Participation Review Committee of its possible breach, pending the outcome of the Committee's proceedings. The Minister must give notice in writing to the person who provided the undertaking of the determination to suspend it, and the notice shall inform the person of a right of appeal against the determination to the Administrative Appeals Tribunal. The Minister may also publish a notice of a determination in the Public Service Gazette. Rights of appeal to the Administrative Appeals Tribunal also exist in respect of any determination made by a Medicare Participation Review Committee.

P.12.1. INITIATION OF EXCESSIVE PATHOLOGY SERVICES

Notice Required

Where the Minister has reasonable grounds for believing that a person, of a specified class of persons, has initiated, or caused or permitted the initiation of excessive pathology services the Minister is required to give notice in writing to the person explaining the grounds for the belief and inviting the person to put a submission to the Minister to show cause why no further action should be taken in the matter.

P.12.2. CLASSES OF PERSONS

The classes of persons are:

(i) the practitioner who initiated the services;

(ii) the employer of the practitioner who caused or permitted the practitioner to initiate the services; or

(iii) an officer of the body corporate employing the practitioner who caused or permitted the practitioner to initiate the services.

P.12.3. DECISIONS BY MINISTER FOR HEALTH AND AGEING

Where a person provides a submission, the Minister may decide to take no further action against the person. Alternatively, the Minister may refer the matter to a Professional Services Review (PSR) Committee, notifying the grounds for believing that excessive pathology services have been initiated. If after 28 days no submission has been received from the person, the Minister must refer the matter to the Committee. The Minister must give to the person notice in writing of the decision.

P.12.4. APPEALS

Unlike the procedures relating to breaches of undertaking there is no power given to the Minister to determine a penalty. The Minister's role is either deciding to take no further action or referring the matter to a PSR Committee. Accordingly, there are no rights of appeal to the Administrative Appeals Tribunal applicable to the above procedures. However, rights of appeal to the Administrative Appeals Tribunal exist in respect of any determination made by a Medicare Participation Review Committee.

P.13.1. PERSONAL SUPERVISION

Introduction

The *Health Insurance Act 1973* provides that the form of undertaking to be given by an Approved Pathology Practitioner may make provision for pathology services carried out under the personal supervision of the Approved Pathology Practitioner.

P.13.2. EXTRACT FROM UNDERTAKING

The following is an extract from the Approved Pathology Practitioner (APP) undertaking:

Part 2 – Personal supervision

2.1 I acknowledge that it is my obligation, subject to Parts 2.2 and 2.4, personally to supervise any person who renders any service on my behalf and I undertake to accept personal responsibility for the rendering of that service under the following conditions of personal supervision:

(i) Subject to the following conditions, I will usually be physically available in the laboratory while services are being provided at the laboratory;
(ii) I may, subject to paragraph (vi) below, be physically absent from the laboratory while services are being rendered outside its normal hours of operation but in that event I will leave with the person rendering the service particulars of the manner in which I may be contacted while the service is being rendered and I must be able to personally attend at the laboratory while the service is being rendered or formally designate another APP present while I am absent;
(iii) I may, subject to paragraph (vi) below, be absent from the laboratory for brief periods due to illness or other personal necessity, or to take part in activities which, in accordance with normal and accepted practice, relate to the provision of services by that laboratory;
(iv) I will personally keep a written log of my absences from the laboratory that extend beyond one workday in respect of that laboratory and will retain that log in the laboratory for 18 months from date of last entry;
(v) If I am to be absent from the laboratory for more than 7 consecutive workdays, I will arrange for another APP to personally supervise the rendering of services in the laboratory. That arrangement shall be recorded in writing and retained in the laboratory for 18 months from date of last entry. Until such person is appointed, and his or her appointment is recorded in writing, I will remain personally responsible to comply with this undertaking;
(vi) If a service is being rendered on my behalf by a person who is not:
(a) a medical practitioner;
(b) a scientist; or
(c) a person having special qualifications or skills relevant to the service being rendered;
and no person in the above groups is physically present in the laboratory, then I must be physically present in the laboratory and closely supervise the rendering of the service;

(vii) I accept responsibility for taking all reasonable steps to ensure that in regard to services rendered by me or on my behalf:
(a) all persons who render services are adequately trained;
(b) all services which are to be rendered in the laboratory are allocated to persons employed by the APA and, these persons shall have appropriate qualifications and experience to render the services;
(c) the methods and procedures in operation in the laboratory for the purpose of rendering services are in accordance with proper and correct practices;
(d) for services rendered, proper quality control methods are established and reviewed to ensure their reliability and effectiveness; and
(e) results of services and tests rendered are accurately recorded and sent to the treating practitioner and, where applicable, a referring practitioner;

(viii) If I perform, or there is performed on my behalf, a service which consists of the analysis of a specimen which I know, or have reason to believe, has been taken other than in accordance with the provisions of section 16A(5AA) of the Act I will endorse, or cause to be endorsed, on the assignment form or the account for that service, as the case may be, particulars of the circumstances in which I believe, or have reason to believe, the specimen was taken.

2.2 Where services are to be rendered on my behalf in a Category B laboratory as defined in the Health Insurance (Accredited Pathology Laboratories – Approval) Principles 2002, I undertake to take all reasonable measures to ensure that the service is rendered under the supervision of an appropriate person as required by those Principles as in force from time to time.
2.3 I acknowledge to the best of my ability that any act or omission by a person, when acting with my authority, whether express or implied, that would, had it been done by me, have resulted in a breach of this undertaking, constitutes a breach of this undertaking by me.
2.4 Parts 2.1(i) to 2.1(vi) and 2.2 of this undertaking do not apply where a laboratory is limited to services (and associated equipment for those services) as detailed in Schedule 3.

P.13.3. NOTES ON THE ABOVE

Part 2 of the APP Undertaking outlines the requirements for the personal supervision by an Approved Pathology Practitioner where a pathology service is rendered by another person on behalf of the APP. It should be noted that "on behalf of" does not relieve an Approved Pathology Practitioner of professional responsibility for the service or from being personally involved in the supervision of services in the laboratory.

P.14.1. CHANGES TO THE PATHOLOGY SERVICES TABLE

Health Insurance Regulations
The *Health Insurance Act 1973* allows the Minister for Health to determine an appropriate Pathology Services Table which is then prescribed by Regulation.

The Minister has established the Pathology Services Table Committee (PSTC) to assist in determining changes to the Table (except new medical services and technologies - see below). Any person or organisation seeking to make a

submission to this Committee can contact the PSTC Secretariat on (02) 6289 4080 or e-mail pstc.secretariat@health.gov.au and/or write to: Secretary, PSTC, MDP 107, Department of Health and Ageing, GPO Box 9848, CANBERRA ACT 2601.

Pathology submissions relating to new medical services and technologies should be forwarded to the Medical Services Advisory Committee (MSAC). MSAC has been established to advise the Minister on the strength of evidence pertaining to new and emerging medical technologies and procedures in relation to their safety, effectiveness and cost effectiveness, and under what circumstances public funding should be supported.

Any person or organisation seeking to make a submission to MSAC can contact the MSAC Secretariat on (02) 6289 6811 or email msac.secretariat@health.gov.au and/or write to: MSAC Secretariat, Australian Government, Department of Health, MDP 106, GPO Box 9848, CANBERRA ACT 2601. The application form and guidelines for applying can also be obtained from MSAC's website – www.msac.gov.au

P.15.1. EXPLANATORY NOTES - DEFINITIONS

Excessive Pathology Service
This means a pathology service for which a Medicare benefit has become or may become payable and which is not reasonably necessary for the adequate medical or dental care of the patient concerned.

P.15.2. GROUP OF PRACTITIONERS

This means:
(i) a practitioner conducting a medical practice or a dental practice, or a participating nurse practitioner practice, or a participating midwife practice together with another practitioner, or other practitioners, participating (whether as employees or otherwise) in the provision of professional services as part of that practice; or
(ii) two or more practitioners conducting a medical practice or a dental practice, or a participating nurse practitioner practice, or a participating midwife practice as partners; or
(iii) those partners together with any other practitioner who participates (whether as an employee or otherwise) in the provision of professional services as part of that practice.

P.15.3. INITIATE

In relation to a pathology service this means to request the provision of pathology services for a patient.

P.15.4. PATIENT EPISODE

A patient episode comprises a pathology service or services specified in one or more items which are provided for a single patient, the need for which was determined under subsection 16A(1) of the Act on the same day, whether they were provided by one or more approved pathology practitioners on one day or over several days and whether they are requested by one or more treating practitioners. Even if a treating practitioner writes separate request forms to cover the collection of specimens at different times, where the decision to collect the multiple specimens was made at the same time, the multiple tests are deemed to belong to the same patient episode. In addition, if more than one request is made, on the same or different days, for tests on the same specimen within 14 days, they are part of the same patient episode.

Rule 4 of the Pathology Services Table provides an exemption to the above and enables services requested on one day which are performed under strictly limited circumstances for seriously or chronically ill patients with certain specified conditions to each be classified as a patient episode. See PD.2 for further information on exemptions.

Rule 14.(8) also provides that only a single patient episode initiation fee will be payable for all the specimens collected on one day from one patient in or by one Approved Pathology Authority.

P.15.5. EPISODE CONE

The episode cone is an arrangement, described in Rule 18, which effectively places an upper limit on the number of items for which Medicare benefits are payable in a patient episode. This cone only applies to services requested by general practitioners for their non-hospitalised patients. Pathology services requested for hospital in-patients, or ordered by specialists, are not subject to these coning arrangements.

When more than 3 items are requested by a general practitioner in a patient episode, the benefits payable will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. Rule 18 provides that for the two items with the highest Schedule fees, Medicare benefits will be payable for each item. The remaining items are regarded as one service for which the benefit payable will be equivalent to that for the item with the third highest Schedule fee. Where items have the same Schedule fee, their item numbers are used as an artificial means to rank them.

The episode cone will apply even when the pathology services in a patient episode are performed by 2 or more Approved Pathology Authorities, with the exception of the services listed below.

The following items are not included in the count of the items performed when applying the episode cone:
(i) all the items in Groups P10, P11, P12 and P13;
(ii) Pap smear testing (items 73053 and 73055);
(iii) all the itemsdetailed at Rule 18 (e) (items 65079, 65082, 65157, 65158, 65166, 65180, 65181, 66606, 66609, 66639, 66642, 66651, 66652, 66663, 66666, 66696, 66697, 66714, 66715, 66723, 66724, 66780, 66783, 66789, 66790, 66792, 66804, 66805, 66816, 66817, 66820, 66821, 66826, 66827, 69325, 69328, 69331, 69379, 69383, 69400, 69401, 69419, 69451, 69500, 69489, 69492, 69497, 69498, 71076, 71090, 71092, 71096, 71148, 71154, 71156, 71169, 71170, 73309, 73312, 73315, 73318);
(iv) supplementary test for Hepatitis B and Hepatitis C (item 69484); and
(v) the carbon-labelled urea breath test to confirm or monitor Helicobacter pylori (item 66900).

P.15.6. PERSONAL SUPERVISION

This means that an Approved Pathology Practitioner will, to the fullest extent possible, be responsible for exercising an acceptable level of control over the rendering of pathology services. See PM.1 to PM.3 for a full description of the responsibilities involved in personal supervision.

P.15.7. PRESCRIBED PATHOLOGY SERVICE

These are simple basic pathology services which are included in Group P9 and may be performed by a medical practitioner in the practitioner's surgery without the need to obtain Approved Pathology Authority, Approved Pathology Practitioner or Accredited Pathology Laboratory status.

P.15.8. PROPRIETOR OF A LABORATORY

This means in relation to a pathology laboratory the person, authority or body of persons having effective control of:
(i) the laboratory premises, whether or not the holder of an estate or interest in the premises;
(ii) the use of equipment used in the laboratory; and
(iii) the employment of staff in the laboratory.

P.15.9. SPECIALIST PATHOLOGIST

This means a medical practitioner recognised for the purposes of the Health Insurance Act 1973 as a specialist in pathology (see 5.1 of the "General Explanatory Notes" in Section 1 of this book). The principal specialty of pathology includes a number of sectional specialties. Accordingly, a medical practitioner who is recognised as a specialist in a sectional specialty of pathology is recognised as a specialist pathologist for this purpose.

P.15.10. DESIGNATED PATHOLOGY SERVICE

This means a pathology service specified in items 65150, 65175 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165. Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some but not all the estimations in a coned item and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the rest, the service provided by the second practitioner is deemed to be the "designated pathology service". Thus the first practitioner claims under the appropriate item for the services which he/she provides while the second practitioner claims one of items 65150, 65175, 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165. Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some, but not all estimations and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the remainder, the first Approved Pathology Practitioner can raise a "patient episode initiation fee". The second Approved Pathology Practitioner who receives the specimen can raise a "specimen referred fee".

P.16.1. INTERPRETATION OF THE SCHEDULE - ITEMS REFERRING TO 'THE DETECTION OF'

Items that contain the term ‘detection of’ should be taken to mean ‘testing for the presence of’.

P.16.2. BLOOD GROUPING - (ITEM 65096)

Where a request includes 'Group and Hold' or 'Group and Save', the appropriate item is 65096.

P.16.3. GLYCOSYLATED HAEMOGLOBIN - (ITEM 66551)

The requirement of "established diabetes" in this item may be satisfied by:

(a) a statement of the diagnosis by the ordering practitioner on the current request form or on a previous request form held in the database of the Approved Pathology Authority; or
(b) two or more blood glucose levels that are in the diabetic range and is contained in the database of the Approved Pathology Authority; or
(c) an oral glucose tolerance test result that is in the diabetic range and is contained in the database of the Approved Pathology Authority.

P.16.4. IRON STUDIES - (ITEM 66596)

Where a request includes 'Iron Studies', 'IS', 'Fe', '% saturation' or 'Iron', the relevant item is 66596.

P.16.5. FAECAL OCCULT BLOOD - (ITEMS 66764 TO 66770)

P.16.6. ANTIBIOTICS/ANTIMICROBIAL CHEMOTHERAPEUTIC AGENTS

A test for the quantitation of antibiotics/antimicrobial chemotherapeutic agents is claimable under item 66800 or 66812 - 'quantitation of a drug being used therapeutically'.

P.16.7. HUMAN IMMUNODEFICIENCY VIRUS (HIV) DIAGNOSTIC TESTS - (IINCLUDED IN ITEMS 69384, 69387, 69390, 69393, 69396, 69405, 69408, 69411, 69413 AND 69415)

Prior to ordering an HIV diagnostics tests (included in items 69384, 69387, 69390, 69393, 69396, 69405, 69408, 69411, 69413, 69415) the ordering practitioner should ensure that the patient has given informed consent. Appropriate discussion should be provided to the patient. Further discussion may be necessary upon receipt of the test results.

P.16.8. HEPATITIS - (ITEM 69481)

Benefits for item 69481 are payable only if the request from the ordering practitioner indicates in writing that the patient is suspected of suffering from acute or chronic hepatitis; either by the use of the provisional diagnosis of hepatitis or by relevant clinical or laboratory information eg "hepatomegaly", "jaundice" or "abnormal liver function tests".

P.16.9. EOSINOPHIL CATIONIC PROTEIN - (ITEM 71095)

Item 71095 applies to children aged less than 12 years who cannot be reliably monitored by spirometry or flowmeter readings.

P.16.10. TISSUE PATHOLOGY AND CYTOLOGY - (ITEMS 72813 TO 73061)

When services described in Group P5 need to be performed upon material which is submitted for cytology items listed in Group P6 only the fee for the P6 item can be claimed.

P.16.11. CERVICAL AND VAGINAL CYTOLOGY - (ITEMS 73053 TO 73057)

Item 73053 applies to the cytological examination of cervical smears collected from women with no symptoms, signs or recent history suggestive of cervical neoplasia as part of routine, biennial examination for the detection of pre-cancerous or cancerous changes. This item also applies to smears repeated due to an unsatisfactory routine smear, or if there is inadequate information provided to use item 73055.

Cytological examinations carried out under item 73053 should be in accordance with the agreed National Policy on Screening for the Prevention of Cervical Cancer. This policy provides for:
(i) an examination interval of two years for women who have no symptoms or history suggestive of abnormal cervical cytology, commencing between the ages of 18 to 20 years, or one to two years after first sexual intercourse, whichever is later; and
(ii) cessation of cervical smears at 70 years for women who have had two normal results within the last five years. Women over 70 who have never been examined, or who request a cervical smear, should be examined.

This policy has been endorsed by the Royal Australian College of General Practitioners, the Royal Australian College of Obstetricians and Gynaecologists, The Royal College of Pathologists of Australasia, the Australian Cancer Society and the National Health and Medical Research Council.

The *Health Insurance Act 1973* excludes payment of Medicare benefits for health screening services except where Ministerial directions have been issued to enable benefits to be paid, such as the Papanicolaou test. As there is now an established policy which has the support of the relevant professional bodies, routine screening in accordance with the policy will be regarded as good medical practice.

The screening policy will not be used as a basis for determining eligibility for benefits. However, the policy will be used as a guide for reviewing practitioner profiles.

Item 73055 applies to cervical cytological examinations where the smear has been collected for the purpose of management, follow up or investigation of a previous abnormal cytology report, or collected from women with symptoms, signs or recent history suggestive of abnormal cervical cytology.

Items 73057 applies to all vaginal cytological examinations, whether for a routine examination or for the follow up or management of a previously detected abnormal smear.

For cervical smears, treating practitioners are asked to clearly identify on the request form to the pathologist, by item number, if the smear has been taken as a routine examination or for the management of a previously detected abnormality.

P.16.12. FRAGILE X (A) TESTS - (ITEMS 73300 AND 73305) AND RET GENETIC TESTS - (ITEMS 73339 AND 73340)

Prior to ordering these tests (73300, 73305, 73339 and 73340) the ordering practitioner should ensure the patient (or an appropriate proxy) has given informed consent. Testing can only be performed after genetic counselling. Appropriate genetic counselling should be provided to the patient either by the specialist treating practitioner, a genetic counselling service or a clinical geneticist on referral. Further counselling may be necessary upon receipt of the test results.

P.16.13. ADDITIONAL BULK BILLING PAYMENT FOR PATHOLOGY SERVICES - (ITEM 74990 AND 74991)

Item 74990 operates in the same way as item 10990 and item 74991 operates in the same way as item 10991, apart from the following differences:

- Item 74990 and 74991 can only be used in conjunction with items in the Pathology Services Table of the MBS;
- Item 74990 and 74991 applies to unreferred pathology services performed by a medical practitioner which are included in Group P9 of the Pathology Services Table, and unreferred pathology services provided by category M laboratories;
- Item 74990 and item 74991 applies to pathology services self determined by general practitioners and specialists with dual qualifications acting in their capacity as general practitioners;
- Specialists and consultant physicians who provide pathology services are not able to claim item 74990 or item 74991 unless, for the purposes of the Health Insurance Act, the medical practitioner is also a general practitioner and the service provided by the medical practitioner has not been referred to that practitioner by another medical practitioner or person with referring rights.

Rules 3 and 18 of the *Health Insurance (Pathology Services Table) Regulations 2003* have been amended to exclude item 74990 and 74991 from the Multiple Services Rule and the Coning Rule.

Item 74991 can only be used where the service is provided at, or from, a practice location in a regional, rural or remote area (RRMA 3 to 7 under the Rural Remote Metropolitan Areas classification system), or in all of Tasmania.

P.16.14. TRANSFER OF EXISTING ITEMS FROM GROUP P1 (HAEMATOLOGY) TO GROUP P7 GENETICS EFFECTIVE 1 MAY 2006.

P16.14 has been created to note the transfer of existing items from Group P1 (Haematology) items 65168, 65174, 65200 and item 66794 from Group P2 (Chemistry) to Group P7 (Genetics) as items 73308, 73311, 73314, 73317 and the introduction of the new item in Group P7 (Genetics) item 73320 HLA-B27 typing by nucleic acid amplification (NAA) which was effective as of 1 May 2006.

P.16.15. RAS GENE MUTATION STATUS (ITEM 73338)

Item 73338 provides for testing of RAS mutations to limit subsidy of anti-EGFR antibodies to only those patients demonstrated to have no RAS mutations.

For a Medicare benefit to be payable, the test must be conducted for all clinically relevant mutations on KRAS exons 2, 3 and 4 and NRAS exons 2, 3 and 4, or until a RAS mutation is found.

Enabling the requirements of the item descriptor to be met once any RAS mutation is found means that once the test indicates that the patient is not RAS wild-type and therefore not suitable for access to cetuximab and panitumumab under the PBS, a pathologist is not required to continue testing for other clinically relevant mutations.

P.17.1. ABBREVIATIONS, GROUPS OF TESTS

As stated at P3.2 of the Outline, details that must be recorded on accounts, receipts or assignment forms of an Approved Pathology Practitioner/Authority include a description of the pathology service that is of sufficient detail to identify the

specific service rendered. The lists of abbreviations for group tests are contained in PQ.4. The lists of abbreviations for individual tests are contained in the Index to this Section. The abbreviations are provided to allow users to identify and refer to particular pathology services, or particular groups of pathology services, more accurately and conveniently.

The above requirements may be used for billing purposes but treating practitioners requesting pathology services are encouraged to use the approved abbreviations. In this regard treating practitioners should note that:

- pathology services cannot be self determined by a rendering pathologist responding to a request. This places the onus for medical necessity on the treating practitioner who, in normal circumstances would, if he or she was unclear in deciding the appropriate test for a clinical situation, consult a pathologist for assistance; and
- Approved Pathology Practitioners/Authorities undertake not to issue accounts etc unless the pathology service was rendered in response to an unambiguous request.

P.17.2. TESTS NOT LISTED

Tests which are not listed in the Pathology Services Table do not attract Medicare benefits. As explained at PN.1 of the Outline, changes to the Pathology Services Table can only be made by the Minister for Health and Ageing.

P.17.3. AUDIT OF CLAIMS

The Department of Human Services is undertaking routine audits of claims for pathology benefits against requested services to ensure compliance with the provisions of the Health Insurance Act 1973.

P.17.4. GROUPS OF TESTS

For the purposes of recording a description of the pathology service on accounts etc, an Approved Pathology Practitioner /Authority may use group abbreviations or group descriptions for the following specified groups of tests. These groups consist of two or more tests within the same item. These groups exclude abbreviations such as MBA and TORCH.

Treating practitioners are encouraged to use these group abbreviations or group descriptions where appropriate.

For ease of identification of group tests, it is recommended that practitioners use the following abbreviations. Tests requested individually may attract Medicare benefits.

Group	Estimations included in Group	Group Abbreviation	Item Numbers
Cardiac enzymes or cardiac markers	Creatine kinase isoemzymes, Myoglobin, Troponin	CE / CM	66518, 66519
Coagulation studies	Full blood count, Prothrombin time, Activated partial thromboplastin time and two or more of the following tests – Fibrinogen, Thrombin, Clotting time, Fibrinogen degradation products, Fibrin monomer, D-dimer factor XIII screening tests	COAG	65129, 65070
Electrolytes	Sodium (NA), Potassium (K), Chloride (CL) and Bicarbonate (HCO3)	E	66509
Full Blood Examination	Erythrocyte count, Haematocrit, Haemoglobin, Platelet count, Red cell count, Leucocyte count, Manual or instrument generated differential, Morphological assessment of blood film where appropriate	FBE, FBC, CBC	65070
Lipid studies	Cholesterol (CHOL) and Triglycerides (TRIG)	FATS	66503
Liver function tests	Alkaline phosphatase (ALP), Alanine aminotransferase (ALT), Aspartate aminotransferase (AST), Albumin (ALB), Bilirubin (BIL), Gamma glutamyl transpeptidase (GGT), Lactate dehydrogenase (LDH), and Protein (PROT)	LFT	66512
Syphilis serology	Rapid plasma regain test (RPR), or Venereal disease research laboratory test (VDRL), and Treponema pallidum haemagglutin test (TPHA), or Fluorescent treponemal antibody-absorption test (FTA)	STS	69387
Urea, Electrolytes,	Urea, Electrolytes, Creatinine	U&E	66512

Group	Estimations included in Group	Group Abbreviation	Item Numbers
Creatinine			

P.18.1. COMPLEXITY LEVELS FOR HISTOPATHOLOGY ITEMS

Only one of these histopathology examination items (72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838) can be claimed in a patient episode.

The remaining items (72844, 72846, 72847, 72848, 72849, 72850, 72851, 72852, 72855, 72856 and 72857) are add-on items, covering enzyme histochemistry and immunohistochemistry, electron microscopy and frozen sections, which can be claimed in addition to the main item.

The list of complexity levels by type of specimen are contained at the back of this Section.

P.19.1. PATHOLOGY SERVICES TABLE

Rules for the Interpretation of the Pathology Services Table

Please note that in the Health Insurance (Pathology Services Table) Regulations 2010 (effective 1 November 2010) rules and sub-rules are referred to as clauses and sub-clauses. In addition in the Regulations a rule that refers to specific items within a pathology group, for example Group P1 Haemotology, is listed directly above the Schedule of Services for that group. A table cross referencing the following rules with the clauses in the Regulations is at the end of this section.

1. (1) In this table

patient episode means:

(a) a pathology service or pathology services (other than a pathology service to which paragraph 1 (1) (b) refers) provided for a single patient whose need for the service or services was determined under section 16A of the Act:

(i) on the same day; or

(ii) if more than 1 test is performed on the 1 specimen within 14 days - on the same or different days;

whether the services:

(iii) are requested by 1 or more practitioners; or

(iv) are described in a single item or in more than 1 item; or

(v) are rendered by 1 approved pathology practitioner or more than 1 approved pathology practitioner; or

(vi) are rendered on the same or different days; or

(b) a pathology service to which rule 4 refers that is provided in the circumstances set out in that rule that relates to the service.

receiving APP means an approved pathology practitioner in an approved pathology authority who performs one or more pathology services in respect of a single patient episode following receipt of a request for those services from a referring APP.

recognised pathologist means a medical practitioner recognised as a specialist in pathology by a determination under section 3D, 3DB or 3E of the Act.

referring APP means an approved pathology practitioner in an approved pathology authority who:

(i) has been requested to render 1 or more pathology services, all of which are requested in a single patient episode; and

(ii) is unable, because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority, to render 1 or more of the pathology services; and

(iii) requests an approved pathology practitioner (the ***receiving APP***) in another approved pathology authority to render the pathology service or services that the referring APP is unable to render; and

(iv) renders each pathology service (if any) included in that patient episode, other than the pathology service or services in respect of which the request mentioned in subparagraph (iii) is made.

serial examinations means a series of examinations requested on 1 occasion whether or not:

(a) the materials are received on different days by the approved pathology practitioner; or

(b) the examinations or cultures were requested on 1 or more request forms by the treating practitioner.

***the* Act** means the *Health Insurance Act 1973*.

1. (2) In these rules, a reference to a request to an approved pathology practitioner includes a reference to a request for a pathologist-determinable service to which subsection 16A (6) of the Act applies.

1. (3) A reference in this table by number to an item that is not included in this table is a reference to the item that has that number in the general medical services table or the diagnostic imaging services table, as the case requires.

1. (4) A reference to a **Group** in the table includes every item in the Group and a reference to a **Subgroup** in the table includes every item in the Subgroup.

Precedence of items

2. (1) If a service is described:
(a) in an item in general terms; and
(b) in another item in specific terms;
only the item that describes the service in specific terms applies to the service.

2. (2) Subject to subrule (3), if:
(a) subrule (1) does not apply; and
(b) a service is described in 2 or more items;
only the item that provides the lower or lowest fee for the service applies to the service.

2. (3) If an item is expressed to include a pathology service that is described in another item, the other item does not apply to the service in addition to the first-mentioned item, whether or not the services described in the 2 items are requested separately.

Application of item 74990 and 74991

2. (4) Despite subrules (1), (2) and (3):
(a) if the pathology service described in item 74991 is provided to a person, either that item or item 74990, but not both those items, applies to the service; and
(b) if item 74990 or 74991 applies to a pathology service, the fee specified in that item applies in addition to the fee specified in any other item in the table that applies to the service.

2. (5) For items 74990 and 74991:
bulk-billed, in relation to a pathology service, means:
(a) a medicare benefit is payable to a person in respect of the service; and
(b) under an agreement entered into under section 20A of the Act:
(i) the person assigns to the practitioner by whom, or on whose behalf, the service is provided, his or her right to the payment of the medicare benefit; and
(ii) the practitioner accepts the assignment in full payment of his or her fee for the service provided.

Commonwealth concession card holder means a person who is a concessional beneficiary within the meaning given by subsection 84 (1) of the *National Health Act 1953*.

unreferred service means a pathology service that:
(a) is provided to a person by, or on behalf of, a medical practitioner, being a medical practitioner who is not a consultant physician, or specialist, in any speciality (other than a medical practitioner who is, for the purposes of the Act, both a general practitioner and a consultant physician, or specialist, in a particular speciality); and
(b) has not been referred to the medical practitioner by another medical practitioner or person with referring rights.

2. (6) For item 74991:
ASGC means the document titled Australian Standard Geographical Classification (ASGC) 2002, published by the Australian Bureau of Statistics, as in force on 1 July 2002.

practice location, in relation to the provision of a pathology service, means the place of practice in respect of which the practitioner by whom, or on whose behalf, the service is provided, has been allocated a provider number by the Commission**.**

Regional, rural or remote area means an area classified as RRMAs 3-7 under the Rural, Remote and Metropolitan Areas Classification.

Rural, Remote and Metropolitan Areas Classification has the meaning given by subrule 3 (1) of Part 2 of Schedule 1 to the general medical services table**.**

SLA means a Statistical Local Area specified in the ASGC.

SSD mean a Statistical Subdivision specified in the ASGC.

Circumstances in which services rendered following 2 requests to be taken to have been rendered following 1 request

3. (1) In subrule 3(2), ***service*** includes assay, estimation and test.

3. (2) Two or more pathology services (other than services to which, under rule 4, this rule does not apply) rendered for a patient following 2 or more requests are taken to have been rendered following a single request if:

(a) the services are listed in the same item; and
(ab) that item is not item 74990 or 74991; and
(b) the patient's need for the services was determined under subsection 16A (1) of the Act on the same day even if the services are rendered by an approved pathology practitioner on more than one day.

Services to which rule 3 does not apply

4. (1) Rule 3 does not apply to a pathology service described in item 65060, 65070, 65120, 65123, 65126, 65129, 65150, 65153, 65156, 66500, 66503, 66506, 66509, 66512, 66584 or 66800, if:
(a) the service is rendered in relation to one or more specimens taken on each of not more than 6 separate occasions in a period of 24 hours; and
(b) the service is rendered to an inpatient in a hospital; and
(c) each service must be rendered as soon as possible after collection and after authorization of the result of the previous specimen; and
(d) the account for the service is endorsed 'Rule 3 Exemption'.

4. (2) Rule 3 does not apply to any of the following pathology services:
(a) estimation of prothrombin time (INR) in respect of a patient undergoing anticoagulant therapy;
(b) quantitative estimation of lithium in respect of a patient undergoing lithium therapy;
(c) a service described in item 65070 in relation to a patient undergoing chemotherapy for neoplastic disease or immunosuppressant therapy;
(d) a service described in item 65070 in relation to clozaril, ticlopidine hydrochloride, methotrexate, gold, sulphasalazine or penicillamine therapy of a patient;
(e) a service described in item 66500 - 66512 in relation to methotrexate or leflunomide therapy of a patient;
(f) quantitative estimation of urea, creatinine and electrolytes in relation to:
(i) cis-platinum or cyclosporin therapy of a patient; or
(ii) chronic renal failure of a patient being treated in a dialysis program conducted by a recognised hospital;
(g) quantitative estimation of albumin and calcium in relation to therapy of a patient with vitamin D, its metabolites or analogues;
(h) quantitative estimation of calcium, phosphate, magnesium, urea, creatinine and electrolytes in cancer patients receiving bisphosphonate infusions.

if:

(i) under a request for a service, other than a request for a service described in paragraph (a), no more than 6 tests are requested; and
(ii) the tests are performed within 6 months of the request; and
(iii) the account for the service is endorsed "Rule 3 Exemption".

4. (3) Rule 3 does not apply to a pathology service described in items 65109 or 65110 if:

(a) The service is rendered on not more than 5 separate occasions in the case of item 65109 and 2 separate occasions in the case of item 65110 in a period of 24 hours; and
(b) The service is rendered in response to a written request separated in time from the previous request; and
(c) The account for the service is endorsed "Rule 3 Exemption".

Item taken to refer only to the first service of a particular kind

5. (1) For an item in Group P1 (Haematology):

(a) if pathology services of a kind referred to in item 65090 or 65093 are rendered for a patient during a period when the patient is in hospital, the item applies only to the first pathology service of that kind rendered for the patient during the period; and

(b) if:

(i) tests (except tests mentioned in item 65099, 65102, 65105 and 65108) are carried out in relation to a patient episode; and

(ii) specimen material from the patient episode is stored; and

(iii) in response to a request made within 14 days of the patient episode, further tests (except tests mentioned in item 65099, 65102, 65105 and 65108) are carried out on the stored material; the later tests and the earlier tests are taken to be part of one patient episode.

5. (2) Benefits for items 65102 and 65108 are payable only if a minimum of 6 units are issued for the patient's care in any 1 day.

5.(3) For items 65099 and 65102:

compatibility tests by crossmatch means that, in addition to all the tests described in paragraphs (a) and (b) of the item, donor red cells from each unit must have been tested directly against the serum of the patient by 1 or more accepted crossmatching techniques.

Certain items not to apply to a service referred by one pathology practitioner to another

6. (1) In this rule:

designated pathology service means a pathology service in respect of tests relating to a single patient episode that are tests of the kind described in item 65150, 65175, 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165.

6. (2) This rule applies in respect of a designated pathology service where:

(a) an approved pathology practitioner ***(practitioner A)*** in an approved pathology authority:

(i) has been requested to render the designated pathology service; and

(ii) is unable, because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority, to render 1 or more of the tests included in the service; and

(iii) requests an approved pathology practitioner ***(practitioner B)*** in another approved pathology authority to render the test or tests that practitioner A is unable to render; and

(iv) renders each test (if any) included in the service, other than the test or tests in respect of which the request mentioned in subparagraph (iii) is made; and

(b) the tests mentioned in subparagraph (a) (iv) that practitioner A renders are not tests constituting a service described in item 65156, 65179, 66653, 66712, 66734, 66788, 66806, 66815, 66822, 66828, 69496, 71093, 71159 or 71168.

6. (3) If this rule applies in respect of a designated pathology service:

(a) item 65150, 65153, 65175, 65176, 65177, 65178, 66650, 66695, 66698, 66701, 66704, 66707, 66711, 66722, 66725, 66728, 66731, 66785, 66800, 66803, 66812, 66819, 66825, 69384, 69387, 69390, 69393, 69396, 69494, 69495, 71089, 71091, 71153, 71155, 71157, 71165, 71166 or 71167 (as the case requires) applies in respect of the test or tests rendered by practitioner A; and

(b) where practitioner B renders a service under a request referred to in subparagraph (2) (a) (iii) and:

(i) practitioner A has rendered one or more of the tests that the service comprises - subject to subrule (4), the amount specified in item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 (as the case requires) shall be taken to be the fee for each test that the service comprises; or

(ii) practitioner A has not rendered any of the tests that the service comprises -

(A) the amount specified in item 65157, 65180, 66651, 66696, 66714, 66723, 66789, 66804, 66816, 66820, 66826, 69400, 69497, 71090, 71154 or 71169 (as the case requires) shall be taken to be the fee for the first test that the service comprises; and

(B) subject to subrule (4), the amount specified in item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 (as the case requires) shall be taken to be the fee for each subsequent test that the service comprises.

6. (4) For paragraph (3) (b), the maximum number of tests to which item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 applies is:

(a) for item 66652, 66715, 66790, 66817, 66821 or 66827:
2 – X; and
(b) for item 65158, 66805, 69498 or 71092:
3 – X; and
(c) for item 71156 or 71170:
4 – X; and
(d) for item 65181 or 66724:
5 – X; and

where X is the number of tests rendered by practitioner A in relation to the designated pathology service in respect of which the request mentioned in that paragraph is made.

6. (5) Items in Group P10 (Patient episode initiation) do not apply to the second mentioned approved pathology practitioner in subrule (2).

Items not to be split

7. Except as stated in rule 6, the amount specified in an item is payable only to one approved pathology practitioner in respect of a single patient episode.

Creatinine ratios – Group P2 (chemical)

8. A pathology service mentioned in an item (except item 66500) in Group P2 (chemical) that:
(a) involves the measurement of a substance in urine; and
(b) requires calculation of a substance/creatinine ratio;
is taken to include the measurement of creatinine necessary for the calculation.

Thyroid function testing

9. (1) For item 66719:
abnormal level of TSH means a level of TSH that is outside the normal reference range in respect of the particular method of assay used to determine the level.

9. (2) Except where paragraph (a) of item 66719 is satisfied, the amount specified in the item is not payable in respect of a pathology service described in the item unless the pathologist who renders the service has a written statement from the medical practitioner who requested the service that satisfies subrule (3).

9. (3) The written statement from the medical practitioner must indicate:

(a) that the tests are required for a particular purpose, being a purpose specified in paragraph (b) of item 66719; or
(b) that the medical practitioner who requested the tests suspects the patient has pituitary dysfunction; or
(c) that the patient is on drugs that interfere with thyroid hormone metabolism or function.

Meaning of "serial examinations or cultures"

10. For an item in Group P3 (Microbiology):
(a) ***serial examinations or cultures*** means a series of examinations or cultures requested on 1 occasion whether or not:
(i) the materials are received on different days by the approved pathology practitioner; or
(ii) the examinations or cultures were requested on 1 or more request forms by the treating practitioner; and

(b) if:
(i) tests are carried out in relation to a patient episode; and
(ii) specimen material from the patient episode is stored; and
(iii) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;
the later tests and the earlier tests are taken to be part of one patient episode.

Investigation for hepatitis serology

11. A medicare benefit is not payable in respect of more than one of items 69475, 69478 and 69481 in a patient episode.

Tests in Group P4 (Immunology) relating to antibodies

12. For items in Group P4 (Immunology), in items 71119, 71121, 71123 and 71125, if:
(a) tests are carried out in relation to a patient episode; and
(b) specimen material from the patient episode is stored; and
(c) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;
the later tests and the earlier tests are taken to be part of one patient episode.

Tests on biopsy material - Group P5 (Tissue pathology) and Group P6 (Cytology)

13. (1) For items in Group P5 (Tissue pathology):
(a) ***biopsy material*** means all tissue received by the Approved Pathology Practitioner:
(i) from a medical procedure or group of medical procedures performed on a patient at the same time; or
(ii) after being expelled spontaneously from a patient.
(b) ***cytology*** means microscopic examination of 1 or more stained preparations of cells separated naturally or artificially from their normal environment by methods recognised as adequate to demonstrate their structure to a degree sufficient to enable an opinion to be formed about whether they are likely to be normal, abnormal but benign, or abnormal and malignant but, in accordance with customary laboratory practice, does not include examination of a blood film and a bone marrow aspirate; and
(c) ***separately identified specimen*** means an individual specimen collected, identified so that it is clearly distinguished from any other specimen, and sent for testing by or on behalf of the treating practitioner responsible for the procedure in which the specimen was taken.

13. (2) For Groups P5 and P6 of the pathology services table, services in Group P6 include any services described in Group P5 on the material submitted for a test in Group P6.

13. (3) For subrule (2), any sample submitted for cytology from which a cell block is prepared does not qualify for a Group P5 item.

13.(4) If more than 1 of the services mentioned in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 are performed in a single patient episode, only the fee for the item performed having the highest specified fee is applicable to the services.

13.(5) If more than 1 histopathological examinations are performed on separate specimens, of different complexity levels, from a single patient episode, a medicare benefit is payable only for the examination that has the highest schedule fee.

13.(6) In items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 a reference to a ***complexity level*** is a reference to the level given to a specimen type mentioned in Part 4 of this Table.

13.(7) If more than 1 of the services mentioned in items 72846, 72847, 72848; 72849 and 72850 or 73059, 73060, 73061, 73064 and 73065 are performed in a single patient episode, a medicare benefit is payable only for the item performed that has the highest scheduled fee.

13.(8) If more than 1 of the services mentioned in items 73049, 73051, 73062, 73063, 73066 and 73067 are performed in a single patient episode, only the fee for the item performed having the higher or highest specified fee applies to the services.

Items in Groups P10 (Patient episode initiation) and P11 (Specimen referred) not to apply in certain circumstances

14. (1) For this rule and items in Groups P10 (Patient episode initiation) and P11 (Specimen referred):

approved collection centre has the same meaning as in Part IIA of the Act.

institution means a place at which residential accommodation or day care is, or both residential accommodation and day care are, made available to:
(a) disadvantaged children; or

(b) juvenile offenders; or
(c) aged persons; or
(d) chronically ill psychiatric patients; or
(e) homeless persons; or
(f) unemployed persons; or
(g) persons suffering from alcoholism; or
(h) persons addicted to drugs; or
(i) physically or mentally handicapped persons;
but does not include:
(j) a hospital; or
(k) a residential aged care home; or
(l) accommodation for aged persons that is attached to a residential aged care home or situated within a residential aged care home.

prescribed laboratory means a laboratory operated by:
(a) the Australian Government; or
(b) an authority of the Commonwealth; or
(c) a State or internal Territory; or
(d) an authority of a State or internal Territory; or
(e) an Australian tertiary education institution.

specimen collection centre has the same meaning as in Part IIA of the Act.

treating practitioner has the same meaning as in paragraph 16A(1)(a) of the Act.

14. (2) If a service described in an item in Group P10 is rendered by, or on behalf of, an approved pathology practitioner who is a recognised pathologist, the relevant one of those items does not apply to the service if:

(a) the service is rendered upon a request made in the course of a service provided to a public patient in a recognised hospital or when attending an outpatient service of a recognised hospital.

14. (3) An item in Group P10 or P11 does not apply to a pathology service to which subsection 16A (7) of the Act applies.

14. (4) An item in Group P10 or P11 does not apply to a pathology service unless at least 1 item in Groups P1 to P8 also applies to the service.

14. (5) Subject to subrule (7), if one item in Group P10 applies to a patient episode, no other item in the Group applies to the patient episode.

14. (6) An item in Group P11 applies only to the approved pathology practitioner or approved pathology authority to whom the specimen mentioned in the item was referred.

14. (7) If, in respect of the same patient episode:
(a) services referred to in 1 or more items in Group P5 and 1 or more of Groups P1, P2, P3, P4, P6, P7 and P8 are rendered by an approved pathology practitioner in the laboratory of another approved pathology authority; or
(b) services referred to in 1 or more items in Group P6 and 1 or more of Groups P1, P2, P3, P4, P5, P7 and P8 are rendered by another approved pathology practitioner in the laboratory of another approved pathology authority;
the fee specified in the applicable item in Group P10 is payable to both approved pathology practitioners.

14. (8) If more than one specimen is collected from a person on the same day for the provision of pathology services:
(a) in accordance with more than 1 request; and
(b) in or by a single approved pathology authority;
the fee specified in the applicable item in Group P10 applies once only to the services unless an exemption listed in Rule 4 applies or an exemption has been granted under Rule 3 "S4B(3)".

14. (9) The amount specified in item 73940 is payable only once in respect of a single patient episode.

Application of an item in Group P11 (Specimen referred) to a service excludes certain other items

15. If item 73940 applies to a patient episode, none of the items in Group P10 applies to any pathology service rendered by the approved pathology authority or approved pathology practitioner who claimed item 73940 in respect of the patient episode.

Circumstances in which an item in Group P11 (Specimen referred) does not apply

16. (1) An item in Group P11 does not apply to a referral if:

(a) a service in respect of the same patient episode has been carried out by the referring approved pathology authority; and
(b) the approved pathology authority to which the referral is made is related to the referring approved pathology authority.

16. (2) An approved pathology authority is ***related to*** another approved pathology authority for subrule (1) if:
(a) both approved pathology authorities are employed (including employed under contract) by the same person, whether or not the person is also an approved pathology authority; or
(b) either of the approved pathology authorities is employed (including employed under contract) by the other; or
(c) both approved pathology authorities are corporations and are related corporations within the meaning of the Corporations Act; or
(d) the approved pathology authorities are partners (whether or not either or both of the approved pathology authorities are individuals and whether or not other persons are in partnership with either or both of the approved pathology authorities; or
(e) both approved pathology authorities are operated by the Commonwealth or an authority of the Commonwealth; or
(f) both approved pathology authorities are operated by the same State or internal Territory or an authority of the same State or internal Territory.

16. (3) An item in Group P11 does not apply to a referral if the following common tests are referred either singly or in combination (except if the following items are referred in combination with other items not similarly specified): 65060, 65070, 65120, 66500, 66503, 66506, 66509, 66512, 66536, 66596, 69300, 69303, 69333 or 73527.

Abbreviations

17. (1) The abbreviations in Part 4 of this table may be used to identify particular pathology services or groups of pathology services.

17. (2) The names of services or drugs not listed in Part 4 of this table must be written in full.

Certain pathology services to be treated as 1 service

18. (1) **In this rule:**

general practitioner means a medical practitioner who:
(a) is not a consultant physician in any specialty; and
(b) is not a specialist in any specialty.

set of pathology services means a group of pathology services:
(a) that consists of services that are described in at least 4 different items; and
(b) all of which are requested in a single patient episode; and
(c) each of which relates to a patient who is not an admitted patient of a hospital; and
(d) excludes services referred to in an item in Group P10, Group P11, Group P12 or Group P13, items 66900, 69484, 73053 and 73055; and
(e) excludes services described in the following items:

65079, 65082, 65157, 65158, 65166, 65180, 65181, 66606, 66610, 66639, 66642, 66651, 66652, 66663, 66666, 66696, 66697, 66714, 66715, 66723, 66724, 66780, 66783, 66789, 66790, 66792, 66804, 66805, 66816, 66817, 66820, 66821, 66826, 66827, 66832, 66834, 66837, 69325, 69328, 69331, 69379, 69383, 69400, 69401, 69419, 69451, 69500, 69484, 69489, 69492, 69497, 69498, 71076, 71090, 71092, 71096, 71148, 71154, 71156, 71169, 71170, 73309, 73312, 73315, 73318, 73321 and 73324;

where those services are performed by an approved pathology practitioner in an accredited pathology laboratory of an approved pathology authority following referral by another approved pathology practitioner in an accredited pathology laboratory of an approved pathology authority which is not **related to** the first mentioned approved pathology authority.

(1A) An approved pathology authority is **related to** another approved pathology authority for the purposes of paragraph 18(1)(e) if that approved pathology authority would be related to the other approved pathology authority for the purposes of rule 16(2).

18. (2) If a general practitioner requests a set of pathology services, the pathology services in the set are to be treated as individual pathology services in accordance with this rule.

18. (3) If the fee specified in 1 item that describes any of the services in the set of pathology services is higher than the fees specified in the other items that describe the services in the set:
(a) the pathology service described in the first-mentioned item is to be treated as 1 pathology service; and
(b) either:
(i) the pathology service in the set that is described in the item that specifies the second-highest fee is to be treated as 1 pathology service; or
(ii) if 2 or more items that describe any of those services specify the second-highest fee — the pathology service described in the item that specifies the second-highest fee, and has the lowest item number, is to be treated as 1 pathology service; and
(c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.

18. (4) If the fees specified in 2 or more items that describe any of the services in the set of pathology services are the same, and higher than the fees specified in the other items that describe the services in the set:
(a) the pathology service in the set that is described in the item that specifies the highest fee, and has the lowest item number, is to be treated as 1 pathology service; and
(b) the pathology service in the set that is described in the item that specifies the highest fee, and has the second-lowest item number, is to be treated as 1 pathology service; and
(c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.

18. (5) If pathology services are to be treated as 1 pathology service under paragraph (3) (c) or (4) (c), the fee for the 1 pathology service is the highest fee specified in any of the items that describe the pathology services that are to be treated as the 1 pathology service.

Hepatitis C viral RNA testing

19. For item 69499 and 69500:
Hepatitis C sero-positive, for a patient, means 2 different assays of Hepatitis C antibodies are positive.

serological status is uncertain**,** for a patient, means any result where 2 different assays of Hepatitis C antibodies are inconclusive.

Haemochromatosis testing

20. For items 73317 and 73318:
elevated serum ferritin for a patient, means a level of ferritin above the normal reference range in respect of the particular method of assay used to determine the level.

Nutritional and toxicity metals testing

22. (1) For this rule:
nutritional metals testing group means items 66819, 66820, 66821 and 66822.
metal toxicity testing group means items 66825, 66826, 66827, 66828, 66831 and 66832.

22. (2) An item in the nutritional metals testing group or the metal toxicity testing group does not apply in relation to a service performed if medicare benefits are paid or payable for tests that are performed for the same patient in 3 patient episodes requested within 6 months before the request for that service, under any of:
(a) that item; or
(b) the other item in the same group; or
(c) an item in the other group.

Antineutrophil Cytoplasmic Antibody

23. A request for Antineutrophil Cytoplasmic Antibody immunofluorescence test (ANCA) shall be deemed to include requests for antineutrophil proteinase 3 antibody test (PR-3 ANCA) and antimyeloperoxidase antibody test (MPO ANCA) where the immunofluorescence test for ANCA is abnormal, or has been abnormal, or those specific antibodies have been previously detected.

Satisfying Requirements Described in Items

24. Unless stated elsewhere in these rules, where an item contains a requirement, this requirement is satisfied if:
(a) The requirement/s as stipulated in the item descriptor are contained in the request form; or
(b) The requirement/s as stipulated in the item descriptor were supplied previously in writing to the APA and this documentation is retained by the APA; or
(c) The results of other laboratory tests performed in the same episode meet the requirement/s as stipulated in the item descriptor; or
(d) The results of laboratory tests that meet the requirement/s as stipulated in the item descriptor are supplied on the request form; or
The results of laboratory tests that meet the requirement/s as stipulated in the item descriptor are contained in the APA's records.

Limitation on certain items

25. (a) For any particular patient, items 66539, 66605, 66606, 66607, 66610, 69380, 69488, 69489, 71075, 71127, 71135 or 71137 is applicable not more than twice in a 12 month period.
(b) For any particular patient, item 66626 is applicable not more than 36 times in a 12 month period.
(c) For any particular patient, items 66655, 66659, 66838, 66841, 69482, 69491, 69499 or 69500 are applicable not more than once in a 12 month period.
(d) For any particular patient, item 66750 or 66751 is applicable not more than once in a pregnancy.
(e) For any particular patient, item 69336 is applicable not more than once in each period of 7 days.
(f) For any particular patient, items 66551, 66660, 69445, 69451, 69483, 71079 or 73523 are applicable not more than 4 times in a 12 month period.
(g) For any particular patient, items 66554, 66830 and 71077 are applicable not more than 6 times in a 12 month period.
(h) For any particular patient, item 66819, 66820, 66821, 66822, 66825, 66826, 66827 or 66828 is applicable not more than 3 times in a 6 month period.
(i) For any particular patient, items 69418 and 69419 are applicable not more than twice in a 24 month period.
(j) For any particular patient, items 73339 and 73340 are applicable not more than once.

Antigen Detection – Group P3 (Microbiology)

26. If the service listed in 69316, 69317, 69319, 69494, 69495, 69496, 69497 or 69498 is a pathologist determinable service the specialist pathologist is required to record the reasons for determining the need for this service.

27. If the service rendered in 71148, 73320 or 73321 is a pathologist determinable service, the specialist pathologist is required to record the reason for determining the need for this service including the result of the service in 71147.

Second Opinion morphology, limitations on items 72858 and 72859

28.1 Items 72858 and 72859 apply:
(a) only to a service that is covered by:
(i) item 65084 or 65087; or
(ii) item 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 or 72838; or
(iii) an item in Group P6 (other than item 73053, 73055 or 73057); and
(b) only if the treating practitioner and the approved pathology practitioner who provided the original opinion on the patient specimen agree that a second opinion is reasonably necessary for diagnostic purposes.

28.2 Items 72858 and 72859 do not apply if the accredited pathology laboratory in which the second opinion is provided is the same laboratory in which the original opinion was provided.

Table for Cross Referencing Rules and Clauses appearing in Regulations

1 Nov 2010 MBS Book Rules	Health Insurance (Pathology Services Table) Regulations 2010 Clauses					
1	Dictionary					
2	1.2.1	2.12.1				
3	1.2.2					
4	1.2.3	2.1.1	2.2.2			
5	2.1.2					
6	1.2.4					
7	1.2.5					
8	2.2.1					
9	2.2.5					
10	2.3.1					
11	2.3.3					
12	2.4.2					
13	2.5.1	2.6.1				
14	2.10.1	2.11.1				
15	2.11.2					
16	2.11.3					
17	1.1.1					
18	1.2.6					
18A	1.2.7					
19	2.3.5					
20	2.7.1					
21	2.2.4					
22	2.2.7					
23	2.4.4					
24	1.2.8	2.4.5				
25	2.2.3	2.2.6	2.2.7	2.3.4	2.4.1	2.8.1
26	2.3.2					
27	2.4.3	2.7.2				

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.

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

Higher rates of benefits are also provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons).

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.

GROUP P1 - HAEMATOLOGY

65060	Haemoglobin, erythrocyte sedimentation rate, blood viscosity - 1 or more tests **Fee:** $7.85 **Benefit:** 75% = $5.90 85% = $6.70
65066	Examination of: (a) a blood film by special stains to demonstrate Heinz bodies, parasites or iron; or (b) a blood film by enzyme cytochemistry for neutrophil alkaline phosphatase, alpha-naphthyl acetate esterase or chloroacetate esterase; or (c) a blood film using any other special staining methods including periodic acid Schiff and Sudan Black; or (d) a urinary sediment for haemosiderin including a service described in item 65072 **Fee:** $10.40 **Benefit:** 75% = $7.80 85% = $8.85
65070	Erythrocyte count, haematocrit, haemoglobin, calculation or measurement of red cell index or indices, platelet count, leucocyte count and manual or instrument generated differential count - not being a service where haemoglobin only is requested - one or more instrument generated set of results from a single sample; and (if performed) (a) a morphological assessment of a blood film; (b) any service in item 65060 or 65072 **Fee:** $16.95 **Benefit:** 75% = $12.75 85% = $14.45
65072	Examination for reticulocytes including a reticulocyte count by any method - 1 or more tests **Fee:** $10.20 **Benefit:** 75% = $7.65 85% = $8.70
65075	Haemolysis or metabolic enzymes - assessment by: (a) erythrocyte autohaemolysis test; or (b) erythrocyte osmotic fragility test; or (c) sugar water test; or (d) G-6-P D (qualitative or quantitative) test; or (e) pyruvate kinase (qualitative or quantitative) test; or (f) acid haemolysis test; or (g) quantitation of muramidase in serum or urine; or (h) Donath Landsteiner antibody test; or (i) other erythrocyte metabolic enzyme tests 1 or more tests **Fee:** $51.95 **Benefit:** 75% = $39.00 85% = $44.20
65078	Tests for the diagnosis of thalassaemia consisting of haemoglobin electrophoresis or chromatography and at least 2 of: (a) examination for HbH; or (b) quantitation of HbA2; or (c) quantitation of HbF; including (if performed) any service described in item 65060 or 65070 **Fee:** $90.20 **Benefit:** 75% = $67.65 85% = $76.70
65079	Tests described in item 65078 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $90.20 **Benefit:** 75% = $67.65 85% = $76.70
65081	Tests for the investigation of haemoglobinopathy consisting of haemoglobin electrophoresis or chromatography and at least 1 of: (a) heat denaturation test; or (b) isopropanol precipitation test; or (c) tests for the presence of haemoglobin S; or (d) quantitation of any haemoglobin fraction (including S, C, D, E); including (if performed) any service described in item 65060, 65070 or 65078 **Fee:** $96.60 **Benefit:** 75% = $72.45 85% = $82.15
65082	Tests described in item 65081 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $96.60 **Benefit:** 75% = $72.45 85% = $82.15
65084	Bone marrow trephine biopsy - histopathological examination of sections of bone marrow and examination of aspirated material (including clot sections where necessary), including (if performed): any test described in item 65060, 65066 or 65070 **Fee:** $165.85 **Benefit:** 75% = $124.40 85% = $141.00
65087	Bone marrow - examination of aspirated material (including clot sections where necessary), including (if performed): any test described in item 65060, 65066 or 65070 **Fee:** $83.10 **Benefit:** 75% = $62.35 85% = $70.65

65090	Blood grouping (including back-grouping if performed) - ABO and Rh (D antigen) **Fee:** $11.15 **Benefit:** 75% = $8.40 85% = $9.50
65093	Blood grouping - Rh phenotypes, Kell system, Duffy system, M and N factors or any other blood group system - 1 or more systems, including item 65090 (if performed) **Fee:** $22.00 **Benefit:** 75% = $16.50 85% = $18.70
65096	Blood grouping (including back-grouping if performed), and examination of serum for Rh and other blood group antibodies, including: (a) identification and quantitation of any antibodies detected; and (b) (if performed) any test described in item 65060 or 65070 **Fee:** $41.00 **Benefit:** 75% = $30.75 85% = $34.85
65099	Compatibility tests by crossmatch - all tests performed on any one day for up to 6 units, including: (a) all grouping checks of the patient and donor; and (b) examination for antibodies, and if necessary identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090 or 65096 (Item is subject to rule 5) **Fee:** $108.90 **Benefit:** 75% = $81.70 85% = $92.60
65102	Compatibility tests by crossmatch - all tests performed on any one day in excess of 6 units, including: (a) all grouping checks of the patient and donor; and (b) examination for antibodies, and if necessary identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090, 65096, 65099 or 65105 (Item is subject to rule 5) **Fee:** $164.60 **Benefit:** 75% = $123.45 85% = $139.95
65105	Compatibility testing using at least a 3 cell panel and issue of red cells for transfusion - all tests performed on any one day for up to 6 units, including: (a) all grouping checks of the patient and donor; and (b) examination for antibodies and, if necessary, identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090 or 65096 (Item is subject to rule 5) **Fee:** $108.90 **Benefit:** 75% = $81.70 85% = $92.60
65108	Compatibility testing using at least a 3 cell panel and issue of red cells for transfusion - all tests performed on any one day in excess of 6 units, including: (a) all grouping checks of the patient and donor; and (b) examination for antibodies and, if necessary, identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090, 65096, 65099 or 65105 (Item is subject to rule 5) **Fee:** $164.60 **Benefit:** 75% = $123.45 85% = $139.95
65109	Release of fresh frozen plasma or cryoprecipitate for the use in a patient for the correction of a coagulopathy – 1 release. **Fee:** $12.90 **Benefit:** 75% = $9.70 85% = $11.00
65110	Release of compatible fresh platelets for the use in a patient for platelet support as prophylaxis to minimize bleeding or during active bleeding – 1 release. **Fee:** $12.90 **Benefit:** 75% = $9.70 85% = $11.00
65111	Examination of serum for blood group antibodies (including identification and, if necessary, quantitation of any antibodies detected) **Fee:** $23.20 **Benefit:** 75% = $17.40 85% = $19.75
65114	1 or more of the following tests: (a) direct Coombs (antiglobulin) test; (b) qualitative or quantitative test for cold agglutinins or heterophil antibodies **Fee:** $9.10 **Benefit:** 75% = $6.85 85% = $7.75
65117	1 or more of the following tests: (a) Spectroscopic examination of blood for chemically altered haemoglobins; (b) detection of methaemalbumin (Schumm's test) **Fee:** $20.25 **Benefit:** 75% = $15.20 85% = $17.25

65120	Prothrombin time (including INR where appropriate), activated partial thromboplastin time, thrombin time (including test for the presence of heparin), test for factor XIII deficiency (qualitative), Echis test, Stypven test, reptilase time, fibrinogen, or 1 of fibrinogen degradation products, fibrin monomer or D-dimer - 1 test **Fee:** $13.70	**Benefit:** 75% = $10.30	85% = $11.65
65123	2 tests described in item 65120 **Fee:** $20.35	**Benefit:** 75% = $15.30	85% = $17.30
65126	3 tests described in item 65120 **Fee:** $27.85	**Benefit:** 75% = $20.90	85% = $23.70
65129	4 or more tests described in item 65120 **Fee:** $35.50	**Benefit:** 75% = $26.65	85% = $30.20
65137	Test for the presence of lupus anticoagulant not being a service associated with any service to which items 65175, 65176, 65177, 65178 and 65179 apply **Fee:** $25.35	**Benefit:** 75% = $19.05	85% = $21.55
65142	Confirmation or clarification of an abnormal or indeterminate result from a test described in item 65175, by testing a specimen collected on a different day - 1 or more tests **Fee:** $25.35	**Benefit:** 75% = $19.05	85% = $21.55
65144	Platelet aggregation in response to ADP, collagen, 5HT, ristocetin or other substances; or heparin, low molecular weight heparins, heparinoid or other drugs - 1 or more tests **Fee:** $56.55	**Benefit:** 75% = $42.45	85% = $48.10
65147	Quantitation of anti-Xa activity when monitoring is required for a patient receiving a low molecular weight heparin or heparinoid - 1 test **Fee:** $37.90	**Benefit:** 75% = $28.45	85% = $32.25
65150	Quantitation of von Willebrand factor antigen, von Willebrand factor activity (ristocetin cofactor assay), von Willebrand factor collagen binding activity, factor II, factor V, factor VII, factor VIII, factor IX, factor X, factor XI, factor XII, factor XIII, Fletcher factor, Fitzgerald factor, circulating coagulation factor inhibitors other than by Bethesda assay - 1 test (Item is subject to rule 6) **Fee:** $70.90	**Benefit:** 75% = $53.20	85% = $60.30
65153	2 tests described in item 65150 (Item is subject to rule 6) **Fee:** $141.85	**Benefit:** 75% = $106.40	85% = $120.60
65156	3 or more tests described in item 65150 (Item is subject to rule 6) **Fee:** $212.75	**Benefit:** 75% = $159.60	85% = $180.85
65157	A test described in item 65150, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18) **Fee:** $70.90	**Benefit:** 75% = $53.20	85% = $60.30
65158	Tests described in item 65150, other than that described in 65157, if rendered by a receiving APP - each test to a maximum of 2 tests (Item is subject to rule 6 and 18) **Fee:** $70.90	**Benefit:** 75% = $53.20	85% = $60.30
65159	Quantitation of circulating coagulation factor inhibitors by Bethesda assay - 1 test **Fee:** $70.90	**Benefit:** 75% = $53.20	85% = $60.30
65162	Examination of a maternal blood film for the presence of fetal red blood cells (Kleihauer test) **Fee:** $10.45	**Benefit:** 75% = $7.85	85% = $8.90
65165	Detection and quantitation of fetal red blood cells in the maternal circulation by detection of red cell antigens using flow cytometric methods including (if performed) any test described in item 65070 or 65162 **Fee:** $34.45	**Benefit:** 75% = $25.85	85% = $29.30
65166	A test described in item 65165 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $34.45	**Benefit:** 75% = $25.85	85% = $29.30

65171	Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency or activated protein C resistance in a first degree relative of a person who has a proven defect of any of the above - 1 or more tests **Fee:** $25.35	**Benefit:** 75% = $19.05	85% = $21.55
65175	Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency, lupus anticoagulant, activated protein C resistance - where the request for the test(s) specifically identifies that the patient has a history of venous thromboembolism - quantitation by 1 or more techniques - 1 test (Item is subject to Rule 6) **Fee:** $25.35	**Benefit:** 75% = $19.05	85% = $21.55
65176	2 tests described in item 65175 (Item is subject to rule 6) **Fee:** $48.65	**Benefit:** 75% = $36.50	85% = $41.40
65177	3 tests described in item 65175 (Item is subject to rule 6) **Fee:** $71.95	**Benefit:** 75% = $54.00	85% = $61.20
65178	4 tests described in item 65175 (Item is subject to rule 6) **Fee:** $95.20	**Benefit:** 75% = $71.40	85% = $80.95
65179	5 tests described in item 65175 (Item is subject to rule 6) **Fee:** $118.50	**Benefit:** 75% = $88.90	85% = $100.75
65180	A test described in item 65175, if rendered by a receiving APA, where no tests in the item have been rendered by the referring APA - 1 test (Item is subject to rule 6 and 18) **Fee:** $25.35	**Benefit:** 75% = $19.05	85% = $21.55
65181	Tests described in item 65175, other than that described in 65180, if rendered by a receiving APA - each test to a maximum of 4 tests (Item is subject to rule 6 and 18) **Fee:** $23.30	**Benefit:** 75% = $17.50	85% = $19.85

GROUP P2 - CHEMICAL

66500	Quantitation in serum, plasma, urine or other body fluid (except amniotic fluid), by any method except reagent tablet or reagent strip (with or without reflectance meter) of: acid phosphatase, alanine aminotransferase, albumin, alkaline phosphatase, ammonia, amylase, aspartate aminotransferase, bicarbonate, bilirubin (total), bilirubin (any fractions), C-reactive protein, calcium (total or corrected for albumin), chloride, creatine kinase, creatinine, gamma glutamyl transferase, globulin, glucose, lactate dehydrogenase, lipase, magnesium, phosphate, potassium, sodium, total protein, total cholesterol, triglycerides, urate or urea - 1 test **Fee:** $9.70 **Benefit:** 75% = $7.30 85% = $8.25
66503	2 tests described in item 66500 **Fee:** $11.65 **Benefit:** 75% = $8.75 85% = $9.95
66506	3 tests described in item 66500 **Fee:** $13.65 **Benefit:** 75% = $10.25 85% = $11.65
66509	4 tests described in item 66500 **Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35
66512	5 or more tests described in item 66500 **Fee:** $17.70 **Benefit:** 75% = $13.30 85% = $15.05
66517	Quantitation of bile acids in blood in pregnancy. To a maximum of 3 tests in a pregnancy. **Fee:** $19.65 **Benefit:** 75% = $14.75 85% = $16.75
66518	Investigation of cardiac or skeletal muscle damage by quantitative measurement of creatine kinase isoenzymes, troponin or myoglobin in blood - testing on 1 specimen in a 24 hour period **Fee:** $20.05 **Benefit:** 75% = $15.05 85% = $17.05
66519	Investigation of cardiac or skeletal muscle damage by quantitative measurement of creatine kinase isoenzymes, troponin or myoglobin in blood - testing on 2 or more specimens in a 24 hour period **Fee:** $40.15 **Benefit:** 75% = $30.15 85% = $34.15
66536	Quantitation of HDL cholesterol **Fee:** $11.05 **Benefit:** 75% = $8.30 85% = $9.40
66539	Electrophoresis of serum for demonstration of lipoprotein subclasses, if the cholesterol is >6.5 mmol/L and triglyceride >4.0 mmol/L or in the diagnosis of types III and IV hyperlipidaemia - (Item is subject to rule 25) **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05
66542	Oral glucose tolerance test for the diagnosis of diabetes mellitus that includes: (a) administration of glucose; and (b) at least 2 measurements of blood glucose; and (c) (if performed) any test described in item 66695 **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
66545	Oral glucose challenge test in pregnancy for the detection of gestational diabetes that includes: (a) administration of glucose; and (b) 1 or 2 measurements of blood glucose; and (c) (if performed) any test in item 66695 **Fee:** $15.80 **Benefit:** 75% = $11.85 85% = $13.45
66548	Oral glucose tolerance test in pregnancy for the diagnosis of gestational diabetes that includes: (a) administration of glucose; and (b) at least 3 measurements of blood glucose; and (c) any test in item 66695 (if performed) **Fee:** $19.90 **Benefit:** 75% = $14.95 85% = $16.95
66551	Quantitation of glycated haemoglobin performed in the management of established diabetes – (Item is subject to rule 25) **Fee:** $16.80 **Benefit:** 75% = $12.60 85% = $14.30
66554	Quantitation of glycated haemoglobin performed in the management of pre-existing diabetes where the patient is pregnant – including a service in item 66551 (if performed) – (Item is subject to rule 25) **Fee:** $16.80 **Benefit:** 75% = $12.60 85% = $14.30

66557	Quantitation of fructosamine performed in the management of established diabetes - each test to a maximum of 4 tests in a 12 month period **Fee:** $9.70	**Benefit:** 75% = $7.30	85% = $8.25
66560	Microalbumin - quantitation in urine **Fee:** $20.10	**Benefit:** 75% = $15.10	85% = $17.10
66563	Osmolality, estimation by osmometer, in serum or in urine - 1 or more tests **Fee:** $24.70	**Benefit:** 75% = $18.55	85% = $21.00
66566	Quantitation of: (a) blood gases (including pO_2, oxygen saturation and pCO_2) ; and (b) bicarbonate and pH; including any other measurement (eg. haemoglobin, lactate, potassium or ionised calcium) or calculation performed on the same specimen - 1 or more tests on 1 specimen **Fee:** $33.70	**Benefit:** 75% = $25.30	85% = $28.65
66569	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 2 specimens performed within any 1 day **Fee:** $42.60	**Benefit:** 75% = $31.95	85% = $36.25
66572	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 3 specimens performed within any 1 day **Fee:** $51.55	**Benefit:** 75% = $38.70	85% = $43.85
66575	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 4 specimens performed within any 1 day **Fee:** $60.45	**Benefit:** 75% = $45.35	85% = $51.40
66578	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 5 specimens performed within any 1 day **Fee:** $69.35	**Benefit:** 75% = $52.05	85% = $58.95
66581	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 6 or more specimens performed within any 1 day **Fee:** $78.25	**Benefit:** 75% = $58.70	85% = $66.55
66584	Quantitation of ionised calcium (except if performed as part of item 66566) - 1 test **Fee:** $9.70	**Benefit:** 75% = $7.30	85% = $8.25
66587	Urine acidification test for the diagnosis of renal tubular acidosis including the administration of an acid load, and pH measurements on 4 or more urine specimens and at least 1 blood specimen **Fee:** $47.55	**Benefit:** 75% = $35.70	85% = $40.45
66590	Calculus, analysis of 1 or more **Fee:** $30.60	**Benefit:** 75% = $22.95	85% = $26.05
66593	Ferritin - quantitation, except if requested as part of iron studies **Fee:** $18.00	**Benefit:** 75% = $13.50	85% = $15.30
66596	Iron studies, consisting of quantitation of: (a) serum iron; and (b) transferrin or iron binding capacity; and (c) ferritin **Fee:** $32.55	**Benefit:** 75% = $24.45	85% = $27.70
66605	Vitamins - quantitation of vitamins B1, B2, B3, B6 or C in blood, urine or other body fluid - 1 or more tests **Fee:** $30.60	**Benefit:** 75% = $22.95	85% = $26.05
66606	A test described in item 66605 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18 and 25) **Fee:** $30.60	**Benefit:** 75% = $22.95	85% = $26.05
66607	Vitamins - quantitation of vitamins A or E in blood, urine or other body fluid - 1 or more tests within a 6 month period **Fee:** $75.75	**Benefit:** 75% = $56.85	85% = $64.40
66610	A test described in item 66607 if rendered by a receiving APP - 1 or more tests **Fee:** $75.75	**Benefit:** 75% = $56.85	85% = $64.40

66623	All qualitative and quantitative tests on blood, urine or other body fluid for: (a) a drug or drugs of abuse (including illegal drugs and legally available drugs taken other than in appropriate dosage); or (b) ingested or absorbed toxic chemicals; including a service described in item 66800, 66803, 66806, 66812 or 66815 (if performed), but excluding: (c) the surveillance of sports people and athletes for performance improving substances; and (d) the monitoring of patients participating in a drug abuse treatment program **Fee:** $41.50 **Benefit:** 75% = $31.15 85% = $35.30
66626	Detection or quantitation or both (not including the detection of nicotine and metabolites in smoking withdrawal programs) of a drug, or drugs, of abuse or a therapeutic drug, on a sample collected from a patient participating in a drug abuse treatment program; but excluding the surveillance of sports people and athletes for performance improving substances; including all tests on blood, urine or other body fluid (Item is subject to rule 25) **Fee:** $24.10 **Benefit:** 75% = $18.10 85% = $20.50
66629	Beta-2-microglobulin - quantitation in serum, urine or other body fluids - 1 or more tests **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10
66632	Caeruloplasmin, haptoglobins, or prealbumin - quantitation in serum, urine or other body fluids - 1 or more tests **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10
66635	Alpha-1-antitrypsin - quantitation in serum, urine or other body fluid - 1 or more tests **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10
66638	Isoelectric focussing or similar methods for determination of alpha-1-antitrypsin phenotype in serum - 1 or more tests **Fee:** $49.05 **Benefit:** 75% = $36.80 85% = $41.70
66639	A test described in item 66638 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $29.20 **Benefit:** 75% = $21.90 85% = $24.85
66641	Electrophoresis of serum or other body fluid to demonstrate: (a) the isoenzymes of lactate dehydrogenase; or (b) the isoenzymes of alkaline phosphatase; including the preliminary quantitation of total relevant enzyme activity - 1 or more tests **Fee:** $29.20 **Benefit:** 75% = $21.90 85% = $24.85
66642	A test described in item 66641 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $29.20 **Benefit:** 75% = $21.90 85% = $24.85
66644	C-1 esterase inhibitor - quantitation **Fee:** $20.15 **Benefit:** 75% = $15.15 85% = $17.15
66647	C-1 esterase inhibitor - functional assay **Fee:** $45.10 **Benefit:** 75% = $33.85 85% = $38.35
66650	Alpha-fetoprotein, CA-15.3 antigen (CA15.3), CA-125 antigen (CA125), CA-19.9 antigen (CA19.9), cancer associated serum antigen (CASA), carcinoembryonic antigen (CEA), human chorionic gonadotrophin (HCG), neuron specific enolase (NSE), thyroglobulin in serum or other body fluid, in the monitoring of malignancy or in the detection or monitoring of hepatic tumours, gestational trophoblastic disease or germ cell tumour - quantitation - 1 test (Item is subject to rule 6) **Fee:** $24.35 **Benefit:** 75% = $18.30 85% = $20.70
66651	A test described in item 66650 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18) **Fee:** $24.35 **Benefit:** 75% = $18.30 85% = $20.70
66652	A test described in item 66650 if rendered by a receiving APP - other than that described in 66651, if rendered by a receiving APP, 1 test (Item is subject to rule 6 and 18) **Fee:** $20.30 **Benefit:** 75% = $15.25 85% = $17.30
66653	2 or more tests described in item 66650 (Item is subject to rule 6) **Fee:** $44.60 **Benefit:** 75% = $33.45 85% = $37.95

	Prostate specific antigen - quantitation - 1 of this item in a 12 month period (Item is subject to rule 25)		
66655	**Fee:** $20.15	**Benefit:** 75% = $15.15	85% = $17.15
	Prostate specific antigen - quantitation in the monitoring of previously diagnosed prostatic disease (including a test described in item 66655)		
66656	**Fee:** $20.15	**Benefit:** 75% = $15.15	85% = $17.15
	Prostate specific antigen - quantitation of 2 or more fractions of PSA and any derived index including (if performed) a test described in item 66656, in the follow up of a PSA result that lies at or above the age related median but below the age related, method specific 97.5% reference limit - 1 of this item in a 12 month period (Item is subject to rule 25)		
66659	**Fee:** $37.30	**Benefit:** 75% = $28.00	85% = $31.75
	Prostate specific antigen – quantitation of 2 or more fractions of PSA and any derived index including (if performed) a test described in item 66656, in the follow up of a PSA result that lies at or above the age related, method specific 97.5% reference limit, but below a value of 10 ug/L – 4 of this item in a 12 month period. (Item is subject to rule 25)		
66660	**Fee:** $37.30	**Benefit:** 75% = $28.00	85% = $31.75
	Quantitation of hormone receptors on proven primary breast or ovarian carcinoma or a metastasis from a breast or ovarian carcinoma or a subsequent lesion in the breast - 1 or more tests		
66662	**Fee:** $79.95	**Benefit:** 75% = $60.00	85% = $68.00
	A test described in item 66662 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)		
66663	**Fee:** $79.95	**Benefit:** 75% = $60.00	85% = $68.00
	Lead quantitation in blood or urine (other than for occupational health screening purposes) to a maximum of 3 tests in a 6 month period - each test		
66665	**Fee:** $30.60	**Benefit:** 75% = $22.95	85% = $26.05
	A test described in item 66665 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)		
66666	**Fee:** $30.60	**Benefit:** 75% = $22.95	85% = $26.05
	Quantitation of serum zinc in a patient receiving intravenous alimentation - each test		
66667	**Fee:** $30.60	**Benefit:** 75% = $22.95	85% = $26.05
	Quantitation of serum aluminium in a patient in a renal dialysis program - each test		
66671	**Fee:** $36.90	**Benefit:** 75% = $27.70	85% = $31.40
	Quantitation of: (a) faecal fat; or (b) breath hydrogen in response to loading with disaccharides; 1 or more tests within a 28 day period		
66674	**Fee:** $39.95	**Benefit:** 75% = $30.00	85% = $34.00
	Test for tryptic activity in faeces in the investigation of diarrhoea of longer than 4 weeks duration in children under 6 years old		
66677	**Fee:** $11.15	**Benefit:** 75% = $8.40	85% = $9.50
	Quantitation of disaccharidases and other enzymes in intestinal tissue - 1 or more tests		
66680	**Fee:** $74.45	**Benefit:** 75% = $55.85	85% = $63.30
	Enzymes - quantitation in solid tissue or tissues other than blood elements or intestinal tissue - 1 or more tests		
66683	**Fee:** $74.45	**Benefit:** 75% = $55.85	85% = $63.30
	Performance of 1 or more of the following procedures: (a) growth hormone suppression by glucose loading; (b) growth hormone stimulation by exercise; (c) dexamethasone suppression test; (d) sweat collection by iontophoresis for chloride analysis; (e) pharmacological stimulation of growth hormone		
66686	**Fee:** $50.65	**Benefit:** 75% = $38.00	85% = $43.10

66695	Quantitation in blood or urine of hormones and hormone binding proteins - ACTH, aldosterone, androstenedione, C-peptide, calcitonin, cortisol, DHEAS, 11-deoxycortisol, dihydrotestosterone, FSH, gastrin, glucagon, growth hormone, hydroxyprogesterone, insulin, LH, oestradiol, oestrone, progesterone, prolactin, PTH, renin, sex hormone binding globulin, somatomedin C(IGF-1), free or total testosterone, urine steroid fraction or fractions, vasoactive intestinal peptide, - 1 test (Item is subject to rule 6) **Fee:** $30.50	**Benefit:** 75% = $22.90	85% = $25.95
66696	A test described in item 66695, if rendered by a receiving APP - where no tests in the item have been rendered by the referring APP (Item is subject to rule 6 and 18) **Fee:** $30.50	**Benefit:** 75% = $22.90	85% = $25.95
66697	Tests described in item 66695, other than that described in 66696, if rendered by a receiving APP - each test to a maximum of 4 tests (Item is subject to rule 6 and 18) **Fee:** $13.20	**Benefit:** 75% = $9.90	85% = $11.25
66698	2 tests described in item 66695 (Item is subject to rule 6) **Fee:** $43.70	**Benefit:** 75% = $32.80	85% = $37.15
66701	3 tests described in item 66695 (Item is subject to rule 6) **Fee:** $56.90	**Benefit:** 75% = $42.70	85% = $48.40
66704	4 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 tests specified on the request form or performs 4 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $70.15	**Benefit:** 75% = $52.65	85% = $59.65
66707	5 or more tests described in item 66695 (Item is subject to rule 6) **Fee:** $83.35	**Benefit:** 75% = $62.55	85% = $70.85
66711	Quantitation in saliva of cortisol in: (a) the investigation of Cushing's syndrome; or (b) the management of children with congenital adrenal hyperplasia (Item is subject to rule 6) **Fee:** $30.15	**Benefit:** 75% = $22.65	85% = $25.65
66712	Two tests described in item 66711 (Item is subject to rule 6) **Fee:** $43.05	**Benefit:** 75% = $32.30	85% = $36.60
66714	A test described in item 66711, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP (Item is subject to rule 6 and 18) **Fee:** $30.15	**Benefit:** 75% = $22.65	85% = $25.65
66715	Tests described in item 66711, other than that described in 66714, if rendered by a receiving APP, each test to a maximum of 1 test (Item is subject to rule 6 and 18) **Fee:** $12.85	**Benefit:** 75% = $9.65	85% = $10.95
66716	TSH quantitation **Fee:** $25.05	**Benefit:** 75% = $18.80	85% = $21.30

66719	Thyroid function tests (comprising the service described in item 66716 and 1 or more of the following tests - free thyroxine, free T3, for a patient, if at least 1 of the following conditions is satisfied: (a) the patient has an abnormal level of TSH; (b) the tests are performed: (i) for the purpose of monitoring thyroid disease in the patient; or (ii) to investigate the sick euthyroid syndrome if the patient is an admitted patient; or (iii) to investigate dementia or psychiatric illness of the patient; or (iv) to investigate amenorrhoea or infertility of the patient; (c) the medical practitioner who requested the tests suspects the patient has a pituitary dysfunction; (d) the patient is on drugs that interfere with thyroid hormone metabolism or function (Item is subject to rule 9) **Fee:** $34.80 **Benefit:** 75% = $26.10 85% = $29.60
66722	TSH quantitation described in item 66716 and 1 test described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $37.90 **Benefit:** 75% = $28.45 85% = $32.25
66723	Tests described in item 66722, that is, TSH quantitation and 1 test described in 66695, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18) **Fee:** $37.90 **Benefit:** 75% = $28.45 85% = $32.25
66724	Tests described in item 66722, if rendered by a receiving APP, other than that described in 66723. It is to include a quantitation of TSH - each test to a maximum of 4 tests described in item 66695 (Item is subject to rule 6 and 18) **Fee:** $13.15 **Benefit:** 75% = $9.90 85% = $11.20
66725	TSH quantitation described in item 66716 and 2 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 tests specified on the request form or performs 3 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $51.05 **Benefit:** 75% = $38.30 85% = $43.40
66728	TSH quantitation described in item 66716 and 3 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 tests specified on the request form or performs 4 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $64.20 **Benefit:** 75% = $48.15 85% = $54.60
66731	TSH quantitation described in item 66716 and 4 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 tests specified on the request form or performs 5 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $77.40 **Benefit:** 75% = $58.05 85% = $65.80
66734	TSH quantitation described in item 66716 and 5 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 6 or more tests specified on the request form) (Item is subject to rule 6) **Fee:** $90.55 **Benefit:** 75% = $67.95 85% = $77.00
66743	Quantitation of alpha-fetoprotein in serum or other body fluids during pregnancy except if requested as part of items 66750 or 66751 **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10
66749	Amniotic fluid, spectrophotometric examination of, and quantitation of: (a) lecithin/sphingomyelin ratio; or (b) palmitic acid, phosphatidylglycerol or lamellar body phospholipid; or (c) bilirubin, including correction for haemoglobin 1 or more tests **Fee:** $32.95 **Benefit:** 75% = $24.75 85% = $28.05

66750	Quantitation, in pregnancy, of any two of the following - total human chorionic gonadotrophin (total HCG), free alpha human chorionic gonadotrophin (free alpha HCG), free beta human chorionic gonadotrophin (free beta HCG), pregnancy associated plasma protein A (PAPP-A), unconjugated oestriol (uE_3), alpha-fetoprotein (AFP) - to detect foetal abnormality, including a service described in 1 or more of items 73527 and 73529 (if performed) - (Item is subject to rule 25) **Fee:** $39.75 **Benefit:** 75% = $29.85 85% = $33.80
66751	Quantitation, in pregnancy, of any three or more tests described in 66750 (Item is subject to rule 25) **Fee:** $55.25 **Benefit:** 75% = $41.45 85% = $47.00
66752	Quantitation of acetoacetate, beta-hydroxybutyrate, citrate, oxalate, total free fatty acids, cysteine, homocysteine, cystine, lactate, pyruvate or other amino acids and hydroxyproline (except if performed as part of item 66773 or 66776) - 1 test **Fee:** $24.70 **Benefit:** 75% = $18.55 85% = $21.00
66755	2 or more tests described in item 66752 **Fee:** $38.85 **Benefit:** 75% = $29.15 85% = $33.05
66756	Quantitation of 10 or more amino acids for the diagnosis of inborn errors of metabolism - up to 4 tests in a 12 month period on specimens of plasma, CSF and urine. **Fee:** $98.30 **Benefit:** 75% = $73.75 85% = $83.60
66757	Quantitation of 10 or more amino acids for monitoring of previously diagnosed inborn errors of metabolism in 1 tissue type. **Fee:** $98.30 **Benefit:** 75% = $73.75 85% = $83.60
66758	Quantitation of angiotensin converting enzyme, or cholinesterase - 1 or more tests **Fee:** $24.70 **Benefit:** 75% = $18.55 85% = $21.00
66761	Test for reducing substances in faeces by any method (except reagent strip or dipstick) **Fee:** $13.15 **Benefit:** 75% = $9.90 85% = $11.20
66764	Examination for faecal occult blood (including tests for haemoglobin and its derivatives in the faeces except by reagent strip or dip stick methods) with a maximum of 3 examinations on specimens collected on separate days in a 28 day period **Fee:** $8.90 **Benefit:** 75% = $6.70 85% = $7.60
66767	2 examinations described in item 66764 performed on separately collected and identified specimens **Fee:** $17.85 **Benefit:** 75% = $13.40 85% = $15.20
66770	3 examinations described in item 66764 performed on separately collected and identified specimens **Fee:** $26.70 **Benefit:** 75% = $20.05 85% = $22.70
66773	Quantitation of products of collagen breakdown or formation for the monitoring of patients with proven low bone mineral density, and if performed, a service described in item 66752 - 1 or more tests *(Low bone densitometry is defined in the explanatory notes to Category 2 - Diagnostic Procedures and Investigations of the Medicare Benefits Schedule)* **Fee:** $24.65 **Benefit:** 75% = $18.50 85% = $21.00
66776	Quantitation of products of collagen breakdown or formation for the monitoring of patients with metabolic bone disease or Paget's disease of bone, and if performed, a service described in item 66752 - 1 or more tests **Fee:** $24.65 **Benefit:** 75% = $18.50 85% = $21.00
66779	Adrenaline, noradrenaline, dopamine, histamine, hydroxyindoleacetic acid (5HIAA), hydroxymethoxymandelic acid (HMMA), homovanillic acid (HVA), metanephrines, methoxyhydroxyphenylethylene glycol (MHPG), phenylacetic acid (PAA) or serotonin quantitation - 1 or more tests **Fee:** $39.95 **Benefit:** 75% = $30.00 85% = $34.00
66780	A test described in item 66779 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $39.95 **Benefit:** 75% = $30.00 85% = $34.00
66782	Porphyrins or porphyrins precursors - detection in plasma, red cells, urine or faeces - 1 or more tests **Fee:** $13.15 **Benefit:** 75% = $9.90 85% = $11.20
66783	A test described in item 66782 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $13.15 **Benefit:** 75% = $9.90 85% = $11.20

	Porphyrins or porphyrins precursors - quantitation in plasma, red cells, urine or faeces - 1 test (Item is subject to rule 6)		
66785	**Fee:** $39.95	**Benefit:** 75% = $30.00	85% = $34.00
	Porphyrins or porphyrins precursors - quantitation in plasma, red cells, urine or faeces - 2 or more tests (Item is subject to rule 6)		
66788	**Fee:** $65.85	**Benefit:** 75% = $49.40	85% = $56.00
	A test described in item 66785 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18)		
66789	**Fee:** $39.95	**Benefit:** 75% = $30.00	85% = $34.00
	A test described in item 66785 other than that described in 66789, if rendered by a receiving APP - to a maximum of 1 test (Item is subject to rule 6 and 18)		
66790	**Fee:** $25.90	**Benefit:** 75% = $19.45	85% = $22.05
	Porphyrin biosynthetic enzymes - measurement of activity in blood cells or other tissues - 1 or more tests		
66791	**Fee:** $74.45	**Benefit:** 75% = $55.85	85% = $63.30
	A test described in item 66791 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)		
66792	**Fee:** $74.45	**Benefit:** 75% = $55.85	85% = $63.30
	Quantitation in blood, urine or other body fluid by any method (except reagent tablet or reagent strip) of any of the following being used therapeutically by the patient from whom the specimen was taken: amikacin, carbamazepine, digoxin, disopyramide, ethanol, ethosuximide, gentamicin, lithium, lignocaine, netilmicin, paracetamol, phenobarbitone, primidone, phenytoin, procainamide, quinidine, salicylate, theophylline, tobramycin, valproate or vancomycin - 1 test (Item to be subject to rule 6) *(See para P16.6 of explanatory notes to this Category)*		
66800	**Fee:** $18.15	**Benefit:** 75% = $13.65	85% = $15.45
	2 tests described in item 66800 (Item is subject to rule 6)		
66803	**Fee:** $30.50	**Benefit:** 75% = $22.90	85% = $25.95
	A test described in item 66800 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18)		
66804	**Fee:** $18.15	**Benefit:** 75% = $13.65	85% = $15.45
	A test described in item 66800 other than that described in 66804, if rendered by a receiving APP - each test to a maximum of 2 tests (Item is subject to rule 6 and 18)		
66805	**Fee:** $12.35	**Benefit:** 75% = $9.30	85% = $10.50
	3 tests described in item 66800 (Item is subject to rule 6)		
66806	**Fee:** $41.85	**Benefit:** 75% = $31.40	85% = $35.60
	Quantitation, not elsewhere described in this Table by any method or methods, in blood, urine or other body fluid, of a drug being used therapeutically by the patient from whom the specimen was taken - 1 test (This fee applies where 1 laboratory performs the only test specified on the request form or performs 1 test and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) *(See para P16.6 of explanatory notes to this Category)*		
66812	**Fee:** $34.80	**Benefit:** 75% = $26.10	85% = $29.60
	2 tests described in item 66812 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)		
66815	**Fee:** $59.55	**Benefit:** 75% = $44.70	85% = $50.65

66816	A test described in item 66812 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18) **Fee:** $34.80	**Benefit:** 75% = $26.10	85% = $29.60
66817	A test described in item 66812, other than that described in 66816, if rendered by a receiving APP - to a maximum of 1 test (Item is subject to rule 6 and 18) **Fee:** $24.75	**Benefit:** 75% = $18.60	85% = $21.05
66819	Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid - 1 test. (Item is subject to rule 6, 22 and 25) **Fee:** $30.60	**Benefit:** 75% = $22.95	85% = $26.05
66820	A test described in item 66819 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6, 18, 22 and 25) **Fee:** $30.60	**Benefit:** 75% = $22.95	85% = $26.05
66821	A test described in item 66819 other than that described in 66820 if rendered by a receiving APP to a maximum of 1 test (Item is subject to rule 6, 18, 22 and 25) **Fee:** $21.80	**Benefit:** 75% = $16.35	85% = $18.55
66822	Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid - 2 or more tests. (Item is subject to rule 6, 22 and 25) **Fee:** $52.45	**Benefit:** 75% = $39.35	85% = $44.60
66825	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 1 test. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 6, 22 and 25) **Fee:** $30.60	**Benefit:** 75% = $22.95	85% = $26.05
66826	A test described in item 66825 if rendered by a receiving APP where no tests have been rendered by the referring APP - 1 test (Item is subject to rules 6, 18, 22 and 25) **Fee:** $30.60	**Benefit:** 75% = $22.95	85% = $26.05
66827	A test described in item 66825, other than that described in 66826, if rendered by a receiving APP to a maximum of 1 test (Item is subject to rules 6, 18, 22 and 25) **Fee:** $21.80	**Benefit:** 75% = $16.35	85% = $18.55
66828	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 2 or more tests. To a maximum of 3 of this item in a 6 month period (Item is subject to rule 6, 22 and 25) **Fee:** $52.45	**Benefit:** 75% = $39.35	85% = $44.60
66830	Quantitation of BNP or NT-proBNP for the diagnosis of heart failure in patients presenting with dyspnoea to a hospital Emergency Department (Item is subject to rule 25) **Fee:** $58.50	**Benefit:** 75% = $43.90	85% = $49.75
66831	Quantitation of copper or iron in liver tissue biopsy **Fee:** $30.95	**Benefit:** 75% = $23.25	85% = $26.35
66832	A test described in item 66831 if rendered by a receiving APP (Item is subject to rule 18A and 22) **Fee:** $30.95	**Benefit:** 75% = $23.25	85% = $26.35

66833	25-hydroxyvitamin D, quantification in serum, for the investigation of a patient who: (a) has signs or symptoms of osteoporosis or osteomalacia; or (b) has increased alkaline phosphatase and otherwise normal liver function tests; or (c) has hyperparathyroidism, hypo- or hypercalcaemia, or hypophosphataemia; or (d) is suffering from malabsorption (for example, because the patient has cystic fibrosis, short bowel syndrome, inflammatory bowel disease or untreated coeliac disease, or has had bariatric surgery); or (e) has deeply pigmented skin, or chronic and severe lack of sun exposure for cultural, medical, occupational or residential reasons; or (f) is taking medication known to decrease 25OH-D levels (for example, anticonvulsants); or (g) has chronic renal failure or is a renal transplant recipient; or (h) is less than 16 years of age and has signs or symptoms of rickets; or (i) is an infant whose mother has established vitamin D deficiency; or (j) is a exclusively breastfed baby and has at least one other risk factor mentioned in a paragraph in this item; or (k) has a sibling who is less than 16 years of age and has vitamin D deficiency **Fee:** $30.05 **Benefit:** 75% = $22.55 85% = $25.55
66834	A test described in item 66833 if rendered by a receiving APP (Item is subject to Rule 18) **Fee:** $30.05 **Benefit:** 75% = $22.55 85% = $25.55
66835	1, 25-dihydroxyvitamin D - quantification in serum, if the request for the test is made by, or on advice of, the specialist or consultant physician managing the treatment of the patient **Fee:** $39.05 **Benefit:** 75% = $29.30 85% = $33.20
66836	1, 25-dihydroxyvitamin D—quantification in serum, if: (a) the patient has hypercalcaemia; and (b) the request for the test is made by a general practitioner managing the treatment of the patient **Fee:** $39.05 **Benefit:** 75% = $29.30 85% = $33.20
66837	A test described in item 66835 or 66836 if rendered by a receiving APP (Item is subject to Rule 18) **Fee:** $39.05 **Benefit:** 75% = $29.30 85% = $33.20
66838	Serum vitamin B12 test (Item is subject to Rule 25) **Fee:** $23.60 **Benefit:** 75% = $17.70 85% = $20.10
66839	Quantification of vitamin B12 markers such as holoTranscobalamin or methylmalonic acid, where initial serum vitamin B12 result is low or equivocal **Fee:** $42.95 **Benefit:** 75% = $32.25 85% = $36.55
66840	Serum folate test and, if required, red cell folate test for a patient at risk of folate deficiency, including patients with malabsorption conditions, macrocytic anaemia or coeliac disease **Fee:** $23.60 **Benefit:** 75% = $17.70 85% = $20.10
66841	Quantitation of HbA1c (glycated haemoglobin) performed for the diagnosis of diabetes in asymptomatic patients at high risk. (Item is subject to rule 25) **Fee:** $16.80 **Benefit:** 75% = $12.60 85% = $14.30
66900	CARBON-LABELLED UREA BREATH TEST using oral C-13 or C-14 urea, including the measurement of exhaled 13CO2 or 14CO2 (except if item 12533 applies) for either:- (a) the confirmation of *Helicobacter pylori* colonisation OR (b) the monitoring of the success of eradication of *Helicobacter pylori.* **Fee:** $77.65 **Benefit:** 75% = $58.25 85% = $66.05

GROUP P3 - MICROBIOLOGY

69300	Microscopy of wet film material other than blood, from 1 or more sites, obtained directly from a patient (not cultures) including: (a) differential cell count (if performed); or (b) examination for dermatophytes; or (c) dark ground illumination; or (d) stained preparation or preparations using any relevant stain or stains; 1 or more tests **Fee:** $12.50 **Benefit:** 75% = $9.40 85% = $10.65
69303	Culture and (if performed) microscopy to detect pathogenic micro-organisms from nasal swabs, throat swabs, eye swabs and ear swabs (excluding swabs taken for epidemiological surveillance), including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in item 69300; specimens from 1 or more sites **Fee:** $22.00 **Benefit:** 75% = $16.50 85% = $18.70
69306	Microscopy and culture to detect pathogenic micro-organisms from skin or other superficial sites, including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in items 69300, 69303, 69312, 69318; 1 or more tests on 1 or more specimens **Fee:** $33.75 **Benefit:** 75% = $25.35 85% = $28.70
69309	Microscopy and culture to detect dermatophytes and other fungi causing cutaneous disease from skin scrapings, skin biopsies, hair and nails (excluding swab specimens) and including (if performed): (a) the detection of antigens not elsewhere specified in this Table; or (b) a service described in items 69300, 69303, 69306, 69312, 69318; 1 or more tests on 1 or more specimens **Fee:** $48.15 **Benefit:** 75% = $36.15 85% = $40.95
69312	Microscopy and culture to detect pathogenic micro-organisms from urethra, vagina, cervix or rectum (except for faecal pathogens), including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in items 69300, 69303, 69306 and 69318; 1 or more tests on 1 or more specimens **Fee:** $33.75 **Benefit:** 75% = $25.35 85% = $28.70
69316	Detection of Chlamydia trachomatis by any method - 1 test (Item is subject to rule 26) **Fee:** $28.65 **Benefit:** 75% = $21.50 85% = $24.40
69317	1 test described in item 69494 and a test described in 69316. (Item is subject to rule 26) **Fee:** $35.85 **Benefit:** 75% = $26.90 85% = $30.50
69318	Microscopy and culture to detect pathogenic micro-organisms from specimens of sputum (except when part of items 69324, 69327 and 69330), including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in items 69300, 69303, 69306 and 69312; 1 or more tests on 1 or more specimens **Fee:** $33.75 **Benefit:** 75% = $25.35 85% = $28.70
69319	2 tests described in item 69494 and a test described in 69316. (Item is subject to rule 26) **Fee:** $42.95 **Benefit:** 75% = $32.25 85% = $36.55
69321	Microscopy and culture of post-operative wounds, aspirates of body cavities, synovial fluid, CSF or operative or biopsy specimens, for the presence of pathogenic micro-organisms involving aerobic and anaerobic cultures and the use of different culture media, and including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) a service described in item 69300, 69303, 69306, 69312 or 69318; specimens from 1 or more sites **Fee:** $48.15 **Benefit:** 75% = $36.15 85% = $40.95
69324	Microscopy (with appropriate stains) and culture for mycobacteria - 1 specimen of sputum, urine, or other body fluid or 1 operative or biopsy specimen, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300 **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55

69325	A test described in item 69324 if rendered by a receiving APP (Item is subject to rule 18) **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55
69327	Microscopy (with appropriate stains) and culture for mycobacteria - 2 specimens of sputum, urine, or other body fluid or 2 operative or biopsy specimens, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300 **Fee:** $85.00 **Benefit:** 75% = $63.75 85% = $72.25
69328	A test described in item 69327 if rendered by a receiving APP (Item is subject to rule 18) **Fee:** $85.00 **Benefit:** 75% = $63.75 85% = $72.25
69330	Microscopy (with appropriate stains) and culture for mycobacteria - 3 specimens of sputum, urine, or other body fluid or 3 operative or biopsy specimens, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300 **Fee:** $128.00 **Benefit:** 75% = $96.00 85% = $108.80
69331	A test described in item 69330 if rendered by a receiving APP (Item is subject to rule 18) **Fee:** $128.00 **Benefit:** 75% = $96.00 85% = $108.80
69333	Urine examination (including serial examination) by any means other than simple culture by dip slide, including: (a) cell count; and (b) culture; and (c) colony count; and (d) (if performed) stained preparations; and (e) (if performed) identification of cultured pathogens; and (f) (if performed) antibiotic susceptibility testing; and (g) (if performed) examination for pH, specific gravity, blood, protein, urobilinogen, sugar, acetone or bile salts **Fee:** $20.55 **Benefit:** 75% = $15.45 85% = $17.50
69336	Microscopy of faeces for ova, cysts and parasites that must include a concentration technique, and the use of fixed stains or antigen detection for cryptosporidia and giardia - including (if performed) a service mentioned in item 69300 - 1 of this item in any 7 day period **Fee:** $33.45 **Benefit:** 75% = $25.10 85% = $28.45
69339	Microscopy of faeces for ova, cysts and parasites using concentration techniques examined subsequent to item 69336 on a separately collected and identified specimen collected within 7 days of the examination described in 69336 - 1 examination in any 7 day period **Fee:** $19.10 **Benefit:** 75% = $14.35 85% = $16.25
69345	Culture and (if performed) microscopy without concentration techniques of faeces for faecal pathogens, using at least 2 selective or enrichment media and culture in at least 2 different atmospheres including (if performed): (a) pathogen identification and antibiotic susceptibility testing; and (b) the detection of clostridial toxins; and (c) a service described in item 69300; - 1 examination in any 7 day period **Fee:** $52.90 **Benefit:** 75% = $39.70 85% = $45.00
69354	Blood culture for pathogenic micro-organisms (other than viruses), including sub-cultures and (if performed): (a) identification of any cultured pathogen; and (b) necessary antibiotic susceptibility testing; to a maximum of 3 sets of cultures - 1 set of cultures **Fee:** $30.75 **Benefit:** 75% = $23.10 85% = $26.15
69357	2 sets of cultures described in item 69354 **Fee:** $61.45 **Benefit:** 75% = $46.10 85% = $52.25
69360	3 sets of cultures described in item 69354 **Fee:** $92.20 **Benefit:** 75% = $69.15 85% = $78.40

69363	Detection of *Clostridium difficile* or *Clostridium difficile* toxin (except if a service described in item 69345 has been performed) - one or more tests **Fee:** $28.65	**Benefit:** 75% = $21.50	85% = $24.40
69378	Quantitation of HIV viral RNA load in plasma or serum in the monitoring of a HIV sero-positive patient not on antiretroviral therapy - 1 or more tests **Fee:** $180.25	**Benefit:** 75% = $135.20	85% = $153.25
69379	A test described in item 69378 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $180.25	**Benefit:** 75% = $135.20	85% = $153.25
69380	Genotypic testing for HIV antiretroviral resistance in a patient with confirmed HIV infection if the patient's viral load is greater than 1,000 copies per ml at any of the following times: o at presentation; or o before antiretroviral therapy: or o when treatment with combination antiretroviral agents fails; maximum of 2 tests in a 12 month period **Fee:** $770.30	**Benefit:** 75% = $577.75	85% = $690.80
69381	Quantitation of HIV viral RNA load in plasma or serum in the monitoring of antiretroviral therapy in a HIV sero-positive patient - 1 or more tests on 1 or more specimens **Fee:** $180.25	**Benefit:** 75% = $135.20	85% = $153.25
69382	Quantitation of HIV viral RNA load in cerebrospinal fluid in a HIV sero-positive patient - 1 or more tests on 1 or more specimens **Fee:** $180.25	**Benefit:** 75% = $135.20	85% = $153.25
69383	A test described in item 69381 if rendered by a receiving APP - 1 or more tests on 1 or more specimens (Item is subject to rule 18) **Fee:** $180.25	**Benefit:** 75% = $135.20	85% = $153.25
69384	Quantitation of 1 antibody to microbial antigens not elsewhere described in the Schedule - 1 test (This fee applies where a laboratory performs the only antibody test specified on the request form or performs 1 test and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) *(See para P16.7 of explanatory notes to this Category)* **Fee:** $15.65	**Benefit:** 75% = $11.75	85% = $13.35
69387	2 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 estimations specified on the request form or performs 2 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) *(See para P16.7 of explanatory notes to this Category)* **Fee:** $29.00	**Benefit:** 75% = $21.75	85% = $24.65
69390	3 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 estimations specified on the request form or performs 3 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) *(See para P16.7 of explanatory notes to this Category)* **Fee:** $42.35	**Benefit:** 75% = $31.80	85% = $36.00
69393	4 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 estimations specified on the request form or performs 4 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) *(See para P16.7 of explanatory notes to this Category)* **Fee:** $55.70	**Benefit:** 75% = $41.80	85% = $47.35

	5 or more tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 estimations specified on the request form or performs 5 of the antibody tests specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) *(See para P16.7 of explanatory notes to this Category)*
69396	**Fee:** $69.10 **Benefit:** 75% = $51.85 85% = $58.75
	A test described in item 69384, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rules 6 and 18)
69400	**Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35
	A test described in item 69384, other than that described in 69400, if rendered by a receiving APP - each test to a maximum of 4 tests (Item is subject to rule 6, 18 and 18A)
69401	**Fee:** $13.35 **Benefit:** 75% = $10.05 85% = $11.35
	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 1 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 *(See para P16.7 of explanatory notes to this Category)*
69405	**Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35
	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 2 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 *(See para P16.7 of explanatory notes to this Category)*
69408	**Fee:** $29.00 **Benefit:** 75% = $21.75 85% = $24.65
	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 3 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 *(See para P16.7 of explanatory notes to this Category)*
69411	**Fee:** $42.35 **Benefit:** 75% = $31.80 85% = $36.00
	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of 4 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 *(See para P16.7 of explanatory notes to this Category)*
69413	**Fee:** $55.70 **Benefit:** 75% = $41.80 85% = $47.35
	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including: (a) the determination of all 5 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitus B, Hepatitus C antibody, HIV antibody and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481 *(See para P16.7 of explanatory notes to this Category)*
69415	**Fee:** $69.10 **Benefit:** 75% = $51.85 85% = $58.75
	A test for high risk human papillomaviruses (HPV) in a patient who: - has received excisional or ablative treatment for high grade squamous intraepithelial lesions (HSIL) of the cervix within the last two years; or - who within the last two years has had a positive HPV test after excisional or ablative treatment for HSIL of the cervix; or - is already undergoing annual cytological review for the follow-up of a previously treated HSIL. - to a maximum of 2 of this item in a 24 month period (Item is subject to rule 25)
69418	**Fee:** $63.55 **Benefit:** 75% = $47.70 85% = $54.05

69419	A test described in item 69418 if rendered by a receiving APP - 1 test (Item is subject to rule 18 and 25) **Fee:** $63.55 **Benefit:** 75% = $47.70 85% = $54.05
69445	Detection of Hepatitis C viral RNA in a patient undertaking antiviral therapy for chronic HCV hepatitis (including a service described in item 69499) - 1 test. To a maximum of 4 of this item in a 12 month period (Item is subject to rule 25) **Fee:** $92.20 **Benefit:** 75% = $69.15 85% = $78.40
69451	A test described in item 69445 if rendered by a receiving APP - 1 test. (Item is subject to rule 18 and 25) **Fee:** $92.20 **Benefit:** 75% = $69.15 85% = $78.40
69471	Test of cell-mediated immunity in blood for the detection of latent tuberculosis in an immunosuppressed or immunocompromised patient - 1 test **Fee:** $34.90 **Benefit:** 75% = $26.20 85% = $29.70
69472	Detection of antibodies to Epstein Barr Virus using specific serology - 1 test **Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35
69474	Detection of antibodies to Epstein Barr Virus using specific serology - 2 or more tests **Fee:** $28.65 **Benefit:** 75% = $21.50 85% = $24.40
69475	One test for hepatitis antigen or antibodies to determine immune status or viral carriage following exposure or vaccination to Hepatitis A, Hepatitis B, Hepatitis C or Hepatitis D (Item subject to rule 11) **Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35
69478	2 tests described in 69475 (Item subject to rule 11) **Fee:** $29.25 **Benefit:** 75% = $21.95 85% = $24.90
69481	Investigation of infectious causes of acute or chronic hepatitis - 3 tests for hepatitis antibodies or antigens, (Item subject to rule 11) *(See para P16.8 of explanatory notes to this Category)* **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50
69482	Quantitation of Hepatitis B viral DNA in patients who are Hepatitis B surface antigen positive and have chronic hepatitis B, but are not receiving antiviral therapy - 1 test (Item is subject to rule 25) **Fee:** $152.10 **Benefit:** 75% = $114.10 85% = $129.30
69483	Quantitation of Hepatitis B viral DNA in patients who are Hepatitis B surface antigen positive and who have chronic hepatitis B and are receiving antiviral therapy - 1 test (Item is subject to rule 25) **Fee:** $152.10 **Benefit:** 75% = $114.10 85% = $129.30
69484	Supplementary testing for Hepatitis B surface antigen or Hepatitis C antibody using a different assay on the specimen which yielded a reactive result on initial testing (Item is subject to rule 18) **Fee:** $17.10 **Benefit:** 75% = $12.85 85% = $14.55
69488	Quantitation of HCV RNA load in plasma or serum in the pretreatment evaluation or the assessment of efficacy of antiviral therapy of a patient with chronic HCV hepatitis - where any request for the test is made by or on the advice of the specialist or consultant physician who manages the treatment of the patient with chronic HCV hepatitis (including a service in item 69499 or 69445) (Item is subject to rule 18 and 25) **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25
69489	A test described in item 69488 if rendered by a receiving APP (Item is subject to rule 18 and 25) **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25

69491	Nucleic acid amplification and determination of Hepatitis C virus (HCV) genotype if: (a) the patient is HCV RNA positive and is being evaluated for antiviral therapy of chronic HCV hepatitis; and (b) the request for the test is made by, or on the advice of, the specialist or consultant physician managing the treatment of the patient; To a maximum of 1 of this item in a 12 month period **Fee:** $204.80	**Benefit:** 75% = $153.60	85% = $174.10
69492	A test described in item 69491 if rendered by a receiving APP - 1 test (Item is subject to rule 18 and 25) **Fee:** $204.80	**Benefit:** 75% = $153.60	85% = $174.10
69494	Detection of a virus or microbial antigen or microbial nucleic acid (not elsewhere specified) 1 test (Item is subject to rule 6 and 26) **Fee:** $28.65	**Benefit:** 75% = $21.50	85% = $24.40
69495	2 tests described in 69494 (Item is subject to rule 6 and 26) **Fee:** $35.85	**Benefit:** 75% = $26.90	85% = $30.50
69496	3 or more tests described in 69494 (Item is subject to rule 6 and 26) **Fee:** $43.05	**Benefit:** 75% = $32.30	85% = $36.60
69497	A test described in item 69494, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6, 18 and 26) **Fee:** $28.65	**Benefit:** 75% = $21.50	85% = $24.40
69498	A test described in item 69494, other than that described in 69497, if rendered by a receiving APP - each test to a maximum of 2 tests (Item is subject to rule 6, 18 and 26) **Fee:** $7.20	**Benefit:** 75% = $5.40	85% = $6.15
69499	Detection of Hepatitis C viral RNA if at least 1 of the following criteria is satisfied: (a) the patient is Hepatitis C seropositive; (b) the patient's serological status is uncertain after testing; (c) the test is performed for the purpose of: (i) determining the Hepatitis C status of an immunosuppressed or immunocompromised patient; or (ii) the detection of acute Hepatitis C prior to seroconversion where considered necessary for the clinical management of the patient; To a maximum of 1 of this item in a 12 month period (Item is subject to rule 19 and 25) **Fee:** $92.20	**Benefit:** 75% = $69.15	85% = $78.40
69500	A test described in item 69499 if rendered by a receiving APP – 1 test (Item is subject to rule 18,19 and 25) **Fee:** $92.20	**Benefit:** 75% = $69.15	85% = $78.40

GROUP P4 - IMMUNOLOGY

71057	Electrophoresis, quantitative and qualitative, of serum, urine or other body fluid all collected within a 28 day period, to demonstrate: (a) protein classes; or (b) presence and amount of paraprotein; including the preliminary quantitation of total protein, albumin and globulin - 1 specimen type **Fee:** $32.90	**Benefit:** 75% = $24.70	85% = $28.00
71058	Examination as described in item 71057 of 2 or more specimen types **Fee:** $50.50	**Benefit:** 75% = $37.90	85% = $42.95
71059	Immunofixation or immunoelectrophoresis or isoelectric focusing of: (a) urine for detection of Bence Jones proteins; or (b) serum, plasma or other body fluid; and characterisation of a paraprotein or cryoglobulin - examination of 1 specimen type (eg. serum, urine or CSF) **Fee:** $35.65	**Benefit:** 75% = $26.75	85% = $30.35
71060	Examination as described in item 71059 of 2 or more specimen types **Fee:** $44.05	**Benefit:** 75% = $33.05	85% = $37.45
71062	Electrophoresis and immunofixation or immunoelectrophoresis or isoelectric focussing of CSF for the detection of oligoclonal bands and including if required electrophoresis of the patient's serum for comparison purposes - 1 or more tests **Fee:** $44.05	**Benefit:** 75% = $33.05	85% = $37.45
71064	Detection and quantitation of cryoglobulins or cryofibrinogen - 1 or more tests **Fee:** $20.75	**Benefit:** 75% = $15.60	85% = $17.65
71066	Quantitation of total immunoglobulin A by any method in serum, urine or other body fluid - 1 test **Fee:** $14.55	**Benefit:** 75% = $10.95	85% = $12.40
71068	Quantitation of total immunoglobulin G by any method in serum, urine or other body fluid - 1 test **Fee:** $14.55	**Benefit:** 75% = $10.95	85% = $12.40
71069	2 tests described in items 71066, 71068, 71072 or 71074 **Fee:** $22.75	**Benefit:** 75% = $17.10	85% = $19.35
71071	3 or more tests described in items 71066, 71068, 71072 or 71074 **Fee:** $30.95	**Benefit:** 75% = $23.25	85% = $26.35
71072	Quantitation of total immunoglobulin M by any method in serum, urine or other body fluid - 1 test **Fee:** $14.55	**Benefit:** 75% = $10.95	85% = $12.40
71073	Quantitation of all 4 immunoglobulin G subclasses **Fee:** $106.15	**Benefit:** 75% = $79.65	85% = $90.25
71074	Quantitation of total immunoglobulin D by any method in serum, urine or other body fluid - 1 test **Fee:** $14.55	**Benefit:** 75% = $10.95	85% = $12.40
71075	Quantitation of immunoglobulin E (total), 1 test. (Item is subject to rule 25) **Fee:** $23.00	**Benefit:** 75% = $17.25	85% = $19.55
71076	A test described in item 71073 if rendered by a receiving APP - 1 test (Item is subject to rule 18) **Fee:** $106.15	**Benefit:** 75% = $79.65	85% = $90.25
71077	Quantitation of immunoglobulin E (total) in the follow up of a patient with proven immunoglobulin-E-secreting myeloma, proven congenital immunodeficiency or proven allergic bronchopulmonary aspergillosis, 1 test. (Item is subject to rule 25) **Fee:** $27.05	**Benefit:** 75% = $20.30	85% = $23.00
71079	Detection of specific immunoglobulin E antibodies to single or multiple potential allergens, 1 test (Item is subject to rule 25) **Fee:** $26.80	**Benefit:** 75% = $20.10	85% = $22.80

71081	Quantitation of total haemolytic complement **Fee:** $40.55	**Benefit:** 75% = $30.45	85% = $34.50
71083	Quantitation of complement components C3 and C4 or properdin factor B - 1 test **Fee:** $20.15	**Benefit:** 75% = $15.15	85% = $17.15
71085	2 tests described in item 71083 **Fee:** $28.95	**Benefit:** 75% = $21.75	85% = $24.65
71087	3 or more tests described in item 71083 **Fee:** $37.70	**Benefit:** 75% = $28.30	85% = $32.05
71089	Quantitation of complement components or breakdown products of complement proteins not elsewhere described in an item in this Schedule - 1 test (Item is subject to rule 6) **Fee:** $29.15	**Benefit:** 75% = $21.90	85% = $24.80
71090	A test described in item 71089, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18) **Fee:** $29.15	**Benefit:** 75% = $21.90	85% = $24.80
71091	2 tests described in item 71089 (Item is subject to rule 6) **Fee:** $52.85	**Benefit:** 75% = $39.65	85% = $44.95
71092	Tests described in item 71089, other than that described in 71090, if rendered by a receiving APP - each test to a maximum of 2 tests (Item is subject to rule 6 and 18) **Fee:** $23.70	**Benefit:** 75% = $17.80	85% = $20.15
71093	3 or more tests described in item 71089 (Item is subject to rule 6) **Fee:** $76.45	**Benefit:** 75% = $57.35	85% = $65.00
71095	Quantitation of serum or plasma eosinophil cationic protein, or both, to a maximum of 3 assays in 1 year, for monitoring the response to therapy in corticosteroid treated asthma, in a child aged less than 12 years *(See para P16.9 of explanatory notes to this Category)* **Fee:** $40.55	**Benefit:** 75% = $30.45	85% = $34.50
71096	A test described in item 71095 if rendered by a receiving APP. (Item is subject to rule 18) **Fee:** $40.55	**Benefit:** 75% = $30.45	85% = $34.50
71097	Antinuclear antibodies - detection in serum or other body fluids, including quantitation if required **Fee:** $24.45	**Benefit:** 75% = $18.35	85% = $20.80
71099	Double-stranded DNA antibodies - quantitation by 1 or more methods other than the Crithidia method **Fee:** $26.50	**Benefit:** 75% = $19.90	85% = $22.55
71101	Antibodies to 1 or more extractable nuclear antigens - detection in serum or other body fluids **Fee:** $17.40	**Benefit:** 75% = $13.05	85% = $14.80
71103	Characterisation of an antibody detected in a service described in item 71101 (including that service) **Fee:** $52.05	**Benefit:** 75% = $39.05	85% = $44.25
71106	Rheumatoid factor - detection by any technique in serum or other body fluids, including quantitation if required **Fee:** $11.30	**Benefit:** 75% = $8.50	85% = $9.65
71119	Antibodies to tissue antigens not elsewhere specified in this Table - detection, including quantitation if required, of 1 antibody **Fee:** $17.35	**Benefit:** 75% = $13.05	85% = $14.75
71121	Detection of 2 antibodies specified in item 71119 **Fee:** $20.80	**Benefit:** 75% = $15.60	85% = $17.70
71123	Detection of 3 antibodies specified in item 71119 **Fee:** $24.25	**Benefit:** 75% = $18.20	85% = $20.65

	Detection of 4 or more antibodies specified in item 71119		
71125	**Fee:** $27.65	**Benefit:** 75% = $20.75	85% = $23.55
	Functional tests for lymphocytes - quantitation other than by microscopy of: (a) proliferation induced by 1 or more mitogens; or (b) proliferation induced by 1 or more antigens; or (c) estimation of 1 or more mixed lymphocyte reactions; including a test described in item 65066 or 65070 (if performed), 1 of this item to a maximum of 2 in a 12 month period		
71127	**Fee:** $176.35	**Benefit:** 75% = $132.30	85% = $149.90
	2 tests described in item 71127		
71129	**Fee:** $217.85	**Benefit:** 75% = $163.40	85% = $185.20
	3 or more tests described in item 71127		
71131	**Fee:** $259.35	**Benefit:** 75% = $194.55	85% = $220.45
	Investigation of recurrent infection by qualitative assessment for the presence of defects in oxidative pathways in neutrophils by the nitroblue tetrazolium (NBT) reduction test		
71133	**Fee:** $10.40	**Benefit:** 75% = $7.80	85% = $8.85
	Investigation of recurrent infection by quantitative assessment of oxidative pathways by flow cytometric techniques, including a test described in 71133 (if performed)		
71134	**Fee:** $104.05	**Benefit:** 75% = $78.05	85% = $88.45
	Quantitation of neutrophil function, comprising at least 2 of the following: (a) chemotaxis; (b) phagocytosis; (c) oxidative metabolism; (d) bactericidal activity; including any test described in items 65066, 65070, 71133 or 71134 (if performed), 1 of this item to a maximum of 2 in a 12 month period		
71135	**Fee:** $207.95	**Benefit:** 75% = $156.00	85% = $176.80
	Quantitation of cell-mediated immunity by multiple antigen delayed type hypersensitivity intradermal skin testing using a minimum of 7 antigens, 1 of this item to a maximum of 2 in a 12 month period		
71137	**Fee:** $30.25	**Benefit:** 75% = $22.70	85% = $25.75
	Characterisation of 3 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations, including a total lymphocyte count or total leucocyte count by any method, on 1 or more specimens of blood, CSF or serous fluid		
71139	**Fee:** $104.05	**Benefit:** 75% = $78.05	85% = $88.45
	Characterisation of 3 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations on 1 or more disaggregated tissue specimens		
71141	**Fee:** $197.35	**Benefit:** 75% = $148.05	85% = $167.75
	Characterisation of 6 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations for the diagnosis (but not monitoring) of an immunological or haematological malignancy, including a service described in 1 or both of items 71139 and 71141 (if performed), on a specimen of blood, CSF, serous fluid or disaggregated tissue		
71143	**Fee:** $260.00	**Benefit:** 75% = $195.00	85% = $221.00
	Characterisation of 6 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations for the diagnosis (but not monitoring) of an immunological or haematological malignancy, including a service described in 1 or more of items 71139, 71141 and 71143 (if performed), on 2 or more specimens of disaggregated tissues or 1 specimen of disaggregated tissue and 1 or more specimens of blood, CSF or serous fluid		
71145	**Fee:** $424.50	**Benefit:** 75% = $318.40	85% = $360.85
	Enumeration of CD34+ cells, only for the purposes of autologous or directed allogeneic haemopoietic stem cell transplantation, including a total white cell count on the pherisis collection		
71146	**Fee:** $104.05	**Benefit:** 75% = $78.05	85% = $88.45
	HLA-B27 typing (Item is subject to rule 27)		
71147	**Fee:** $40.55	**Benefit:** 75% = $30.45	85% = $34.50

	A test described in item 71147 if rendered by a receiving APP. (Item is subject to rule 18 and 27)		
71148	**Fee:** $40.55	**Benefit:** 75% = $30.45	85% = $34.50
	Complete tissue typing for 4 HLA-A and HLA-B Class I antigens (including any separation of leucocytes), including (if performed) a service described in item 71147		
71149	**Fee:** $108.25	**Benefit:** 75% = $81.20	85% = $92.05
	Tissue typing for HLA-DR, HLA-DP and HLA-DQ Class II antigens (including any separation of leucocytes) - phenotyping or genotyping of 2 or more antigens		
71151	**Fee:** $118.85	**Benefit:** 75% = $89.15	85% = $101.05
	Investigations in the assessment or diagnosis of systemic inflammatory disease or vasculitis - antineutrophil cytoplasmic antibody immunofluorescence (ANCA test), antineutrophil proteinase 3 antibody (PR-3 ANCA test), antimyeloperoxidase antibody (MPO ANCA test) or antiglomerular basement membrane antibody (GBM test) - detection of 1 antibody (Item is subject to rule 6 and 23)		
71153	**Fee:** $34.55	**Benefit:** 75% = $25.95	85% = $29.40
	A test described in item 71153, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test. (Item is subject to rule 6, 18 and 23)		
71154	**Fee:** $34.55	**Benefit:** 75% = $25.95	85% = $29.40
	Detection of 2 antibodies described in item 71153 (Item is subject to rule 6 and 23)		
71155	**Fee:** $47.45	**Benefit:** 75% = $35.60	85% = $40.35
	Tests described in item 71153, other than that described in 71154, if rendered by a receiving APP – each test to a maximum of 3 tests (Item is subject to rule 6, 18 and 23)		
71156	**Fee:** $12.85	**Benefit:** 75% = $9.65	85% = $10.95
	Detection of 3 antibodies described in item 71153 (Item is subject to rule 6 and 23)		
71157	**Fee:** $60.30	**Benefit:** 75% = $45.25	85% = $51.30
	Detection of 4 or more antibodies described in item 71153 (Item is subject to rule 6 and 23)		
71159	**Fee:** $73.15	**Benefit:** 75% = $54.90	85% = $62.20
	Detection of one of the following antibodies (of 1 or more class or isotype) in the assessment or diagnosis of coeliac disease or other gluten hypersensitivity syndromes and including a service described in item 71066 (if performed): a) Antibodies to gliadin; or b) Antibodies to endomysium; or c) Antibodies to tissue transglutaminase; - 1 test		
71163	**Fee:** $24.75	**Benefit:** 75% = $18.60	85% = $21.05
	Two or more tests described in 71163 and including a service described in 71066 (if performed)		
71164	**Fee:** $39.90	**Benefit:** 75% = $29.95	85% = $33.95
	Antibodies to tissue antigens (acetylcholine receptor, adrenal cortex, heart, histone, insulin, insulin receptor, intrinsic factor, islet cell, lymphocyte, neuron, ovary, parathyroid, platelet, salivary gland, skeletal muscle, skin basement membrane and intercellular substance, thyroglobulin, thyroid microsome or thyroid stimulating hormone receptor) - detection, including quantitation if required, of 1 antibody (Item is subject to rule 6)		
71165	**Fee:** $34.55	**Benefit:** 75% = $25.95	85% = $29.40
	Detection of 2 antibodies described in item 71165 (Item is subject to rule 6)		
71166	**Fee:** $47.45	**Benefit:** 75% = $35.60	85% = $40.35
	Detection of 3 antibodies described in item 71165 (Item is subject to rule 6)		
71167	**Fee:** $60.30	**Benefit:** 75% = $45.25	85% = $51.30

71168	Detection of 4 or more antibodies described in item 71165 (Item is subject to rule 6) **Fee:** $73.15	**Benefit:** 75% = $54.90	85% = $62.20
71169	A test described in item 71165, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP – 1 test (Item is subject to rule 6 and 18) **Fee:** $34.55	**Benefit:** 75% = $25.95	85% = $29.40
71170	Tests described in item 71165, other than that described in 71169, if rendered by a receiving APP - each test to a maximum of 3 tests (Item is subject to rule 6 and 18) **Fee:** $12.85	**Benefit:** 75% = $9.65	85% = $10.95
71180	Antibody to cardiolipin or beta-2 glycoprotein I – detection, including quantitation if required; one antibody specificity (IgG or IgM) **Fee:** $34.55	**Benefit:** 75% = $25.95	85% = $29.40
71183	Detection of two antibodies described in item 71180 **Fee:** $47.45	**Benefit:** 75% = $35.60	85% = $40.35
71186	Detection of three or more antibodies described in item 71180 **Fee:** $60.30	**Benefit:** 75% = $45.25	85% = $51.30
71189	Detection of specific IgG antibodies to 1 or more respiratory disease allergens not elsewhere specified. **Fee:** $15.50	**Benefit:** 75% = $11.65	85% = $13.20
71192	2 items described in item 71189. **Fee:** $28.35	**Benefit:** 75% = $21.30	85% = $24.10
71195	3 or more items described in item 71189. **Fee:** $40.05	**Benefit:** 75% = $30.05	85% = $34.05
71198	Estimation of serum tryptase for the evaluation of unexplained acute hypotension or suspected anaphylactic event, assessment of risk in stinging insect anaphylaxis, exclusion of mastocytosis, monitoring of known mastocytosis. **Fee:** $40.55	**Benefit:** 75% = $30.45	85% = $34.50
71200	Detection and quantitation, if present, of free kappa and lambda light chains in serum for the diagnosis or monitoring of amyloidosis, myeloma or plasma cell dyscrasias. **Fee:** $59.60	**Benefit:** 75% = $44.70	85% = $50.70
71203	Determination of HLAB5701 status by flow cytometry or cytotoxity assay prior to the initiation of Abacavir therapy including item 73323 if performed. **Fee:** $40.55	**Benefit:** 75% = $30.45	85% = $34.50

	GROUP P5 - TISSUE PATHOLOGY
72813	Examination of complexity level 2 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13) **Fee:** $71.50 **Benefit:** 75% = $53.65 85% = $60.80
72816	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen (Item is subject to rule 13) **Fee:** $86.35 **Benefit:** 75% = $64.80 85% = $73.40
72817	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 to 4 separately identified specimens (Item is subject to rule 13) **Fee:** $96.80 **Benefit:** 75% = $72.60 85% = $82.30
72818	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 5 or more separately identified specimens (Item is subject to rule 13) **Fee:** $107.05 **Benefit:** 75% = $80.30 85% = $91.00
72823	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen (Item is subject to rule 13) **Fee:** $97.15 **Benefit:** 75% = $72.90 85% = $82.60
72824	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 to 4 separately identified specimens (Item is subject to rule 13) **Fee:** $141.35 **Benefit:** 75% = $106.05 85% = $120.15
72825	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 5 to 7 separately identified specimens (Item is subject to rule 13) **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25
72826	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 8 to 11 separately identified specimens (Item is subject to rule 13) **Fee:** $194.60 **Benefit:** 75% = $145.95 85% = $165.45
72827	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions – 12 to 17 separately identified specimens (Item is subject to Rule 13) **Fee:** $208.95 **Benefit:** 75% = $156.75 85% = $177.65
72828	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions – 18 or more separately identified specimens (Item is subject to Rule 13) **Fee:** $223.30 **Benefit:** 75% = $167.50 85% = $189.85
72830	Examination of complexity level 5 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13) **Fee:** $274.15 **Benefit:** 75% = $205.65 85% = $233.05

	Examination of complexity level 6 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13)		
72836	**Fee:** $417.20	**Benefit:** 75% = $312.90	85% = $354.65
	Examination of complexicity level 7 biopsy material with multiple tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens. (Item is subject to rule 13)		
72838	**Fee:** $466.85	**Benefit:** 75% = $350.15	85% = $396.85
	Enzyme histochemistry of skeletal muscle for investigation of primary degenerative or metabolic muscle diseases or of muscle abnormalities secondary to disease of the central or peripheral nervous system - 1 or more tests		
72844	**Fee:** $30.75	**Benefit:** 75% = $23.10	85% = $26.15
	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 antibodies except those listed in 72848 (Item is subject to rule 13)		
72846	**Fee:** $59.60	**Benefit:** 75% = $44.70	85% = $50.70
	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4-6 antibodies (Item is subject to rule 13)		
72847	**Fee:** $89.40	**Benefit:** 75% = $67.05	85% = $76.00
	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 of the following antibodies - oestrogen, progesterone and c-erb-B2 (HER2) (Item is subject to rule 13)		
72848	**Fee:** $74.50	**Benefit:** 75% = $55.90	85% = $63.35
	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen – 7-10 antibodies (Item is subject to rule 13)		
72849	**Fee:** $104.30	**Benefit:** 75% = $78.25	85% = $88.70
	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen – 11 or more antibodies (Item is subject to rule 13)		
72850	**Fee:** $119.20	**Benefit:** 75% = $89.40	85% = $101.35
	Electron microscopic examination of biopsy material - 1 separately identified specimen (Item is subject to rule 13)		
72851	**Fee:** $184.35	**Benefit:** 75% = $138.30	85% = $156.70
	Electron microscopic examination of biopsy material - 2 or more separately identified specimens (Item is subject to rule 13)		
72852	**Fee:** $245.80	**Benefit:** 75% = $184.35	85% = $208.95
	Intraoperative consultation and examination of biopsy material by frozen section or tissue imprint or smear - 1 separately identified specimen (Item is subject to rule 13)		
72855	**Fee:** $184.35	**Benefit:** 75% = $138.30	85% = $156.70
	Intraoperative consultation and examination of biopsy material by frozen section or tissue imprint or smear - 2 to 4 separately identified specimens (Item is subject to rule 13)		
72856	**Fee:** $245.80	**Benefit:** 75% = $184.35	85% = $208.95
	Intraoperative consultation and examination of biopsy material by frozen section or tissue imprint or smear - 5 or more separately identified specimens (Item is subject to rule 13)		
72857	**Fee:** $286.75	**Benefit:** 75% = $215.10	85% = $243.75

72858	A second opinion, provided in a written report, where the opinion and report together require no more than 30 minutes to complete, on a patient specimen, requested by a treating practitioner, where further information is needed for accurate diagnosis and appropriate patient management. *(See para P19.1 of explanatory notes to this Category)* **Fee:** $180.00 **Benefit:** 75% = $135.00 85% = $153.00
72859	A second opinion, provided in a written report, where the opinion and report together require more than 30 minutes to complete, on a patient specimen, requested by a treating practitioner, where further information is needed for accurate diagnosis and appropriate patient management. *(See para P19.1 of explanatory notes to this Category)* **Fee:** $370.00 **Benefit:** 75% = $277.50 85% = $314.50

GROUP P6 - CYTOLOGY

73043	Cytology (including serial examinations) of nipple discharge or smears from skin, lip, mouth, nose or anus for detection of precancerous or cancerous changes 1 or more tests **Fee:** $22.85 **Benefit:** 75% = $17.15 85% = $19.45
73045	Cytology (including serial examinations) for malignancy (other than an examination mentioned in item 73053); and including any Group P5 service, if performed on: (a) specimens resulting from washings or brushings from sites not specified in item 73043; or (b) a single specimen of sputum or urine; or (c) 1 or more specimens of other body fluids; 1 or more tests **Fee:** $48.60 **Benefit:** 75% = $36.45 85% = $41.35
73047	Cytology of a series of 3 sputum or urine specimens for malignant cells **Fee:** $94.70 **Benefit:** 75% = $71.05 85% = $80.50
73049	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues - 1 identified site **Fee:** $68.15 **Benefit:** 75% = $51.15 85% = $57.95
73051	Cytology of material obtained directly from a patient at one identified site by fine needle aspiration of solid tissue or tissues if a recognized pathologist: (a) performs the aspiration; or (b) attends the aspiration and performs cytological examination during the attendance **Fee:** $170.35 **Benefit:** 75% = $127.80 85% = $144.80
73053	Cytology of a smear from cervix where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each examination (a) for the detection of precancerous or cancerous changes in women with no symptoms, signs or recent history suggestive of cervical neoplasia, or (b) if a further specimen is taken due to an unsatisfactory smear taken for the purposes of paragraph (a); or (c) if there is inadequate information provided to use item 73055; *(See para P16.11 of explanatory notes to this Category)* **Fee:** $19.45 **Benefit:** 75% = $14.60 85% = $16.55
73055	Cytology of a smear from cervix, not associated with item 73053, where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each test (a) for the management of previously detected abnormalities including precancerous or cancerous conditions; or (b) for the investigation of women with symptoms, signs or recent history suggestive of cervical neoplasia; *(See para P16.11 of explanatory notes to this Category)* **Fee:** $19.45 **Benefit:** 75% = $14.60 85% = $16.55
73057	Cytology of smears from vagina, not associated with item 73053 or 73055 and not to monitor hormone replacement therapy, where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each test *(See para P16.11 of explanatory notes to this Category)* **Fee:** $19.45 **Benefit:** 75% = $14.60 85% = $16.55
73059	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 antibodies except those listed in 73061 (Item is subject to rule 13) **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55
73060	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4 to 6 antibodies (Item is subject to rule 13) **Fee:** $57.35 **Benefit:** 75% = $43.05 85% = $48.75

73061	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 of the following antibodies - oestrogen, progesterone and c-erb-B2 (HER2) (Item is subject to rule 13) **Fee:** $51.20	**Benefit:** 75% = $38.40	85% = $43.55
73062	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues – 2 or more separately identified sites. **Fee:** $89.00	**Benefit:** 75% = $66.75	85% = $75.65
73063	Cytology of material obtained directly from a patient at one identified site by fine needle aspiration of solid tissue or tissues if an employee of an approved pathology authority attends the aspiration for confirmation of sample adequacy **Fee:** $99.35	**Benefit:** 75% = $74.55	85% = $84.45
73064	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen – 7 to 10 antibodies (Item is subject to rule 13) **Fee:** $71.70	**Benefit:** 75% = $53.80	85% = $60.95
73065	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062, 73063, 73066 and 73067 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 11 or more antibodies (Item is subject to rule 13) **Fee:** $86.00	**Benefit:** 75% = $64.50	85% = $73.10
73066	Cytology of material obtained directly from a patient at 2 or more separately identified sites by fine needle aspiration of solid tissue or tissues if a recognized pathologist: (a) performs the aspiration; or (b) attends the aspiration and performs cytological examination during the attendance **Fee:** $221.45	**Benefit:** 75% = $166.10	85% = $188.25
73067	Cytology of material obtained directly from a patient at 2 or more separately identified sites by fine needle aspiration of solid tissue or tissues if an employee of an approved pathology authority attends the aspiration for confirmation of sample adequacy **Fee:** $129.15	**Benefit:** 75% = $96.90	85% = $109.80

GROUP P7 - GENETICS

73287	The study of the whole of every chromosome by cytogenetic or other techniques, performed on 1 or more of any tissue or fluid except blood (including a service mentioned in item 73293, if performed) - 1 or more tests **Fee:** $394.55 **Benefit:** 75% = $295.95 85% = $335.40
73289	The study of the whole of every chromosome by cytogenetic or other techniques, performed on blood (including a service mentioned in item 73293, if performed) - 1 or more tests **Fee:** $358.95 **Benefit:** 75% = $269.25 85% = $305.15
73290	The study of the whole of each chromosome by cytogenetic or other techniques, performed on blood or bone marrow, in the diagnosis and monitoringof haematological malignancy (including a service in items 73287 or 73289, if performed). - 1 or more tests. **Fee:** $394.55 **Benefit:** 75% = $295.95 85% = $335.40
73291	Analysis of one or more chromosome regions for specific constitutional genetic abnormalities of blood or fresh tissue in a) diagnostic studies of a person with developmental delay, intellectual disability, autism, or at least two congenital abnormalities, in whom cytogenetic studies (item 73287 or 73289) are either normal or have not been performed; or b) studies of a relative for an abnormality previously identified in such an affected person. – 1 or more tests. **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35
73292	Analysis of chromosomes by genome-wide micro-array including targeted assessment of specific regions for constitutional genetic abnormalities in diagnostic studies of a person with developmental delay, intellectual disability, autism, or at least two congenital abnormalities (including a service in items 73287, 73289 or 73291, if performed) – 1 or more tests. **Fee:** $589.90 **Benefit:** 75% = $442.45 85% = $510.40
73293	Analysis of one or more regions on all chromosomes for specific constitutional genetic abnormalities of fresh tissue in diagnostic studies of the products of conception, including exclusion of maternal cell contamination. – 1 or more tests. **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35
73294	Analysis of the PMP22 gene for constitutional genetic abnormalities causing peripheral neuropathy, either as: a) diagnostic studies of an affected person; or b) studies of a relative for an abnormality previously identified in an affected person – 1 or more tests. **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35
73300	Detection of mutation of the FMR1 gene where: (a) the patient exhibits intellectual disability, ataxia, neurodegeneration, or premature ovarian failure consistent with an FMRI mutation; or (b) the patient has a relative with a FMR1 mutation 1 or more tests **Fee:** $101.30 **Benefit:** 75% = $76.00 85% = $86.15
73305	Detection of mutation of the FMR1 gene by Southern Blot analysis where the results in item 73300 are inconclusive *(See para P16.12 of explanatory notes to this Category)* **Fee:** $202.65 **Benefit:** 75% = $152.00 85% = $172.30
73308	Characterisation of the genotype of a patient for Factor V Leiden gene mutation, or detection of the other relevant mutations in the investigation of proven venous thrombosis or pulmonary embolism - 1 or more tests **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00
73309	A test described in item 73308, if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00
73311	Characterisation of the genotype of a person who is a first degree relative of a person who has proven to have 1 or more abnormal genotypes under item 73308 - 1 or more tests **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00
73312	A test described in item 73311, if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00

73314	Characterisation of gene rearrangement or the identification of mutations within a known gene rearrangement, in the diagnosis and monitoring of patients with laboratory evidence of: (a) acute myeloid leukaemia; or (b) acute promyelocytic leukaemia; or (c) acute lymphoid leukaemia; or (d) chronic myeloid leukaemia; **Fee:** $230.95	**Benefit:** 75% = $173.25	85% = $196.35
73315	A test described in item 73314, if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $230.95	**Benefit:** 75% = $173.25	85% = $196.35
73317	Detection of the C282Y genetic mutation of the HFE gene and, if performed, detection of other mutations for haemochromatosis where: (a) the patient has an elevated transferrin saturation or elevated serum ferritin on testing of repeated specimens; or (b) the patient has a first degree relative with haemochromatosis; or (c) the patient has a first degree relative with homozygosity for the C282Y genetic mutation, or with compound heterozygosity for recognised genetic mutations for haemochromatosis (Item is subject to rule 20) **Fee:** $36.45	**Benefit:** 75% = $27.35	85% = $31.00
73318	A test described in item 73317, if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18 and 20) **Fee:** $36.45	**Benefit:** 75% = $27.35	85% = $31.00
73320	Detection of HLA-B27 by nucleic acid amplification includes a service described in 71147 unless the service in item 73320 is rendered as a pathologist determinable service. (Item is subject to rule 27) **Fee:** $40.55	**Benefit:** 75% = $30.45	85% = $34.50
73321	A test described in item 73320, if rendered by a receiving APP - 1 or more tests. (Item is subject to rule 18 and 27) **Fee:** $40.55	**Benefit:** 75% = $30.45	85% = $34.50
73323	Determination of HLAB5701 status by molecular techniques prior to the initiation of Abacavir therapy including item 71203 if performed. **Fee:** $40.55	**Benefit:** 75% = $30.45	85% = $34.50
73324	A test described in item 73323 if rendered by a receiving APP 1 or more tests (Item is subject to Rule 18) **Fee:** $40.95	**Benefit:** 75% = $30.75	85% = $34.85
73325	Characterisation of mutations in: (a) the JAK2 gene; or (b) the MPL gene; or (c) both genes; in the diagnostic work-up, by, or on behalf of, the specialist or consultant physician, of a patient with clinical and laboratory evidence of: a) polycythaemia vera; or b) essential thrombocythaemia; 1 or more tests **Fee:** $74.50	**Benefit:** 75% = $55.90	85% = $63.35
73326	Characterisation of the gene rearrangement FIP1L1-PDGFRA in the diagnostic work-up and management of a patient with laboratory evidence of: a) mast cell disease; or b) idiopathic hypereosinophilic syndrome; or c) chronic eosinophilic leukaemia;. 1 or more tests **Fee:** $230.95	**Benefit:** 75% = $173.25	85% = $196.35

73327	Detection of genetic polymorphisms in the Thiopurine S-methyltransferase gene for the prevention of dose-related toxicity during treatment with thiopurine drugs; including (if performed) any service described in item 65075. 1 or more tests **Fee:** $51.95 **Benefit:** 75% = $39.00 85% = $44.20
73332	An in situ hybridization (ISH) test of tumour tissue from a patient with breast cancer requested by, or on the advice of, a specialist or consultant physician who manages the treatment of the patient to determine if the requirements relating to human epidermal growth factor receptor 2 (HER2) gene amplification for access to trastuzumab under the Pharmaceutical Benefits Scheme (PBS) or the Herceptin Program are fulfilled. **Fee:** $315.40 **Benefit:** 75% = $236.55 85% = $268.10
73333	Detection of germline mutations of the von Hippel-Lindau (VHL) gene: – in a patient who has a clinical diagnosis of VHL syndrome and: (i) a family history of VHL syndrome and one of the following: (A) haemangioblastoma (retinal or central nervous system); (B) phaeochromocytoma; (C) renal cell carcinoma; or (ii) 2 or more haemangioblastomas; or (iii) one haemangioblastoma and a tumour or a cyst of: (A) the adrenal gland; or (B) the kidney; or (C) the pancreas; or (D) the epididymis; or (E) a broad ligament (other than epididymal and single renal cysts, which are common in the general population); or – in a patient presenting with one or more of the following clinical features suggestive of VHL syndrome: (i) haemangioblastomas of the brain, spinal cord, or retina; (ii) phaeochromocytoma; (iii) functional extra-adrenal paraganglioma **Fee:** $600.00 **Benefit:** 75% = $450.00 85% = $520.50
73334	Detection of germline mutations of the von Hippel-Lindau (VHL) gene in biological relatives of a patient with a known mutation in the VHL gene **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00
73335	Detection of somatic mutations of the von Hippel-Lindau (VHL) gene in a patient with: (a) 2 or more tumours comprising: (i) 2 or more haemangioblastomas, or (ii) one haemangioblastoma and a tumour of: (A) the adrenal gland; or (B) the kidney; or (C) the pancreas; or (D) the epididymis; and (b) no germline mutations of the VHL gene identified by genetic testing **Fee:** $470.00 **Benefit:** 75% = $352.50 85% = $399.50
73336	A test of tumour tissue from a patient with unresectable stage III or stage IV metastatic cutaneous melanoma, requested by, or on behalf of, a specialist or consultant physician, to determine if the requirements relating to BRAF V600 mutation status for access to dabrafenib under Pharmaceutical Benefits Scheme (PBS) are fulfilled. **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35
73337	A test of tumour tissue from a patient diagnosed with non-small cell lung cancer, shown to have non-squamous histology or histology not otherwise specified, requested by, or on behalf of, a specialist or consultant physician, to determine if the requirements relating to epidermal growth factor receptor (EGFR) gene status for access to erlotinib or gefitinib under the Pharmaceutical Benefits Scheme (PBS) are fulfilled. **Fee:** $397.35 **Benefit:** 75% = $298.05 85% = $337.75
73338	A test of tumour tissue from a patient with metastatic colorectal cancer (stage IV), requested by a specialist or consultant physician, to determine if the requirements relating to rat sarcoma oncogene (RAS) gene mutation status for access to cetuximab or panitumumab under the Pharmaceutical Benefits Scheme (PBS) are fulfilled, if: (a) the test is conducted for all clinically relevant mutations on KRAS exons 2, 3 and 4 and NRAS exons 2, 3, and 4; or (b) a RAS mutation is found. *(See para P16.15 of explanatory notes to this Category)* **Fee:** $362.59 **Benefit:** 75% = $271.95 85% = $308.25

73339	Detection of germline mutations in the RET gene in patients with a suspected clinical diagnosis of multiple endocrine neoplasia type 2 (MEN2) requested by a specialist or consultant physician who manages the treatment of the patient. One test. (Item is subject to rule 25) *(See para P16.12 of explanatory notes to this Category)* **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00
73340	Detection of a known mutation in the RET gene in an asymptomatic relative of a patient with a documented pathogenic germline RET mutation requested by a specialist or consultant physician who manages the treatment of the patient. One test. (Item is subject to rule 25) *(See para P16.12 of explanatory notes to this Category)* **Fee:** $200.00 **Benefit:** 75% = $150.00 85% = $170.00
73341	Fluorescence in situ hybridisation (FISH) test of tumour tissue from a patient with locally advanced or metastatic non-small cell lung cancer, which is of non-squamous histology or histology not otherwise specified, with documented evidence of anaplastic lymphoma kinase (*ALK*) immunoreactivity by immunohistochemical (IHC) examination giving a staining intensity score > 0, and with documented absence of activating mutations of the epidermal growth factor receptor (*EGFR*) gene, requested by a specialist or consultant physician to determine if requirements relating to *ALK* gene rearrangement status for access to crizotinib under the Pharmaceutical Benefits Scheme (PBS) are fulfilled. **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00
New 73342	An in situ hybridisation (ISH) test of tumour tissue from a patient with metastatic adenocarcinoma of the stomach or gastro-oesophageal junction, with documented evidence of human epidermal growth factor receptor 2 (*HER2*) overexpression by immunohistochemical (IHC) examination giving a staining intensity score of 2+ or 3+ on the same tumour tissue sample, requested by, or on the advice of, a specialist or consultant physician who manages the treatment of the patient to determine if the requirements relating to *HER2* gene amplification for access to trastuzumab under the Pharmaceutical Benefits Scheme are fulfilled. **Fee:** $315.40 **Benefit:** 75% = $236.55 85% = $268.10

	GROUP P8 - INFERTILITY AND PREGNANCY TESTS		
73521	Semen examination for presence of spermatozoa or examination of cervical mucus for spermatozoa (Huhner's test) **Fee:** $9.70	**Benefit:** 75% = $7.30	85% = $8.25
73523	Semen examination (other than post-vasectomy semen examination), including: (a) measurement of volume, sperm count and motility; and (b) examination of stained preparations; and (c) morphology; and (if performed) (d) differential count and 1 or more chemical tests; (Item is subject to rule 25) **Fee:** $41.75	**Benefit:** 75% = $31.35	85% = $35.50
73525	Sperm antibodies - sperm-penetrating ability - 1 or more tests **Fee:** $28.35	**Benefit:** 75% = $21.30	85% = $24.10
73527	Human chorionic gonadotrophin (HCG) - detection in serum or urine by 1 or more methods for diagnosis of pregnancy - 1 or more tests **Fee:** $10.00	**Benefit:** 75% = $7.50	85% = $8.50
73529	Human chorionic gonadotrophin (HCG), quantitation in serum by 1 or more methods (except by latex, membrane, strip or other pregnancy test kit) for diagnosis of threatened abortion, or follow up of abortion or diagnosis of ectopic pregnancy, including any services performed in item 73527 - 1 test **Fee:** $28.65	**Benefit:** 75% = $21.50	85% = $24.40

	GROUP P9 - SIMPLE BASIC PATHOLOGY TESTS		
73801	Semen examination for presence of spermatozoa **Fee:** $6.90	**Benefit:** 75% = $5.20	85% = $5.90
73802	Leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin, haematocrit or erythrocyte count - 1 test **Fee:** $4.55	**Benefit:** 75% = $3.45	85% = $3.90
73803	2 tests described in item 73802 **Fee:** $6.35	**Benefit:** 75% = $4.80	85% = $5.40
73804	3 or more tests described in item 73802 **Fee:** $8.15	**Benefit:** 75% = $6.15	85% = $6.95
73805	Microscopy of urine, whether stained or not, or catalase test **Fee:** $4.55	**Benefit:** 75% = $3.45	85% = $3.90
73806	Pregnancy test by 1 or more immunochemical methods **Fee:** $10.15	**Benefit:** 75% = $7.65	85% = $8.65
73807	Microscopy for wet film other than urine, including any relevant stain **Fee:** $6.90	**Benefit:** 75% = $5.20	85% = $5.90
73808	Microscopy of Gram-stained film, including (if performed) a service described in item 73805 or 73807 **Fee:** $8.65	**Benefit:** 75% = $6.50	85% = $7.40
73809	Chemical tests for occult blood in faeces by reagent stick, strip, tablet or similar method **Fee:** $2.35	**Benefit:** 75% = $1.80	85% = $2.00
73810	Microscopy for fungi in skin, hair or nails - 1 or more sites **Fee:** $6.90	**Benefit:** 75% = $5.20	85% = $5.90
73811	Mantoux test **Fee:** $11.20	**Benefit:** 75% = $8.40	85% = $9.55
73828	Semen examination for presence of spermatozoa by a participating nurse practitioner **Fee:** $6.90	**Benefit:** 85% = $5.90	
73829	Leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin, haematocrit or erythrocyte count by a participating nurse practitioner - 1 test **Fee:** $4.55	**Benefit:** 85% = $3.90	
73830	2 tests described in item 73829 by a participating nurse practitioner **Fee:** $6.35	**Benefit:** 85% = $5.40	
73831	3 or more tests described in item 73829 by a participating nurse practitioner **Fee:** $8.15	**Benefit:** 85% = $6.95	
73832	Microscopy of urine, whether stained or not, or catalase test by a participating nurse practitioner **Fee:** $4.55	**Benefit:** 85% = $3.90	
73833	Pregnancy test by 1 or more immunochemical methods by a participating nurse practitioner **Fee:** $10.15	**Benefit:** 85% = $8.65	
73834	Microscopy for wet film other than urine, including any relevant stain by a participating nurse practitioner **Fee:** $6.90	**Benefit:** 85% = $5.90	
73835	Microscopy of Gram-stained film, including (if performed) a service described in item 73832 or 73834 by a participating nurse practitioner **Fee:** $8.65	**Benefit:** 85% = $7.40	
73836	Chemical tests for occult blood in faeces by reagent stick, strip, tablet or similar method by a participating nurse practitioner **Fee:** $2.35	**Benefit:** 85% = $2.00	
73837	Microscopy for fungi in skin, hair or nails by a participating nurse practitioner – 1 or more sites **Fee:** $6.90	**Benefit:** 85% = $5.90	

GROUP P10 - PATIENT EPISODE INITIATION

73899	Initiation of a patient episode that consists of a service described in item 72858 or 72859 in circumstances other than those mentioned in item 73900 **Fee:** $5.95	**Benefit:** 75% = $4.50	85% = $5.10
73900	Initiation of a patient episode that consists of a service described in item 72858 or 72859 if the service is rendered in a prescribed laboratory. **Fee:** $2.40	**Benefit:** 75% = $1.80	85% = $2.05
73920	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected in an approved collection centre that the APA operates in the same premises as it operates a category GX or GY pathology laboratory **Fee:** $2.40	**Benefit:** 75% = $1.80	85% = $2.05
73922	Initiation of a patient episode that consists of a service described in item 73053, 73055 or 73057 (in circumstances other than those described in item 73923). **Fee:** $8.20	**Benefit:** 75% = $6.15	85% = $7.00
73923	Initiation of a patient episode that consists of a service described in items 73053, 73055 or 73057 if: (a) the person who is a private patient in a recognised hospital: or (b) the person receives the service from a prescribed laboratory **Fee:** $2.40	**Benefit:** 75% = $1.80	85% = $2.05
73924	Initiation of a patient episode that consists of 1 or more services described in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 (in circumstances other than those described in item 73925) from a person who is an in-patient of a hospital. **Fee:** $14.65	**Benefit:** 75% = $11.00	85% = $12.50
73925	Initiation of a patient episode that consists of 1 or more services described in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 if the person is: (a) a private patient of a recognised hospital; or (b) a private patient of a hospital who receives the service or services from a prescribed laboratory. **Fee:** $2.40	**Benefit:** 75% = $1.80	85% = $2.05
73926	Initiation of a patient episode that consists of 1 or more services described in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 (in circumstances other than those described in item 73927) from a person who is not a patient of a hospital. **Fee:** $8.20	**Benefit:** 75% = $6.15	85% = $7.00
73927	Initiation of a patient episode by a prescribed laboratory that consists of 1 or more services described in items, 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 from a person who is not a patient of a hospital. **Fee:** $2.40	**Benefit:** 75% = $1.80	85% = $2.05
73928	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected in an approved collection centre. Unless item 73920 or 73929 applies **Fee:** $5.95	**Benefit:** 75% = $4.50	85% = $5.10
73929	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner for a prescribed laboratory or by an employee of an approved pathology authority, who conducts a prescribed laboratory, if the specimen is collected in an approved pathology collection centre **Fee:** $2.40	**Benefit:** 75% = $1.80	85% = $2.05
73930	Initiation of a patient episode by collection of a specimen for a service for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person who is an in-patient of a hospital other than a recognised hospital. Unless item 73931 applies **Fee:** $5.95	**Benefit:** 75% = $4.50	85% = $5.10

73931	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if: – the specimen is collected by an approved pathology practitioner for a prescribed laboratory or by an employee of an approved pathology authority, who conducts a prescribed laboratory, from a person who is a private patient in a hospital or – the person is a private patient in a recognised hospital and the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73932	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person in the place where the person was residing. Unless item 73933 applies **Fee:** $10.25 **Benefit:** 75% = $7.70 85% = $8.75
73933	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner for a prescribed laboratory or by an employee of an approved pathology authority, who conducts a prescribed laboratory, from a person in the place where the person is residing **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73934	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 and 73926) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person in a residential aged care home or institution. Unless 73935 applies **Fee:** $17.60 **Benefit:** 75% = $13.20 85% = $15.00
73935	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner or by an employee of an approved pathology authority, who conducts a prescribed laboratory, from a person in a residential aged care home or institution **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73936	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected from the person by the person. **Fee:** $5.95 **Benefit:** 75% = $4.50 85% = $5.10
73937	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926), if the specimen is collected from the person by the person and if: – the service is performed in a prescribed laboratory or – the person is a private patient in a recognised hospital **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73938	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by or on behalf of the treating practitioner. Unless item 73939 applies **Fee:** $7.95 **Benefit:** 75% = $6.00 85% = $6.80
73939	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926), if the specimen is collected by or on behalf of the treating practitioner and if: – the service is performed in a prescribed laboratory or – the person is a private patient in a recognised hospital **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05

	GROUP P11 - SPECIMEN REFERRED
73940	Receipt of a specimen by an approved pathology practitioner of an approved pathology authority from another approved pathology practitioner of a different approved pathology authority or another approved pathology authority (Item is subject to rules 14, 15 and 16) **Fee:** $10.25 **Benefit:** 75% = $7.70 85% = $8.75

GROUP P12 - MANAGEMENT OF BULK-BILLED SERVICES

A pathology service to which an item in this table (other than this item or item 74991) applies if:

(a) the service is an unreferred service; and

(b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and

(c) the person is not an admitted patient of a hospital; 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 P16.13 of explanatory notes to this Category)

74990 **Fee:** $7.05 **Benefit:** 85% = $6.00

A pathology service to which an item in this table (other than this item or item 74990) applies if:

(a) the service is an unreferred service; and

(b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and

(c) the person is not an admitted patient of a hospital; and

(d) the service is bulk-billed in respect of the fees for:

(i) this item; and

(ii) the other item in this table applying to the service; and

(e) the service is provided at, or from, a practice location in:

(i) a regional, rural or remote area; or

(ii) Tasmania; or

(iii) A geographical area included in any of the following SSD spatial units:

(A) Beaudesert Shire Part A
(B) Belconnen
(C) Darwin City
(D) Eastern Outer Melbourne
(E) East Metropolitan, Perth
(F) Frankston City
(G) Gosford-Wyong
(H) Greater Geelong City Part A
(I) Gungahlin-Hall
(J) Ipswich City (part in BSD)
(K) Litchfield Shire
(L) Melton-Wyndham
(M) Mornington Peninsula Shire
(N) Newcastle
(O) North Canberra
(P) Palmerston-East Arm
(Q) Pine Rivers Shire
(R) Queanbeyan
(S) South Canberra
(T) South Eastern Outer Melbourne
(U) Southern Adelaide
(V) South West Metropolitan, Perth
(W) Thuringowa City Part A
(X) Townsville City Part A
(Y) Tuggeranong
(Z) Weston Creek-Stromlo
(ZA) Woden Valley
(ZB) Yarra Ranges Shire Part A; or

(iv) the geographical area included in the SLA spatial unit of Palm Island (AC)

(See para P16.13 of explanatory notes to this Category)

74991 **Fee:** $10.65 **Benefit:** 85% = $9.10

	GROUP P13 - BULK-BILLING INCENTIVE
74992	A payment when the episode is bulk billed and includes item 73920. **Fee:** $1.60 **Benefit:** 75% = $1.20 85% = $1.40
74993	A payment when the episode is bulk billed and includes item 73922 or 73926. **Fee:** $3.75 **Benefit:** 75% = $2.85 85% = $3.20
74994	A payment when the episode is bulk billed and includes item 73924. **Fee:** $3.25 **Benefit:** 75% = $2.45 85% = $2.80
74995	A payment when the episode is bulk billed and includes item 73899, 73900, 73928, 73930 or 73936. **Fee:** $4.00 **Benefit:** 75% = $3.00 85% = $3.40
74996	A payment when the episode is bulk billed and includes item 73932 or 73940. **Fee:** $3.70 **Benefit:** 75% = $2.80 85% = $3.15
74997	A payment when the episode is bulk billed and includes item 73934. **Fee:** $3.30 **Benefit:** 75% = $2.50 85% = $2.85
74998	A payment when the episode is bulk billed and includes item 73938. **Fee:** $2.00 **Benefit:** 75% = $1.50 85% = $1.70
74999	A payment when the episode is bulk billed and includes item 73923, 73925, 73927, 73929, 73931, 73933, 73935, 73937 or 73939. **Fee:** $1.60 **Benefit:** 75% = $1.20 85% = $1.40

INDEX

A

Abnormal heamoglobins AH 65117
Acetoacetate ACP 66500
Acid phosphatase ACP 66500
Actinimycetes - microbial antibody testing ACT 69384
Activated Protein C resistance APC 65142
Activated Protein C resistance APC 65171
Adenovirus - microbial antibody testing ADE 69384
Adrenocorticotropic hormone (ACTH) ACTH 66695
AFB microscopy & culture of sputum - 1 specimen AFB1 69324
AFB microscopy & culture of sputum - 2 specimens AFB2 69327
AFB microscopy & culture of sputum - 3 specimens AFB3 69330
Alanine aminotransferase ALT 66500
Albumin ALB 66500
Alcohol (ethanol) ETOH 66626
Alcohol (ethanol) ETOH 66800
Aldosterone ALDS 66695
ALK gene testing 73341
Alkaline phosphatase - isoenzymes ALPI 66641
Alkaline phosphatase ALP 66500
Alpha-1-antitrypsin AAT 66635
Alpha-fetoprotein AFP 66650
Alpha-fetoprotein AFP 66651
Alpha-fetoprotein AFP 66652
Alpha-fetoprotein AFP 66653
Alpha-fetoprotein AFP 66743
Aluminium - renal dialysis ALR 66671
Amikacin 66800
Amino acids AA 66752
Amiodarone AMIO 66812
Amitriptyline AMIT 66812
Ammonia NH3 66500
Amniotic fluid examination AFE 66749
Amylase AMS 66500
Amylobarbitone AMYL 66812
Androstenedione ANDR 66695
Angiotensin converting exzyme ACE 66758
Anti - Xa activity QAXA 65147
Antibiotic & antimicrobial chemotherapeutic agents - guantitation QQA 66812
Antibiotic & antimicrobial chemotherapeutic agents - quantitation QAA 66800
Antibodies to extractable nuclear antigens - characterisation of antibodies if p 71103
Antibodies to extractable nuclear antigens - detection ENA 71101
Antibodies to nuclear antigens - detection ANA 71097
Antibodies to nuclear antigens - quantitation & measurement of DNA binding if po 71099
Antibodies to tissue antibodies - liver/kidney microsomes LKA 71119
Antibodies to tissue antigens - ANCA - myeloperoxidase MPO 71153
Antibodies to tissue antigens - ANCA - PR3 PR3 71153
Antibodies to tissue antigens - anti - actin AACT 71119
Antibodies to tissue antigens - anti - endomysial EMA 71163
Antibodies to tissue antigens - coeliac disease panel CLC 71163
Antibodies to tissue antigens - coeliac disease panel CLC 71164
Antibodies to tissue antigens - gastric parietal cell PCA 71119
Antibodies to tissue antigens - gliadin IgA GLIA 71163
Antibodies to tissue antigens - gliadin IgG GLIG 71163
Antibodies to tissue antigens - Jo-1 JO1 71119
Antibodies to tissue antigens - keratin KERA 71119
Antibodies to tissue antigens - mitochondria MA 71119
Antibodies to tissue antigens - neutrophil cytoplasm ANCA 71153
Antibodies to tissue antigens - PM-Sc1 PM1 71119
Antibodies to tissue antigens - reticulin RCA 71119
Antibodies to tissue antigens - Sc1-70 SCL 71119
Antibodies to tissue antigens - smooth muscle SMA 71119
Antibodies to tissue antigens - tissue transglutaminase TTG 71163
Antibodies to tissue antigens - TSH receptor antibody test TSHA 71165
Antibodies to tissue antigens -glomerular basement membrane GBM 71153
Antibody to cardiolipin or beta 2 glycoprotein ACB 71180
Antithrombin III ATH 65177
Antithrombin III ATH 65179
Antithrombin III ATH 65142
Antithrombin III ATH 65171
Antithrombin III ATH 65176
Antithrombin III ATH 65175
Antithrombin III ATH 65178
Anus - cytology on specimens from SMCY 73043
Apolipoprotein B/A1 ratio APO 66536
Arsenic AS 66826
Arsenic AS 66825
Arsenic AS 66827
Arsenic AS 66828
Aspartate aminotransferase AST 66500
Aspergillus - microbial antibody testing ASP 69384
Avian precipitins (bird fancier's disease) - microbial antibody testing APP 69384

B

B12 markers vitamin B12M 66839
B12 vitamin B12 66838
Barbiturate BARB 66800
Beryllium BE 66825
Beryllium BE 66827
Beryllium BE 66826
Beryllium BE 66828
Beta-2 microglobulin BMIC 66629
Beta-hydroxybutrate BHYB 66500
Bicarbonate HCO3 66500
Bilirubin (all fractions) - in urine UBIL 66500
Bilirubin (all fractions) - neonatal BILN 66749
Bilirubin (all fractions) BILI 66500
Bird fancier's disease (see avian precipitins) APP 69384
Blastomyces - microbial antibody testing BLM 69384
Blood - compatability testing XMAT 65108
Blood - compatability testing XMAT 65105
Blood - compatability testing XMAT 65099
Blood - compatability testing XMAT 65102
Blood - culture BC 69357
Blood - culture BC 69354
Blood - culture BC 69360
Blood - faecal occult FOB 66770
Blood - faecal occult FOB 66764
Blood - faecal occult FOB 66767
Blood - film BF 65066
Blood - full examination FBE 65070
Blood - gas GAS 66566
Blood - group & blood group antibodies BGAB 65096
Blood - group antibodies BGA 65111
Blood - group systems BGS 65093
Blood - grouping - ABO & RH (D antigens) BG 65090
Blood - viscosity VISC 65060

BNP or NT-proBNP quantitation BNP 66830
Body cavities - aspirations of - microscopy & culture of material from MCOP 69321
Body fluids - cytology BFCY 73045
Bone - low mineral densities CBLB 66773
Bone - metabolic bone disease CBMB 66776
Bone marrow examination - aspirate BMEA 65087
Bone marrow examination - trephine BMET 65084
Bordetella pertussis - microbial antibody testing BOR 69384
Borrelia burgdorferi - microbial antibody testing BOB 69384
Breath hydrogen test BHT 66674
Bromide BRMD 66812
Brucella - microbial antibody testing BRU 69384
Bulk billing incentive 74995

C

C-l esterase inhibitor - functional CEIF 66647
C-l esterase inhibitor - quantitation CEIQ 66644
C-Peptide CPEP 66695
C-Reactive protein CRP 66500
CA-125 antigen C125 66650
CA-15.3 antigen CA15 66650
CA-19.9 antigen 66650
Caeruloplasmin CPLS 66632
Calcitonin CALT 66695
Calcium (total or corrected for albumin) CA 66500
Calcium - ionised ICA 66584
Calculus analysis CALC 66590
Campylobacter jejuni - microbial testing antibody CAM 69384
Candida - microbial antibody testing CAN 69384
Carbamazepine (Tegretol) CARB 66800
Carboxyhaemoglobin COHB 65117
Carcinoembryonic antigen CEA 66650
Cardiac enzymes (see test groups at PQ.4) CE 66506
Catecholamines CAT 66779
Cell mediated immunity - delayed type - hypersensitivity test CMI 71137
Cell-mediated immunity in blood CMIB 69471
Cervix - cytology - abnormalities CCRA 73055
Cervix - cytology - routine CCR 73053
Cervix - microscopy & culture of material from MCGR 69312
CFS - microscopy & culture of material from MCPO 69321
Characterisation of antibodies if positive ENA ENAP 71103
Chemicals, toxic (ingested or absorbed) - assays DRGO 66623
Chlamydia - microbial antibody testing CHL 69384
Chloral hydrate CHHY 66812
Chlorazepate CHZP 66812
Chloride CL 66500
Chloroquinine CLOQ 66812
Chlorpromazine CHLO 66812
Cholesterol - HDL HDLC 66536
Cholesterol CHOL 66500
Cholinesterase CHSE 66758
Chorionic gonadotrophin - detection for pregnancy diagnosis HCGP 73529
Chorionic gonadotrophin - detection for pregnancy diagnosis HCGP 73527
Chorionic gonadotrophin - quantitation HCG 66653
Chorionic gonadotrophin - quantitation HCG 66652
Chorionic gonadotrophin - quantitation HCG 66651
Chorionic gonadotrophin - quantitation HCG 66650
Chorionic gonadotrophin - quantitation HCG 73529
Chromosome identification - studies - blood CSB 73289
Chromosome identification - studies - other than blood CS 73287
Chromosome identification and banding 73287
Chromosome identification and banding 73289
Chronic eosinophilic leukaemia 73326
Cimetidine CMTD 66812
Clobazam CLOB 66812
Clomipramine CLOM 66812
Clonazepam (Rivotril) CLON 66812
Clostridium difficile - microbial antigen testing CLDT 69363
Coagulation - studies (see test groups at para PQ4) COAG 65120
Coagulation factor inhibitors by Bethesda assay BETH 65159
Coccidiodes - microbial antibody testing CCC 69384
Coeliac antibodies CLC 71163
Coeliac antibodies CLC 71164
Cold agglutinins CAG 65114
Collagen - low bone CBLB 66773
Collagen - metabolic disease CBMB 66776
Combatability testing XMAT 65102
Combatability testing XMAT 65099
Combatability testing XMAT 65105
Combatability testing XMAT 65108
Complement, total haemolytic - components C3 C3 71083
Complement, total haemolytic - components C4 C4 71083
Complement, total haemolytic - other components COMP 71089
Complement, total haemolytic - properdin factor B PFB 71083
Complement, total haemolytic COM 71081
Copper CU 66831
Cortisol CORT 66695
Cortisol in saliva CORS 66711
Cortisol in saliva CORS 66712
Coxsackie B1-6 - microbial antibody testing COX 69384
Creatine Kinase - isoenzyme (electrophoresis) CKIE 66518
Creatine kinase - isoenzymes CKI 66518
Creatine kinase CK 66500
Creatinine C 66500
Cryofibrinogen - detection and quantitation CFID 71064
Cryoglobulins - characterisation by electrophoresis, and immunoelectrophoresis o 71059
Cryoglobulins - detection and quantitation CGLD 71064
Cryptococcus - microbial antibody testing CRY 69384
Cultural examination of faeces FCS 69345
Cyclic AMP CAMP 66695
Cyclosporin A CLSA 66812
Cystine - qualitative UCYS 66752
Cystine - quantitative CYST 66752
Cytology - fine needle aspiration of solid tissues - aspiration or attendance by 73051
Cytology - fine needle aspiration of solid tissues FNCY 73049
Cytology - from 3 sputum or urine specimens SPCY 73047
Cytology - from body fluids, sputum (1 specimen), urine, washings or brushings B 73045
Cytology - from cervix - abnormalities CCRA 73055
Cytology - from cervix - routine CCR 73053
Cytology - from skin, nipple discharge, lip, mouth, nose or anus SMCY 73043
Cytology - from vagina CVO 73057
Cytomegalovirus - microbial antibody testing CMV 69384
Cytomegalovirus serology in pregnancy - microbial antibody testing CMVP 69405
Cytomegalovirus serology in pregnancy - microbial antibody testing CMVP 69408
Cytomegalovirus serology in pregnancy - microbial antibody testing CMVP 69411

D

D-dimer test DD 65120
Dehydroepiandrosterone sulphate (DHEAS) DHEA 66695
Dengue - microbial antibody testing DEN 69384
Desipramine DESI 66812
Dexamethasone - suppression test DEXA 66686
Dexamethasone DXST 66686
DHEAS (Dehydroepiandrosterone sulphate) DHEA 66695
Diazepam DIAZ 66812
Differential cell count DIFF 66812
Digoxin DIG 66800

Dihydrotestosterone DHTS 66695
Diphenylhydantoin (Dilantin) DIL 66812
Diphtheria - microbial antibody testing DIP 69384
Direct Coombs test CMBS 65114
Disopyramide (Rythmodan) DISO 66800
DNA binding - quantitation & measurement if positive ANA ANAP 71099
DNA, (double-stranded DNA) antibody DSDNA 71099
Donath Landsteiner antibody test DLAT 65075
Doxepin hydrochloride DOXE 66812
Drugs - abuse treatment programme - assay DATP 66626
Drugs - inappropriate dosage - assay DRGO 66623
Drugs - therapeutic - assay (See individual drugs) 66800
Drugs - therapeutic - assay (See individual drugs) 66812
Dynamic function tests GHSE 66686

E

Ear - microscopy & culture of material from MCSW 69303
Echinococcus - microbial antibody testing ECC 69384
Echis test ECHI 65120
ECHO-Coxsackie group - microbial antibody testing ECH 69384
Electrolytes (see test groups at para PQ.4) E 66509
Electron microscopy of biopsy material EM 72851
Electron microscopy of biopsy material EM 72852
Electrophoresis - quantitation of paraprotein classes or paraprotein EPPI 71058
Electrophoresis - quantitation of paraprotein classes or paraprotein EPPI 71057
Electrophoresis, and immunofixation or immunoelectrophoresis or isoelectric focu 71059
Electrophoresis, and immunofixation or immunoelectrophoresis or isoelectric focu 71059
Electrophoresis, to demonstrate - creatine kinase isoenzymes CKIE 66518
Electrophoresis, to demonstrate - lactate dehydrogenase isoenzymes LDI 66641
Electrophoresis, to demonstrate - lipoprotein subclasses LEPG 66539
Endomysium antibodies EMA 71163
Entamoeba histolytica - microbial antibody testing AMO 69384
Enzyme assays of solid tissue or tissues ENZS 66683
Enzyme histochemistry of skeletal muscle EHSK 72844
Eosinophil cationic protein ECP 71095
Epstein Barr virus - microbial antibody testing - EBV 69472
Epstein Barr virus - microbial antibody testing - EBV 69474
Erythrocyte - assessment of haemolysis ERYH 65075
Erythrocyte - assessment of metabolic enzymes ERYM 65075
Erythrocyte - count RCC 65070
Erythrocyte - sedimentation rate ERS 65060
Essential thrombocythaemia 73325
Ethanol (alcohol) ETOH 66626
Ethanol (alcohol) ETOH 66800
Ethosuximide (Zarontin) ETHO 66800
Extractable nuclear antigens - detection of antibodies to ENA 71101
Eye - microscopy & culture of material from MCSW 69303

F

Factor II FII 65150
Factor IX FIX 65150
Factor V FV 65150
Factor VII FVII 65150
Factor VIII VIII 65150
Factor X FX 65150
Factor XI FXI 65150
Factor XII FXII 65150
Factor XIII deficiency test F13D 65150
Factor XIII XIII 65150
Faecal blood FOB 66764
Faecal blood FOB 66767
Faecal blood FOB 66770
faecal fat - haemoglobin FFH 66764
Faecal fat - reducing substances FRS 66761
Faecal fat FFAT 66674
Faeces - culture FCS 69345
Faeces - microscopy for parasites OCP 69336
Faeces - microscopy for parasites OCP 69339
Ferritin (see also Iron Studies) FERR 66593
Fibrin monomer FM 65120
Fibrinogen - degradation products FDP 65120
Fibrinogen FIB 65120
Fitzgerald factor FGF 65150
Flecainide FLEC 66812
Fletcher factor FF 65150
Fluorescent treponemal antibody - absorption test (FTA-ABS) - microbial antibody 69384
Fluoxetine FLUX 66812
Foetal red blood cells - Kliehauer KLEI 65162
Folate - serum SF 66840
Follicle stimulating hormone FSH 66695
Fragile X FXS 73300
Fragile X FXS 73305
Frozen section diagnosis of biopsy material FS 72856
Frozen section diagnosis of biopsy material FS 72855
Fructosamine FRUC 66557
Full blood examination FBE 65070

G

Gamma glutamyl transpeptidase GGT 66500
Gastric parietal cell - triple antigens - antibodies PCA 71119
Gastrin GAST 66695
Gentamicin 66800
Gliadin antibodies GLIA 71163
Globulin GLOB 66500
Glucagon GLGO 66695
Glucose - tolerance test GTT 66542
Glucose GLUC 66500
Glycosylated haemoglobin (Hb Alc) GHB 66551
Group P9 - simple basic pathology tests 73802
Group P9 - simple basic pathology tests 73811
Group P9 - simple basic pathology tests 73810
Group P9 - simple basic pathology tests 73809
Group P9 - simple basic pathology tests 73803
Group P9 - simple basic pathology tests 73804
Group P9 - simple basic pathology tests 73805
Group P9 - simple basic pathology tests 73806
Group P9 - simple basic pathology tests 73807
Group P9 - simple basic pathology tests 73808
Group P9 - simple basic pathology tests 73801
Growth hormone - stimulation by exercise or L-dopa GHSE 66686
Growth hormone - suppression by dexamethasone or glucose GHSG 66686
Growth hormone GH 66695

H

Haematocrit HCT 65070
Haemoglobin HB 65060
Haemoglobinopathy tests - HMGP 65081
Haemophilus influenzae - microbial antibody testing HUS 69384
Haloperidol HALO 66812
Haptoglobins HGLB 66632
HDL Cholesterol HDLC 66536
Heparin - test HEPR 65144
Hepatitis B or C confirmatory test HSVP 69484
Hepatitis investigation - 3 markers HEP3 69481
Hepatitis serology - in pregnancy HEPP 69411
Hepatitis serology - in pregnancy HEPP 69413

Hepatitis serology - in pregnancy HEPP 69405
Hepatitis serology - in pregnancy HEPP 69408
Hepatitis status or carriage - 1 marker HEP1 69475
Hepatitis status or carriage - 2 markers HEP2 69478
Herpes simplex virus - microbial antibody testing HPA 69384
Heterophil antibodies IM 65114
HIAA (hydroxyindoleacetic acid) HIAA 66779
Histamine HIAM 66779
Histopathology of biopsy material HIST 72830
Histopathology of biopsy material HIST 72836
Histopathology of biopsy material HIST 72813
Histopathology of biopsy material HIST 72816
Histopathology of biopsy material HIST 72817
Histopathology of biopsy material HIST 72818
Histopathology of biopsy material HIST 72823
Histopathology of biopsy material HIST 72824
Histopathology of biopsy material HIST 72825
Histopathology of biopsy material HIST 72826
Histopathology of biopsy material HIST 72827
Histopathology of biopsy material HIST 72828
Histoplasma - microbial antibody testing HIP 69384
HIV - antiretroviral therapy TVLT 69381
HIV - cerebrospinal fluid CVLT 69382
HIV - genotypic testing for HIV 69380
HIV - monitoring MVLT 69378
HLA typing - HLA class 2 HLA2 71151
HLA typing - HLA-B27 HLAB 71147
HLAB5701 - status by flow cytometry or cytotoxity assay HLAF 71203
HLAB5701 - status by molecular techniques or cytotoxity assay HLAM 73323
HLT typing - HLA class 1 HLA1 71149
HMMA (hydroxy-3-methoxymandelic acid, previously known as VMA) HMMA 66779
HMPG (hydroxy-methoxy phenylethylene glycol) HMPG 66779
Homovanillic acid HVA 66779
Hormone receptor assay - breast HRA 66662
Hormone receptor assay - ovary HRO 66662
Hormones & hormone binding proteins (see individual hormones and proteins) 66695
Hormones - 11 deoxycortisol DCOR 66695
Hormones - adrenocorticotrophic hormone ACTH 66695
Hormones - aldosterone ALDS 66695
Hormones - androstenedione ANDR 66695
Hormones - C-Peptide CPEP 66695
Hormones - Calcitonin CALT 66695
Hormones - cortisol CORT 66695
Hormones - cyclic AMP CAMP 66695
Hormones - dehydroepiandrosterone sulphate (DHEAS) DHEA66695
Hormones - dihydrotestosterone DHTS 66695
Hormones - follicle stimulating hormone FSH 66695
Hormones - gastrin GAST 66695
Hormones - glucagon GLGO 66695
Hormones - growth hormone - stimulation by exercise or L-dopa GHSE 66686
Hormones - growth hormone - suppression by dexamethasone or glucose GHSG 66686
Hormones - growth hormone GH 66695
Hormones - hormone receptor assay - breast HRA 66662
Hormones - hormones receptor assay - ovary HRO 66662
Hormones - human chorionic gonadotrophin - detection for pregnancy diagnosis HCG 73527
Hormones - human chorionic gonadotrophin - detection for pregnancy diagnosis HCG 73529
Hormones - human chorionic gonadotrophin - quantitation HCG 73529
Hormones - human chorionic gonadotrophin - quantitation HCG 66652
Hormones - human chorionic gonadotrophin - quantitation HCG 66651
Hormones - human chorionic gonadotrophin - quantitation HCG 66650
Hormones - human chorionic gonadotrophin - quantitation HCG 66653
Hormones - hydroxyprogesterone OHP 66695
Hormones - insulin INS 66695
Hormones - luteinizing hormone LH 66695
Hormones - oestradiol E2 66695
Hormones - oestrone - E1 66695
Hormones - parathyroid hormone PTH 66695
Hormones - progesterone PROG 66695
Hormones - prolactin PROL 66695
Hormones - renin 66695
Hormones - sex hormone binding globulin SHBG 66695
Hormones - somatomedin SOMA 66695
Hormones - stimulation by exercise or L-dopa GHSE 66686
Hormones - suppression by dexamethasone or glucose GHSG66686
Hormones - testosterone TES 66695
Hormones - urine steroid fraction or fractions USF 66695
Hormones - vasoactive intestinal peptide VIP 66695
Hormones - vasopressin ADH 66695
Huhner's test HT 73521
Human chorionic gonadatrophin - detection for diagnosis of pregnancy HCGP 73529
Human chorionic gonadatrophin - detection for diagnosis of pregnancy HCGP 73527
Human chorionic gonadatrophin - quantitation HCG 66653
Human chorionic gonadatrophin - quantitation HCG 73529
Human chorionic gonadatrophin - quantitation HCG 66652
Human chorionic gonadatrophin - quantitation HCG 66650
Human chorionic gonadatrophin - quantitation HCG 66651
HVA (homovanillic acid) HVA 66779
Hydatid - microbial antibody testing HYD 69384
Hydroxy methoxy phenylethylene glycol HMPG 66779
Hydroxy-3-methoxymandelic acid, (previously known as VMA) HMMA 66779
Hydroxychloroquinine HOCQ 66812
Hydroxyindoleacetic acid HIAA 66779
Hydroxyprogesterone OHP 66695
Hydroxyproline HYDP 66752

I

Idiopathic hypereosinophilic syndrome 73326
Imipramine IMIP 66812
Immediate frozen section diagnosis of biopsy material FS 72855
Immediate frozen section diagnosis of biopsy material FS 72856
Immunocyto. 1-3 antibodies ICC 73059
Immunocyto. 1-3 antibodies ICC 73061
Immunocyto. 4 + antibodies ICC1 73060
Immunoelectrophoresis and electrophoresis - characterisation of cryoglobulins RY 71059
Immunoelectrophoresis and electrophoresis - characterisation of paraprotein PPRO 71059
Immunoglobulins - A IGA 71066
Immunoglobulins - D IGD 71074
Immunoglobulins - E (total) IGE 71075
Immunoglobulins - E (total) IGE 71076
Immunoglobulins - E (total) IGE 71077
Immunoglobulins - E (total) IGE 71079
Immunoglobulins - G IGG 71068
Immunoglobulins - M IGM 71072
Immunoglobulins -G, 4 subclasses SIGG 71073
Immunohistochemical investigation of biopsy material HIS 72846
Immunohistochemical investigation of biopsy material HIS 72847
Immunohistochemical investigation of biopsy material HIS 72848
Infectious mononucleosis IM 69384

Influenza A - microbial antibody testing FLA 69384
Influenza B - microbial antibody testing FLB 69384
Insulin INS 66695
Intestinal disaccharidases INTD 66680
Iron studies (iron, transferrin & ferritin) IS 66596
Isoelectric focussing and electrophoresis - characterisation of cryoglobulins RY 71059
Isoelectric focussing and electrophoresis - characterisation of paraprotein PPRO 71059

J

Jo-1 - tissue antigens - antibodies JO1 71119

K

Keratin - tissue antigens - antibodies KERA 71119
Kleihauer test KLEI 65162
KRAS gene mutation status 73338

L

Lactate - dehydrogenase isoenzymes LDI 66641
Lactate - dehydrogenase LDH 66500
Lactate LACT 66500
Lamellar body phospholipid LBPH 66749
Lead PB 66665
Lecithin/sphingomyelin ratio (amniotic fluid) LS 66749
Legionella pneumophila - serogroup 1 - microbial antibody testing LP1 69384
Legionella pneumophila - serogroup 2 - microbial antibody testing LP2 69384
Leishmaniasis - microbial antibody testing LEI 69384
Leptospira - microbial antibody testing LEP 69384
Leucocyte count - 3 surface markers - blood, CSF, serous fluid LMH3 71139
Leucocyte count - 3 surface markers - tissue LMT3 71141
Leucocyte count - 6 surface markers - blood, CSF, serous fluid & tissue(s) LMHT 71145
Leucocyte count - 6 surface markers - blood, CSF, serous fluid or tissue LM6 71143
Leucocyte count - CD34 surface marker only - blood LMCD34 71146
Leucocyte count WCC 65070
Light chains - free kappa or lambda LCHS 71200
Lignocaine LIGN 66800
Lip - cytology on specimens from SMCY 73043
Lipase LIP 66500
Lipid studies (see test groups at para PQ.4) 66500
Lipoprotein subclasses - electrophoresis LEPG 66539
Listeria - microbial antibody testing LIS 69384
Lithium LI 66800
Liver/kidney microsomes - tissue antigens - antibodies LKA 71119
Lupus anticoagulant LUPA 65137
Lupus anticoagulant LUPA 65142
Luteinizing hormone LH 66695
Lymphocytes - functional tests - 1 test LF1 71127
Lymphocytes - functional tests - 2 test LF2 71129
Lymphocytes - functional tests - 3 tests LF3 71131

M

Magnesium MG 66500
Mammary serum antigen MSA 66650
Mantoux test MANT 73811
Mast cell disease 73326
Measles - microbial antigen testing MEA 69384
Metabolic bone disease CBMB 66776
Metanephrines MNEP 66779
Methadone MTDN 66812
Methaemalbumin detection (Schumm's test) SCHM 65117
Methotrextate MTTA 66812
Methsuximide MSUX 66812
Methylphenobarbitone MPBT 66812
Metronidazole MRDZ 66812
Mexiletine (Mexitil) MEX 66812
Mianserin MIAS 66812
Microalbumin MALB 66560
Microbial antibody testing - Varicella zoster VCZ 69384
Microbial antibody testing - actinomyetes ACT 69384
Microbial antibody testing - adenovirus ADE 69384
Microbial antibody testing - aspergillus ASP 69384
Microbial antibody testing - avian precipitins (bird fancier's disease) APP 69384
Microbial antibody testing - Blastomyces BLM 69384
Microbial antibody testing - Bordetella pertussis BOR 69384
Microbial antibody testing - Borrelia burgdorferi BOB 69384
Microbial antibody testing - Brucella BRU 69384
Microbial antibody testing - Campylobacter jejuni CAM 69384
Microbial antibody testing - Candida CAN 69384
Microbial antibody testing - Chlamydia CHL 69384
Microbial antibody testing - Coccidiodes CCC 69384
Microbial antibody testing - Coxsackie B1-6 COX 69384
Microbial antibody testing - cryptococcus CRY 69384
Microbial antibody testing - cytomegalovirus CMV 69384
Microbial antibody testing - cytomegalovirus serology in pregnancy CMVP 69384
Microbial antibody testing - dengue DEN 69384
Microbial antibody testing - diphtheria DIP 69384
Microbial antibody testing - echinococcus ECC 69384
Microbial antibody testing - echo-coxsackie group ECH 69384
Microbial antibody testing - Entamoeba histolytica AMO 69384
Microbial antibody testing - Epstein Barr virus EBV 69474
Microbial antibody testing - Eptein Barr virus EBV 69472
Microbial antibody testing - fluorescent treponemal antibody - absorption test (69384
Microbial antibody testing - Haemophilus influenzae HUS 69384
Microbial antibody testing - herpes simplex virus HPA 69384
Microbial antibody testing - Histoplasma HIP 69384
Microbial antibody testing - Human Immunodeficiency Virus 69384
Microbial antibody testing - hydatid HYD 69384
Microbial antibody testing - infectious mononucleosis IM 69384
Microbial antibody testing - influenza A FLA 69384
Microbial antibody testing - influenza B FLB 69384
Microbial antibody testing - Legionella pneumophila - serogroup 1 LP1 69384
Microbial antibody testing - Legionella pneumophila - serogroup 2 LP2 69384
Microbial antibody testing - leishmaniasis LEI 69384
Microbial antibody testing - Leptospira LEP 69384
Microbial antibody testing - Listeria LIS 69384
Microbial antibody testing - measles MEA 69384
Microbial antibody testing - Micropolyspora faeni MIC 69384
Microbial antibody testing - mumps MUM 69384
Microbial antibody testing - Murray Valley encephalitis MVE 69384
Microbial antibody testing - Mycoplasma pneumoniae MYC 69384
Microbial antibody testing - Neisseria meningitidis MEN 69384
Microbial antibody testing - Newcastle disease NCD 69384
Microbial antibody testing - parainfluenza 1 PF1 69384
Microbial antibody testing - parainfluenza 2 PF2 69384
Microbial antibody testing - parainfluenza 3 PF3 69384
Microbial antibody testing - paratyphi PTY 69384
Microbial antibody testing - pertussis PER 69384
Microbial antibody testing - poliomyelitis PLO 69384
Microbial antibody testing - Proteus OX 19 POX 69384
Microbial antibody testing - Proteus OXK POK 69384
Microbial antibody testing - Q fever QFF 69384

Microbial antibody testing - rapid plasma reagin test RPR 69384
Microbial antibody testing - respiratory syncytial virus RSV 69384
Microbial antibody testing - Ross River virus RRV 69384
Microbial antibody testing - rubella RUB 69384
Microbial antibody testing - Salmonella typhi (H) SAH 69384
Microbial antibody testing - Salmonella typhi (O) SAO 69384
Microbial antibody testing - Schistosoma STO 69384
Microbial antibody testing - streptococcal serology - anti DNASE B titre ADNB 69384
Microbial antibody testing - streptococcal serology - anti-streptolysin O titre 69384
Microbial antibody testing - Strptococcus pneumoniae PCC 69384
Microbial antibody testing - tetanus TET 69384
Microbial antibody testing - Thermoactinomyces vulgaris THE 69384
Microbial antibody testing - thermopolyspora TPS 69384
Microbial antibody testing - Toxocara TOC 69384
Microbial antibody testing - toxoplasma TOX 69384
Microbial antibody testing - TPHA (Treponema pallidum haemagglutination test) TP 69384
Microbial antibody testing - Treponema pallidum haemagglutination test TPHA 69384
Microbial antibody testing - trichinosis TOS 69384
Microbial antibody testing - typhus, Weil-Felix TYP 69384
Microbial antibody testing - VDRL (Venereal Disease Research Laboratory) VDRL 69384
Microbial antibody testing - Yersinia entercolitica YER 69384
Microbial antigen testing - Clostridium difficile CLDT 69363
Microscopic examination of - faeces for parasites OCP 69336
Microscopic examination of - faeces for parasites OCP 69339
Microscopy & culture of - material from nose, throat, eye or ear MCSW 69303
Microscopy & culture of - material from skin MCSK 69309
Microscopy & culture of - postoperative wounds, aspirates of body cavities MCPO 69321
Microscopy & culture of - specimens of sputum MCSP 69318
Microscopy & culture of - specimens of sputum, urine or other body fluids for my 69327
Microscopy & culture of - specimens of sputum, urine or other body fluids for my 69330
Microscopy & culture of - specimens of sputum, urine or other body fluids for my 69324
Microscopy & culture of - superficial sites MCSS 69306
Microscopy & culture of - urethra, vagina, cervix or rectum MCGR 69312
Microscopy of wet film material other than blood MWFM 69300
Microscopy, culture, identification & sensitivity of urine UMCS 69333
Mitachondria - tissue antigens - antibodies MA 71119
Mouth - cytology on specimens from SMCY 73043
Mumps - microbial antibody testing MUM 69384
Murray Valley encephalitis - microbial antibody testing MVE 69384
Mycobacteria microscopy & culture of sputum - 1 specimen AFB1 69324
Mycobacteria microscopy & culture of sputum - 2 specimens AFB2 69327
Mycobacteria microscopy & culture of sputum - 3 specimens AFB3 69330
Mycoplasma pneumoniae - microbial antibody testing MYC 69384
Myoglobin MYOG 66518

N

N-acetyl procainamide NAPC 66812
Neisseria menigitidis antibody testing MEN 69384
Netilmicin 66800
Neutrophil functions NFT 71135
Newcastle disease - microbial antibody testing NCD 69384
Nipple discharge - cytology on specimens from SMCY 73043
Nitrazepam NITR 66812
Nordothiepin NDIP 66812
Norfluoxetine NFLE 66812
Nortriptyline NORT 66812
Nose - cytology on specimens from SMCY 73043
Nose - microscopy & culture of material from MCSW 69303
Nuclear antigens - detection of antibodies to ANA 71097

O

Oestradiol E2 66695
Oestrone E1 66695
Oligoclonal proteins OGP 71062
Op/biopsy specimens - microscopy & culture of material from MCPO 69321
Oral glucose challenge test - gestational diabetes OGCT 66545
Oral glucose tolerance test - gestational diabetes GTTP 66542
Osmolality, serum or urine OSML 66563
Oxalate OXAL 66752
Oxazepam OXAZ 66812

P

PAA (phenyl acetic acid) PAA 66779
Palmitic acid in amniotic fluid PALM 66749
Pap smear CCR 73053
Papanicolaou test CCR 73053
Paracetamol PARA 66800
Parainfluenza 1 - microbial antibody testing PF1 69384
Parainfluenza 2 - microbial antibody testing PF2 69384
Parainfluenza 3 - microbial antibody testing PF3 69384
Paraprotein characterisation - by electrophoresis, and immunoelectrophoresis or 71059
Paraprotein characterisation - on concurrently collected serum or urine PPSU 71060
Paraprotein quantitation - by electrophoresis EPPI 71057
Paraquat PARQ 66812
Parasites - microscopic examination of faeces OCP 69336
Parasites - microscopic examination of faeces OCP 69339
Parathyroid hormone (PTH) PTH 66695
Paratyphi - microbial antibody testing PTY 69384
Partial thromboplastin time PTT 65120
Patient Episode Initiation private 73899
Patient Episode Initiation public 73900
Pentobarbitone PENT 66812
Perhexiline PHEX 66812
Pertussis - microbial antibody testing PER 69384
Phenobarbitone PHBA 66800
Phensuximide PHEN 66812
Phenylacetic acid PAA 66779
Phenytoin PHEY 66800
Phosphate PHOS 66500
Phosphatidylglycerol PTGL 66749
Platelet - aggregation PLTG 65144
Platelet count PLTC 65070
PM-Sc1 - tissue antigens - antibodies PM1 71119
Poliomyelitis - microbial antibody testing PLO 69384
Polycythaemia vera 73325
Porphobilinogen in urine UPG 66782
Porphyrins - quantitative test, 1 or more fractions PR 66785
Porphyrins in urine - qualitative test UPR 66782
Potassium K 66500
Prealbumin PALB 66632
Prednisolone PRED 66812
Pregnancy serology - 1 test MSP1 69405
Pregnancy serology - 2 tests MSP2 69408
Pregnancy serology - 3 tests MSP3 69411
Pregnancy serology - 4 tests MSP4 69413
Pregnancy testing 73806

Pregnancy testing - bile acids in blood BABP 66517
Pregnancy testing - HCG detection HCGP 73527
Pregnancy testing - HCG detection HCGP 73529
Pregnancy testing - HCG quantitation HCG 73529
Primidone PRIM 66800
Procainamide PCAM 66800
Progesterone PROG 66695
Prolactin PROL 66695
Propranolol PPNO 66812
Prostate specific antigen PSA 66655
Prostate specific antigen PSA 66656
Prostate specific antigen PSA 66659
Protein C PROC 65142
Protein C PROC 65171
Protein S PROS 65142
Protein S PROS 65171
Protein, quantitation of - alpha fetoprotein AFP 66650
Protein, quantitation of - alpha fetoprotein AFP 66651
Protein, quantitation of - alpha fetoprotein AFP 66652
Protein, quantitation of - alpha fetoprotein AFP 66653
Protein, quantitation of - alpha fetoprotein AFP 66743
Protein, quantitation of - alpha-l-antitrypsin AAT 66635
Protein, quantitation of - beta-2-microglobulin BMIC 66629
Protein, quantitation of - C-1 esterase inhibitor CEI 66644
Protein, quantitation of - caeruloplasmin CPLS 66632
Protein, quantitation of - classes or presence and amount of paraprotein by elec 71057
Protein, quantitation of - classes or presence and amount of paraprotein by elec 71058
Protein, quantitation of - ferritin (see also Iron studies) FERR 66593
Protein, quantitation of - haptoglobins HGLB 66632
Protein, quantitation of - microalbumin MALB 66560
Protein, total - quantitation of PROT 66500
Proteus OX 19 - microbial antibody testing POX 69384
Proteus OXK - microbial antibody testing POK 69384
Prothrombin time PT 65120
Pyruvate PVTE 66500

Q

Q Fever - microbial antibody testing QFF 69384
Quinalbarbitone QUIB 66812
Quinidine QUIN 66800
Quinine QNN 66812

R

Rapid plasma reagin test - microbial antibody testing RPR 69384
RAST RAST 71079
Rectum - microscopy & culture of material from MCGR 69312
Red blood cells - Kleihauer KLEI 65162
Red cell porphyrins - qualitative test RCP 66782
Renin REN 66695
Reptilase test REPT 65120
Respiratory syncytial virus - microbial antibody testing RSV 69384
Reticulin - tissue antigens - antibodies RCA 71119
Reticulocyte count RETC 65072
Rheumatoid factor - quantitation RFQ 71106
Rheumatoid factor RF 71106
Ross River virus - microbial antibody testing RRV 69384
RSV (respiratory syncytial virus) - microbial antibody testing RSV 69384
Rubella - serology RUB 69384

S

Salicylate (aspirin) SALI 66800
Salmonella typhi (H) - microbial antibody testing SAH 69384
Salmonella typhi (O) - microbial antibody testing SAO 69384
Schistosoma - microbial antibody testing STO 69384
Scl-70 - tissue antigens - antibodies SCL 71119
Second, expert, opinion morphology, complex - SEOC 72859
Second, expert, opinion morphology, non-complex - SEON 72858
Semen examination - for spermatozoa (post vasectomy) SES 73521
Semen examination SEE 73523
Serotonin 5HT 66779
Serum - B12 B12 66838
Serum Folate & Red cell folate if required 66840
Serum Folate SF 66840
Sex hormone binding globulin SHBG 66695
SF 66840
Skin - microscopy & culture of material from MCSS 69306
Skin - microscopy, culture & Chlamydia of material from MCSK 69309
Skin cytology SMCY 73043
Smooth muscle - tissue antigens - antibodies SMA 71119
Snake venom HISS 66623
Sodium NA 66500
Solid tissue or tissues - chemical assays ENZS 66683
Solid tissue or tissues - cytology of fine needle aspiration FNCY 73049
Solid tissue or tissues - cytology of fine needle aspitation by, or in presence 73051
Somatomedin SOMA 66695
Sotalol SALL 66812
Specific IgC antibodies - respiratory disease allergens RDA 71189
Specific IgG or IgE antibodies RAST 71079
Specimen dissection - level 7 SPE7 72838
Sperm antibodies - penetrating ability SPA 73525
Sperm antibodies SAB 73525
Sputum - cytology (1 specimen) BFCY 73045
Sputum - cytology (3 specimens) SPCY 73047
Sputum - for mycobacteria - 1 specimen AFB1 69324
Sputum - for mycobacteria - 2 specimens AFB2 69327
Sputum - for mycobacteria - 3 specimens AFB3 69330
Sputum - microscopy & culture of specimens MCSP 69318
Stelazine STEL 66812
Steroid fraction or fractions in urine USF 66695
Streptococcal serology - anti-DNASE B titre - microbial antibody testing ADNB 69384
Streptococcal serology - anti-streptolysin O titre - microbial antibody testing 69384
Streptococcus pneumoniae - microbial antibody testing PCC 69384
Stypven test STYP 65120
Sugar water test SWT 65075
Sulthiame (Ospolot) SUL 66812
Syphilis serology (see test groups at para PQ.4) STS 69387

T

Testosterone TES 66695
Tetanus - microbial antibody testing TET 69384
Thalassaemia studies TS 65078
Theophylline THEO 66800
Thermaactinomyces vulgaris - microbial antibody testing THE 69384
Thermopolyspora - microbial antibody testing TPS 69384
Thiopentone TOPO 66812
Thiopurine S-methyltransferase 73327
Thioridazine THIO 66812
Throat - microscopy & culture of material from MCSW 69303
Thrombin time TT 65120
Thyroglobulin TGL 66650
Thyroid function tests (including TSH) TFT 66719
Thyroid stimulating hormone 66734

Thyroid stimulating hormone (if requested on its own, or as a preliminary test 66716
Thyroid stimulating hormone (if requested with other hormones referred to in ite 66728
Thyroid stimulating hormone (if requested with other hormones referred to in ite 66722
Thyroid stimulating hormone (if requested with other hormones referred to in ite 66724
Thyroid stimulating hormone (if requested with other hormones referred to in ite 66731
Thyroid stimulating hormone (if requested with other hormones referred to in ite 66723
Thyroid stimulating hormone (if requested with other hormones referred to in ite 66725
Tissue transglutaminase antibodies TTG 71163
Tobramicin 66800
Total protein PROT 66500
Toxocara - microbial antibody testing TOC 69384
Toxoplasma - microbial antibody testing TOX 69384
TPHA (Treponema pallidum haemagglutination test) 69384
Treponema pallidum haemagglutination test 69384
Trichinosis - microbial antibody testing TOS 69384
Triglycerides TRIG 66500
Trimipramine TRIM 66812
Troponin TROP 66518
Tryptase - serum TRYP 71198
Tryptic activity in faeces TAF 66677
Tuberculosis MANT 73811
Tumour markers - CA-125 antigen C125 66650
Tumour markers - CA-15.3 anitgen CA15 66650
Tumour markers - CA-19.9 antigen CA19 66650
Tumour markers - carcinoembryonic antigen CEA 66650
Tumour markers - mammary serum antigen MSA 66650
Tumour markers - prostate specific antigen PSA 66656
Tumour markers - prostatic acid phosphatase - 1 or more fractions ACP 66656
Tumour markers - thryroglobulin TGL 66650
Typhus, Weil-Felix - microbial antibody testing TYP 69384

U

Urate URAT 66500
Urea U 66500
Urethra - microscopy & culture of material from MCGR 69312
Urine - acidification test UAT 66587
Urine - catalase test UCAT 73805
Urine - cystine (cysteine) UCYS 66782
Urine - cytology - on 1 specimen BFCY 73045
Urine - cytology - on 3 specimens SPCY 73047
Urine - haemoglobin UHB 66782
Urine - microscopy, culture, identification & sensitivity UMCS 69333
Urine - porphyrins - qualitative test UPR 66782
Urine - prophobilinogen UPG 66782
Urine - steroid fraction or fractions USF 66695
Urine - urobilinogen UUB 66782

V

Vagina - cytology on specimens from CVO 73057
Vagina - microscopy & culture of material from MCGR 69312
Valproate (Epilim) VALP 66800
Vancomycin VAN 66800
Varicella zoster - microbial antibody testing VCZ 69384
Vasoactive intestinal peptide VIP 66695
Vasopressin ADH 66695
VDRL (Venereal Disease Researce Laboratory) - microbial antibody testing VDRL 69384
Viscosity of blood or plasma VISC 65060
Vitamins - 1,25-dihydroxyvitamin D 66835,66836
Vitamins - 25-hydroxyvitamin D 66833
Vitamins - B12 B12 66838
Vitamins - B12 markers B12M 66839
Vitamins - D VITD 66833,66835,66836
Vitamins - quantitation of A or E 66607
Vitamins - quantitation of B1, B2, B3, B6 or C 66605
Von Hippel-Lindau - Diagnostics (germline) 73333
Von Hippel-Lindau - Predictive (relatives) 73334
Von Hippel-Lindau - Somatic 73335
Von Willebrand's factor antigen VWA 65150
Von Willebrand's factor VWF 65150

W

Warfarin WFR 66812

Y

Yersinia entercolitica - microbial antibody testing YER 69384

Z

Zinc ZN 66667

COMPLEXITY LEVELS FOR HISTOPATHOLOGY ITEMS

Specimen Type	Complexity level
Adrenal resection, neoplasm	5
Adrenal resection, not neoplasm	4
Anus, all specimens not otherwise specified	3
Anus, neoplasm, biopsy	4
Anus, neoplasm, radical resection	6
Anus, submucosal resection – neoplasm	5
Appendix	3
Artery, all specimens not otherwise specified	3
Artery, biopsy	4
Bartholin's gland - cyst	3
Bile duct, resection - all specimens	6
Bone, biopsy, curettings or fragments - lesion	5
Bone, biopsy or curettings quantitation - metabolic disease	6
Bone, femoral head	4
Bone, resection, neoplasm - all sites and types	6
Bone marrow, biopsy	4
Bone - all specimens not otherwise specified	4
Brain neoplasm, resection - cerebello-pontine angle	4
Brain or meninges, biopsy - all lesions	5
Brain or meninges, not neoplasm - temporal lobe	6
Brain or meninges, resection - neoplasm (intracranial)	5
Brain or meninges, resection - not neoplasm	4
Branchial cleft, cyst	4
Breast, excision biopsy, guidewire localisation - non-palpable lesion	6
Breast, excision biopsy, or radical resection, malignant neoplasm or atypical proliferative disease - all specimen types	6
Breast, incision biopsy or needle biopsy, malignant neoplasm - all specimen types	4
Breast – microdochectomy	6
Breast, orientated wide local excision for carcinoma, with margin assessment	7
Breast tissue - all specimens not otherwise specified	4
Bronchus, biopsy	4
Carotid body - neoplasm	5
Cholesteatoma	3
Digits, amputation - not traumatic	4
Digits, amputation - traumatic	2
Ear, middle and inner - not cholesteatoma	4
Endocrine neoplasm - not otherwise specified	5
Extremity, amputation or disarticulation – neoplasm	6
Extremity, amputation - not otherwise specified	4
Eye, conjunctiva - biopsy or pterygium	3
Eye, cornea	4
Eye, enucleation or exenteration - all lesions	6
Eye - not otherwise specified	4
Fallopian tube, biopsy	4

Specimen Type	Complexity level
Fallopian tube, ectopic pregnancy	4
Fallopian tube, sterilization	2
Fetus with dissection	6
Foreskin - new born	2
Foreskin - not new born	3
Gallbladder	3
Gallbladder and porta hepatis-radical resection	6
Ganglion cyst, all sites	3
Gum or oral mucosa, biopsy	4
Heart valve	4
Heart - not otherwise specified	5
Hernia sac	2
Hydrocele sac	2
Jaw, upper or lower, including bone, radical resection for neoplasm	6
Joint and periarticular tissue, without bone - all specimens	3
Joint tissue, including bone - all specimens	4
Kidney, biopsy including transplant	5
Kidney, nephrectomy transplant	5
Kidney, partial or total nephrectomy or nephroureterectomy - neoplasm	6
Kidney, partial or total nephrectomy - not neoplasm	4
Large bowel (including rectum), biopsy - all sites	4
Large bowel, colostomy - stoma	3
Large bowel (including rectum), biopsy, for confirmation or exclusion of Hirschsprung's Disease	5
Large bowel (including rectum), polyp	4
Large bowel, segmental resection - colon, not neoplasm	5
Large bowel (including rectum), segmental resection, neoplasm	6
Large bowel (including rectum), submucosal resection – neoplasm	5
Larynx, biopsy	4
Larynx, partial or total resection	5
Larynx, resection with nodes or pharynx or both	6
Lip, biopsy - all specimens not otherwise specified	3
Lip, wedge resection or local excision with orientation	4
Liver, hydatid cyst or resection for trauma	4
Liver, total or subtotal hepatectomy - neoplasm	6
Liver - all specimens not otherwise specified	5
Lung, needle or transbronchial biopsy	4
Lung, resection - neoplasm	6
Lung, wedge biopsy	5
Lung segment, lobar or total resection	6
Lymph node, biopsy - all sites	4
Lymph node, biopsy – for lymphoma or lymphoproliferative disorder	5
Lymph nodes, regional resection - all sites	5
Mediastinum mass	5
Muscle, biopsy	6
Nasopharynx or oropharynx, biopsy	4
Nerve, biopsy neuropathy	5

Specimen Type	Complexity level
Nerve, neurectomy or removal of neoplasm	4
Nerve - not otherwise specified	3
Nose, mucosal biopsy	4
Nose or sinuses, polyps	3
Odontogenic neoplasm	5
Odontogenic or dental cyst	4
Oesophagus, biopsy	4
Oesophagus, diverticulum	3
Oesophagus, partial or total resection	6
Oesophagus, submucosal resection – neoplasm	5
Omentum, biopsy	4
Ovary with or without tube - neoplasm	5
Ovary with or without tube - not neoplasm	4
Pancreas, biopsy	5
Pancreas, cyst	4
Pancreas, subtotal or total with or without splenectomy	6
Parathyroid gland(s)	4
Penisectomy with node dissection	5
Penisectomy - simple	4
Peritoneum, biopsy	4
Pituitary neoplasm	4
Placenta - not third trimester	4
Placenta - third trimester, abnormal pregnancy or delivery	4
Pleura or pericardium, biopsy or tissue	4
Products of conception, spontaneous or missed abortion	4
Products of conception, termination of pregnancy	3
Prostate, radical prostatectomy or cystoprostatectomy for carcinoma	7
Prostate, radical resection	6
Prostate - all types of specimen not otherwise specified	4
Retroperitoneum, neoplasm	5
Salivary gland, Mucocele	3
Salivary gland, neoplasm - all sites	5
Salivary gland - all specimens not otherwise specified	4
Sinus, paranasal, biopsy	4
Sinus, paranasal, resection - neoplasm	6
Skin, biopsy - blistering skin diseases	4
Skin biopsy - for investigation of alopecia other than for male pattern baldness, where serial horizontal sections are taken	5
Skin, biopsy - for investigation of lymphoproliferative disorder	5
Skin, biopsy - inflammatory dermatosis	4
Skin,eyelid, wedge resection	4
Skin, local resection - orientation	4
Skin, resection of malignant melanoma or melanoma in-situ	5
Skin - all specimens not otherwise specified including all neoplasms and cysts	3
Small bowel - biopsy, all sites	4
Small bowel, diverticulum	3

Specimen Type	Complexity level
Small bowel, resection - neoplasm	6
Small bowel – resection, all specimens	5
Small bowel, submucosal resection – neoplasm	5
Soft tissue, infiltrative lesion, extensive resections at least 5cm in maximal dimension	6
Soft tissue, lipoma and variants	3
Soft tissue, neoplasm, not lipoma - all specimens	5
Soft tissue - not otherwise specified	4
Spleen	5
Stomach, endoscopic biopsy or endoscopic polypectomy	4
Stomach, resection, neoplasm - all specimens	6
Stomach, submucosal resection – neoplasm	5
Stomach - all specimens not otherwise specified	4
Tendon or tendon sheath, giant cell neoplasm	4
Tendon or tendon sheath - not otherwise specified	3
Testis, biopsy	5
Testis and adjacent structures, castration	2
Testis and adjacent structures, neoplasm with or without nodes	5
Testis and adjacent structures, vas deferens sterilization	2
Testis and adjacent structures - not otherwise specified	3
Thymus - not otherwise specified	5
Thyroglossal duct - all lesions	4
Thyroid - all specimens	5
Tissue or organ not otherwise specified, abscess	3
Tissue or organ not otherwise specified, haematoma	3
Tissue or organ not otherwise specified, malignant neoplasm with regional nodes	6
Tissue or organ not otherwise specified, neoplasm local	4
Tissue or organ not otherwise specified, pilonidal cyst or sinus	3
Tissue or organ not otherwise specified, thrombus or embolus	3
Tissue or organ not otherwise specified, veins varicosity	3
Tissue or organ - all specimens not otherwise specified	3
Tongue, biopsy	4
Tongue or tonsil, neoplasm local	5
Tongue or tonsil, neoplasm with nodes	6
Tonsil, biopsy - excluding resection of whole organ	4
Tonsil or adenoids or both	2
Trachea, biopsy	4
Ureter, biopsy	4
Ureter, resection	5
Urethra, biopsy	4
Urethra, resection	5
Urinary bladder, partial or total with or without prostatectomy	6
Urinary bladder, transurethral resection of neoplasm	5
Urinary bladder - all specimens not otherwise specified	4
Uterus, cervix, curettings or biopsy	4
Uterus, cervix cone, biopsy (including LLETZ or LEEP biopsy)	5
Uterus, endocervix, polyp	3

Specimen Type	Complexity level
Uterus, endometrium, polyp	3
Uterus with or without adnexa, malignant neoplasm - all specimen types not otherwise specified	6
Uterus with or without adnexa, neoplasm, Wertheim's or pelvic clearance	6
Uterus and/or cervix - all specimens not otherwise specified	4
Vagina, biopsy	4
Vagina, radical resection	6
Vaginal mucosa, incidental	3
Vulva or labia, biopsy	4
Vulval, subtotal or total with or without nodes	6

CLEFT LIP AND CLEFT PALATE SERVICES

CATEGORY 7

SUMMARY OF CHANGES FROM 1/1/2016

The 1/1/2016 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

There are no changes to this Category for 1 January 2016.

C.1.1. INTRODUCTION - MEDICARE BENEFITS

The Medicare Benefits Schedule includes certain professional services in respect of the treatment of cleft lip and cleft palate conditions for which Medicare benefits are payable. These services are normally described as dental services. However, for the purposes of these Notes the word "medical" is to be interpreted to include "dental". The definition of professional service as contained in the Health Insurance Act provides that such a service must be "clinically relevant". A clinically relevant service means a service rendered by a medical or dental practitioner or optometrist that is generally accepted in the medical, dental or optometrical profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered.

Medicare benefits are payable in respect of services listed in the Schedule, when the services are rendered by eligible dental practitioners to prescribed dental patients.

The Schedule lists three categories of professional services:

- (Group C1) Orthodontic Services
- (Group C2) Oral and Maxillofacial Surgical Services
- (Group C3) General and Prosthodontic Services

C.2.1. DENTAL PRACTITIONER ELIGIBILITY

In order to attract Medicare benefits, all treatment must be carried out by eligible dental practitioners who are resident in Australia.

All registered dental practitioners are entitled to perform simple extraction services covered by Items 75200–75206 listed in Group C2 of the Schedule and the general and prosthodontic services listed in Group C3 of the Schedule.

Dental practitioners who wish to perform those orthodontic services listed in Group C1 of the Schedule must be registered in the specialty of orthodontics.

Dental practitioners who were previously accredited to provide Cleft Lip and Cleft Palate services who do not meet the registration requirements as a dental specialist will be grandfathered under legislative arrangements that came into force on 1 November 2012.

Oral and maxillofacial services listed in Group C2 may be performed by:

- Medical practitioners who are specialists in the practice of their specialty of oral and maxillofacial surgery; and
- Dental practitioners who were approved by the Minister prior to 1 November 2004 for the purposes of Subsection 3 (1) of the Act to carry out prescribed medical services (oral and maxillofacial surgery) contained in the Medicare Benefits Schedule.

C.3.1. PATIENT ELIGIBILITY

To be eligible to claim benefits for Schedule services performed by eligible dental practitioners, a patient must satisfy the following criteria:

(a) The patient must be an Australian resident or any other person or class of persons whom the Minister declares to be eligible. All eligible persons will be issued with a Medicare card on application as evidence of their eligibility.

(b) Under the provisions of Section 3BA of the Health Insurance Act a patient must be a prescribed dental patient, ie

- a person aged up to 22 years, in respect of whom, a certificate has been issued by a medical practitioner or dental practitioner approved by the Minister, stating that the person is suffering from a clef lip or cleft palate condition*;
- a person aged up to 28 years, in respect of whom, prior to turning 22 years,
  - a certificate has been issued by a medical practitioner or dental practitioner approved by the Minister, stating that the person is suffering from a cleft lip or cleft palate condition*, and
  - that person commenced treatment for a cleft lip or cleft palate condition;
- a person aged 28 and over requiring a specific course of treatment for the repair of previous reconstructive surgery, provided that:
  - prior to turning 22 years, a certificate has been issued by a medical practitioner or dental practitioner approved by the Minister, stating that the person is suffering from a cleft lip or cleft palate condition*, and
  - the person received treatment for a cleft lip or cleft palate condition prior to turning 28 years, and
  - if the Minister has declared in writing that he or she is satisfied that:
    (i) because of exceptional circumstances, the person required repair of previous reconstructive surgery in connection with the condition, and

(ii) the person therefore needs to undergo that course of treatment; and

- a person aged up to 22 years in respect of whom a certificate has been issued by a medical practitioner or dental practitioner approved by the Minister, stating that the person is suffering from a condition determined by the Minister to be a condition to which the definition of a prescribed dental patient under Section 3BA of the Act applies.

In consultation with the professions, the Department of Health has completed as review of the conditions described as 'other' underpinning the Cleft Lip and Cleft palate Scheme. A Ministerial Determination is now in place for these 'other' conditions, enabling the payment of Medicare benefits for the conditions listed below.

Conditions for which a patient may be prescribed include the following:

1. Oral and/or facial clefting	
Limited to	Cleft lip, alveolus and/or palate
	Tessier facial cleft
2. Congenital or hereditary craniofacial malformation, deformation or disruption	
Limited to	Achondroplasia
	Branchial arch disorders including: Hemifacial/craniofacial microsomia, Goldenhar syndrome, DiGeorge syndrome, Velocardiofacial syndrome
	CHARGE syndrome
	Congenital hemifacial hyperplasia
	Congenital lymphatic and/or vascular malformations of the head & neck, cystic hygroma, Sturge-Weber syndrome, *excluding haemangiomas, birth marks and naevi.*
	Craniofacial Neurofibromatosis Type 1
	Craniometaphyseal dysplasia
	Ectodermal dysplasia
	Hemifacial atrophy (Parry Romberg syndrome)
	Mandibulofacial dysostosis (Treacher Collins syndrome)
	Maxillonasal dysplasia (Binder syndrome)
	Oral-facial digital syndrome Type 1
	Pierre Robin sequence
	Rubinstein-Taybi syndrome
	Sphrintzen-Goldberg syndrome
	Solitary median maxillary central incisor syndrome
	Stickler syndrome
	Syndromic craniosynostoses including: Apert, Crouzon, Pfeiffer, Saethre Chotzen, and Muenke syndromes
	Trichorhinophalangeal syndrome Type 1
3. Hereditary conditions presenting with the absence of 6 (six) or more permanent teeth, excluding 3rd molars	
4. Hereditary conditions where the presence of supernumerary teeth is a major feature	
Limited to	Cleidocranial dysplasia
	Gardner syndrome
5. Hereditary conditions affecting the formation of enamel and/or dentine of all teeth	
Limited to	Amelogenesis imperfecta
	Dentinogenesis imperfecta
	Regional odontodysplasia

*Note: The above conditions have been listed in the terminology that they are generally known under. Some conditions are similar to, or otherwise known as, other conditions on the list.

Please contact the Department of Human Services by telephone on 1300 652 492 if the condition is not listed here.

C.3.2. APPLICATION FOR APPROVAL FOR REPAIRS TO PREVIOUS RECONSTRUCTIVE WORK

Applicants aged 28 and over seeking approval for repairs to previous reconstructive work under the Cleft Lip and Cleft Palate Scheme will be required to provide clinical details outlining the need for the repair of previous reconstructive surgery.

NOTE: *Patients aged over 28 years of age are not eligible to receive Medicare payments for treatment until approval from the Minister's delegate has been obtained.*

Applications should include the following:

- a treatment plan devised by the treating professional, for the repair of the reconstructive surgery to be performed, including:
    - an indicative time period for which patient eligibility for claiming related treatments should be reinstated
    - date/s the treatment is expected to commence and
    - date/s the treatment is expected to be completed.
- proof of previous eligibility and treatment under the Cleft Lip and Cleft Palate Scheme. This should take the form of a letter from the treating practitioner, which lists the patient details as follows:
    - full name
    - date of birth
    - address
    - condition
    - Cleft Palate Number
    - date (or approximate) of original surgery

- a clinical report from the treating professional, describing the nature of the repair, information detailing the previous reconstructive surgery provided and an outline of the work to be undertaken.

This information will be forwarded to the Department of Human Services (DHS) for confirmation of eligibility.

Further information about the Scheme is available on the DHS' website at :
http://www.humanservices.gov.au/customer/services/medicare/cleft-lip-and-cleft-palate-scheme

Assessment of Applications
Assessment will take into account the information provided by the applicant and consider the circumstances surrounding each individual application. In the assessment, "previous reconstructive surgery" means surgery undertaken to repair structural defects in connection with a cleft lip or cleft palate condition. Repairs to this surgery must be in relation to the failure or deterioration of this surgery and due to that failure or deterioration, the patient requires further surgical intervention to restore optimal function.

Repair to previous reconstructive surgery may involve items in both the main Medicare Benefits Schedule, and items in the Cleft Lip and Cleft Palate Schedule. Under Section 3BA (2A), upon gaining the Minister's approval, applicants will have full access to items in the Cleft Lip and Cleft Palate Schedule that are necessary for the restoration of optimal function (provided the items are rendered by suitably qualified / approved practitioners).

The identification of the cleft condition and the issue of the Certificate can be undertaken through a special cleft lip and cleft palate clinic or by a medical or dental practitioner authorised for this purpose by the Minister. Cleft lip and cleft palate clinics operate in at least one public hospital in each Australian State/Territory capital city. A list of these clinics and their addresses appears at the end of these Notes.

Practitioners whose patients are unable to attend the hospital clinic should send records of the cleft condition to the Clinic for identification of the condition and issue of the Certificate.

The Certificate is a formal document required under the provisions of the Act. Because the Certificate may have to last for up to twenty-eight years, each eligible patient will also be issued with a plastic identification card. These cards, which are more durable than the paper Certificates, can be used by patients (or parents or guardians) to claim Medicare benefits. Facsimiles of the Certificate and card appear at the end of these Notes.

Patients are eligible for Medicare benefits for treatment received from the date of issue of their Certificate. Where treatment is required immediately after birth, practitioners should telephone a Clinic or approved practitioner so that a Certificate can be prepared which will be effective from that day.

C.3.3. VISITORS TO AUSTRALIA

Medicare benefits for the Cleft Lip and Cleft Palate Scheme are generally not payable to visitors to Australia or temporary residents.

C.3.4. HEALTH CARE EXPENSES INCURRED OVERSEAS

Medicare does not cover medical or hospital expenses incurred outside Australia.

C.4.1. SCHEDULE FEES AND MEDICARE BENEFITS

Medicare benefits are based on fees determined for each Schedule service. The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in the Schedule is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered.

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

There are presently two levels of Medicare benefit payable for cleft lip and cleft palate services:

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

(b) **85% of the Schedule fee,** or the Schedule fee less $76.20 (indexed annually), whichever is the greater, for all other professional services.

It should be noted that the Health Insurance Act makes provision for private medical insurance to cover the "patient gap" (ie, the difference between the Medicare benefit and the Schedule fee) for services attracting benefit at the 75% level. Patients may insure with private health insurance organisations for the gap between the 75% Medicare benefit and the Schedule fee or for amounts in excess of the Schedule fee where the patient has an agreement with their health fund.

C.4.2. WHERE MEDICARE BENEFITS ARE NOT PAYABLE

Medicare benefits are not payable in respect of a professional service where the medical expenses for the service:-

(a) are paid/payable to a public hospital;

(b) are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability. (Please note that if the medical expenses relate to a compensable injury/illness for which the insurer/compensation agency is disputing liability, then Medicare benefits are payable until the liability is accepted);

(c) are for a medical examination for the purposes of life insurance, superannuation, a provident account scheme, or admission to membership of a friendly society; or

(d) are incurred in mass immunisation.

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

(a) the service is rendered by or on behalf of, or under an arrangement with the Australian Government, a State or Territory, a local government body or an authority established under Commonwealth, State or Territory law;

(b) the medical expenses are incurred by the employer of the person to whom the service is rendered;

(c) the person to whom the service is rendered is employed in an industrial undertaking and that service is rendered for the purposes related to the operation of the undertaking; or

(d) the services is a health screening service.

Benefits are not payable for items 75150 to 75621 unless the patient was referred by letter of Referral by a dental practitioner accredited for orthodontic services.

C.4.3. LIMITING RULE

In no circumstances will the benefit payable for a professional service exceed the fee charged for the service.

C.5.1. PENALTIES

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 counseled 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.

C.6.1. BILLING OF THE PATIENT

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

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

(a) Patient's name;
(b) The date on which the professional service was rendered;
(c) A description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment is provided in a hospital or day-hospital facility (other than a Medicare hospital patient), that is, the words (ie, accommodation and nursing care) "admitted patient" immediately preceding the description of the service or an asterisk "*" directly after an item number where used;
(d) The name and practice address or name and provider number of the practitioner who actually rendered the service; (Where the practitioner has more than one practice location recorded with the Department of Human Services, the provider number used should be that which is applicable to the practice location at or from which the service was given).

Each account must also carry a certification by the accredited dental practitioner that:-

(a) the patient's eligibility certificate or identification card has been sighted (this can be done by quoting the number on the identification card); and
(b) the service was required for the treatment associated with the cleft condition.

Where a practitioner wishes to apportion the total fee between the appropriate professional fee for the particular service and any balance outstanding in respect of services rendered previously, the practitioner should ensure that the balance is described in such a way (eg balance of account) that it cannot be mistaken as being a separate service. In particular no item number should be shown against the balance.

Only one original itemised account should be issued in respect of any one medical service and any duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

C.6.2. CLAIMING OF BENEFITS

Claiming Benefits

The patient, upon receipt of a practitioner's account, has three courses open for paying the account and receiving benefits as outlined below.

Paid Accounts

The patient may pay the account and subsequently present the receipt at a Medicare customer service centre for assessment and payment of the Medicare benefit in cash. In these circumstances, where a claimant personally attends a customer service centre, the claimant is not required to complete a Medicare Patient Claim Form (PC1).

In circumstances where the claimant is seeking a cheque payment of the Medicare benefit or is arranging for an agent to receive the Medicare benefit on the claimant’s behalf, completion of a Medicare Patient Claim Form (PC1) is still required.

Unpaid and Partially Paid Accounts

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

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

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

Assignment of Benefits (Direct-Billing) Arrangements
Under the Health Insurance Act the Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need. If a practitioner direct-bills, the practitioner undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:-

- The patient's Medicare card number must be quoted on all direct-bill forms for that patient.
- The basic forms provided are loose leaf to enable the patient details to be imprinted from the Medicare card.
- The forms include information required by Regulations under Subsection 19(6) of the Health Insurance Act.
- The practitioner must cause the particulars relating to the professional service to be set out on the assignment form before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it.

Where a patient is unable to sign the assignment form:

- the signature of the patient's parent, guardian or other responsible person (other than the doctor, doctor's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable; or
- In the absence of a "responsible person" the patient signature section should be left blank.

Where the signature space is either left blank or another person signs on the patient's behalf, the form **must** include:

- the notation “Patient unable to sign” and
- in the section headed 'Practitioner's Use', an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand etc.) and this note should be signed or initialled by the doctor. If in the opinion of the practitioner the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

The administration of the direct-billing arrangements under Medicare as well as the payment of Medicare benefits on patient claims is the responsibility of **the Department of Human Services**. Any enquiries in regard to these matters should therefore be directed to Medicare offices or enquiry points.

Under Medicare any eligible dental practitioner can accept assignment of benefit and direct-bill for any eligible person.

Use of Medicare Cards in Direct Billing
An eligible person who applies to enrol for Medicare benefits (using a Medicare Enrolment/Amendment Application) will be issued with a uniquely numbered Medicare card which shows the Medicare card number, the patient identification number (reference number), the applicant's first given name, initial of second given name, surname and an effective "valid to" date. These cards may be issued on an individual or family basis. Up to 5 persons may be listed on the one Medicare card, and up to 9 persons may be listed under the one Medicare card number.

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

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

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

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

Assignment of Benefit Forms
To meet varying requirements the following types of stationery are available from Medicare. Note that these forms are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of the Department of Human Services.
(a) *Form DB2.* This form is used to assign benefits for services other than requested pathology. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Patient copy and a Practitioner copy.
(b) *Form DB4.* Is a continuous stationery version of Form DB2, and has been designed for use on most office accounting machines.

The Claim for Assigned Benefits (Form DB1N, DB1H)
Practitioners who accept assigned benefits must claim from Medicare using either Claim for Assigned Benefits form DB1N or DB1H. The DB1N form should be used where services are rendered to persons for treatment provided out of hospital or day hospital treatment. The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than public patients). Both forms have been designed to enable benefit for a claim to be directed to a practitioner other than the one who rendered the services. The facility is intended for use in situations such as where a short term locum is acting on behalf of the principal doctor and setting the locum up with a provider number and pay-group link for the principal doctor's practice is impractical. Practitioners should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.

The DB1N and DB1H are also loose leaf to enable imprinting of practitioner details using the special Medicare imprinter. For this purpose, practitioner cards, showing the practitioner's name, practice address and provider numbers are available from Medicare on request.

Direct-Bill Stationery
Medical practitioners and eligible dental practitioners wishing to direct-bill may obtain information on direct-bill stationery by telephoning **132150**. Information on the completion of the forms and direct-bill procedures are provided with the forms. Information on direct-billing is available from any Medicare office.

Time Limits Applicable to Lodgement of Claims for Assigned Benefits
A time limit of two years applies to the lodgement of claims with Medicare under the direct-billing (assignment of benefit) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than two years earlier than the date the claim was lodged with Medicare.

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

C.7.1. INTERPRETATION OF THE CLEFT LIP AND CLEFT PALATE SCHEME

The prescribed services in this section have been grouped according to the general nature of the services: orthodontic, oral surgical and general and prosthodontic.

Each professional service listed in the Schedule is a complete medical service in itself. Where a service is rendered partly by one practitioner and partly by another, only the one amount of benefit is payable.

C.7.2. MULTIPLE OPERATION RULE

The Schedule fee for two or more operations performed on a patient on the one occasion is calculated by the following rule:-

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

NOTE: 1. Fees so calculated which result in a sum which is not a multiple of 5 cents are taken to the next higher multiple of 5 cents.
2. Where two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.
3. The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees and benefits specified in the Schedule apply. For these purposes the term “operation” includes items 75200- 75615.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

C.7.3. ADMINISTRATION OF ANAESTHETICS

When a medical practitioner administers an anaesthetic in connection with a dental procedure prescribed for the payment of Medicare benefits (and the procedure has been performed by an eligible dental practitioner), Medicare benefits are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.

To ascertain the Schedule fee for the anaesthetic, medical practitioners should refer to Group T10 – Relative Value Guide for Anaesthesia - of the Medicare Benefits Schedule Book.

C.7.4. DEFINITIONS

Orthodontic treatment planning
Orthodontic treatment planning is defined as the measurement and analysis of the face and jaws and occlusion providing a diagnosis and planned prescription of appliances and treatment required.

Study models
Study models are defined as orthodontic plaster casts of the upper and lower teeth and alveolar processes.

C.7.5. REFERRAL OF ORAL AND MAXILLOFACIAL SURGICAL SERVICES - (ITEMS 75150 TO 75621)

Benefits are payable for items 75150 to 75621 only where the service has been rendered to a patient who has been referred by letter of Referral by an eligible orthodontist.

Item 75621 may be claimed in association with items 45720 to 45754 where the service is performed by a practitioner holding a FRACDS (OMS) qualification with access to Category 3 of the MBS.

C.7.6. GENERAL AND PROSTHODONTIC SERVICES - (ITEM 75800)

Item number 75800 refers to a consultation by a dentist for prevention and prophylaxis and includes such services as dietary advice, oral hygiene and fluoride treatment.

C.7.7. OVER-SERVICING

Over-servicing must be avoided. In the case of denture services, examples of over-servicing might be:-

- Unjustifiably frequent replacement of dentures;
- Provision of new dentures when relining or re-modelling of an existing prosthesis would meet the clinical need;
- Provision of metal dentures where an acrylic denture would meet the clinical need.

The Schedule includes an item for metal dentures to allow for the provision of a precise, long-term prosthesis. The item is not intended for use during the period of growth, where prostheses must be replaced or altered frequently, unless there is some definite and extraordinary clinical requirement.

C.8.1. CLEFT LIP AND CLEFT PALATE CLINICS

NEW SOUTH WALES
Dental Department
Westmead Children's Hospital
Locked Bag 4001
Cnr Hawkesbury Rd & Hainsworth Street
WESTMEAD 2145 (02) 9845 2582

Orthodontic Department
United Dental Hospital of Sydney
2nd Floor
2 Chalmers Street
SURRY HILLS 2010 (02) 9293 8314

Children's Outpatients
Sydney Children's Hospital
High Street

RANDWICK 2031 (02) 9382 1470

Paediatric Outpatient's Dept.
John Hunter Children's Hospital
Locked Bag 1
NEWCASTLE MC 2310 (02) 4921 3750

VICTORIA
Cleft Palate Clinic
Monash Medical Centre
246 Clayton Road
CLAYTON 3168 (03) 9594 2380

Cleft Coordinator
Department of Plastic and Maxillofacial Surgery
Royal Children's Hospital
Flemington Road
PARKVILLE 3052 (03) 9345 6582

QUEENSLAND
Children's Oral Health Service
Level 5, Coles Health Services Centre
Royal Children's Hospital
Herston Road
HERSTON 4029 (07) 3636 1025

Combined Cleft Lip & Palate Clinic
Townsville Cleft Palate Clinic
Special Clinics
Townsville General Hospital
Eyre Street
NORTH WARD QLD 4810 (07) 4781 9304

Children's Specialist Clinic
Mater Children's Hospital
Annerley Road
SOUTH BRISBANE QLD 4101 (07) 3840 8180

SOUTH AUSTRALIA
Director
Paediatric Dental Unit
Women and Children's Hospital
72 King William Road
NORTH ADELAIDE 5006 (08) 8161 7379

Dental Clinic
Flinders Medical Centre
South Road
BEDFORD PARK 5042 (08) 8204 4188

Australian Craniofacial Unit
Women's and Children's Hospital
72 King William Road
NORTH ADELAIDE SA 5006 (08) 8161 7235

WESTERN AUSTRALIA
Dental Unit
Princess Margaret Hospital
Thomas Street
SUBIACO 6008 (08) 9340 8342

TASMANIA
Oral and Maxillofacial Unit
Level 5A

Royal Hobart Hospital
Liverpool Street
HOBART 7000 (03) 6222 8413

AUSTRALIAN CAPITAL TERRITORY
School Dental Clinic
ACT Health
1st Floor
Cnr Alinga and Moore Streets
CANBERRA CITY 2600 (02) 6205 5111
(Enquiries only)

NORTHERN TERRITORY
Senior Dentist Urban
Northern Territory Department of Health
Dental Clinic
9 Scaturchio Street
CASURINA NT 0810 (08) 8922 6466

Northern Territory Department of Health
Dental Clinic
Community Health Centre
Flynn Drive
ALICE SPRINGS 0870 (08) 8951 6713

C.8.2. COMMONWEALTH DEPARTMENT OF HEALTH AND AGEING ADDRESSES

Postal : GPO Box 9848 in each Capital City

NEW SOUTH WALES
Level 7
1 Oxford Street
SYDNEY 2000 Tel (02) 9263 3555

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

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

SOUTH AUSTRALIA
Commonwealth Centre
55 Currie Street
ADELAIDE 5000 Tel (08) 8237 8111

WESTERN AUSTRALIA
152-158 St George's Terrace
PERTH 6000 Tel (08) 9346 5111

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

AUSTRALIAN CAPITAL TERRITORY
Alexander Building
Furzer Street
PHILLIP 2606 Tel (02) 6289 1555

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

C.8.3. THE DEPARTMENT OF HUMAN SERVICES MEDICARE ADDRESSES

Postal : Medicare, GPO Box 9822, in your capital city
or by email: medicare.prov@medicareaustralia.gov.au

Phone Enquiries

Public enquiries: **132 011**
Provider enquiries: **132 150**

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.

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

Higher rates of benefits are also provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons).

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.

GROUP C1 - ORTHODONTIC SERVICES

Note: In this Group, benefit is only payable where the service has been rendered to a patient by a dental practitioner who is registered in the specialty of orthodontics, except for the services covered by Items 75009-75023 which may also be rendered by a medical practitioner who is a specialist in the practice of his or her specialty of oral and maxillofacial surgery.

CONSULTATIONS

75001	INITIAL PROFESSIONAL ATTENDANCE in a single course of treatment by an eligible orthodontist (AO) **Fee:** $85.55	**Benefit:** 75% = $64.20	85% = $72.75
75004	PROFESSIONAL ATTENDANCE by an eligible orthodontist subsequent to the first professional attendance by the orthodontist in a single course of treatment (AO) **Fee:** $43.00	**Benefit:** 75% = $32.25	85% = $36.55
75006	PRODUCTION OF DENTAL STUDY MODELS (not being a service associated with a service to which item 75004 applies) prior to provision of a service to which: (a) item 75030, 75033, 75034, 75036, 75037, 75039, 75045 or 75051 applies; or (b) an item in Group T8 or Groups 03 to 09 applies; in a single course of treatment **Fee:** $76.25	**Benefit:** 75% = $57.20	85% = $64.85

RADIOGRAPHY

75009	ORTHODONTIC RADIOGRAPHY orthopantomography (panoramic radiography), including any consultation on the same occasion **Fee:** $68.15	**Benefit:** 75% = $51.15	85% = $57.95
75012	ORTHODONTIC RADIOGRAPHY ANTEROPOSTERIOR CEPHALOMETRIC RADIOGRAPHY with cephalometric tracings OR LATERAL CEPHALOMETRIC RADIOGRAPHY with cephalometric tracings including any consultation on the same occasion **Fee:** $108.05	**Benefit:** 75% = $81.05	85% = $91.85
75015	ORTHODONTIC RADIOGRAPHY ANTEROPOSTERIOR AND LATERAL CEPHALOMETRIC RADIOGRAPHY, with cephalometric tracings including any consultation on the same occasion **Fee:** $148.55	**Benefit:** 75% = $111.45	85% = $126.30
75018	ORTHODONTIC RADIOGRAPHY ANTEROPOSTERIOR AND LATERAL CEPHALOMETRIC RADIOGRAPHY, with cephalometric tracings and orthopantomography including any consultation on the same occasion **Fee:** $189.25	**Benefit:** 75% = $141.95	85% = $160.90
75021	ORTHODONTIC RADIOGRAPHY hand-wrist studies (including growth prediction) including any consultation on the same occasion **Fee:** $232.05	**Benefit:** 75% = $174.05	85% = $197.25
75023	INTRAORAL RADIOGRAPHY - single area, periapical or bitewing film **Fee:** $46.45	**Benefit:** 75% = $34.85	85% = $39.50

PRESURGICAL INFANT MAXILLARY ARCH REPOSITIONING

75024	PRESURGICAL INFANT MAXILLARY ARCH REPOSITIONING including supply of appliances and all adjustments of appliances and supervision - WHERE 1 APPLIANCE IS USED **Fee:** $600.10	**Benefit:** 75% = $450.10	85% = $520.60
75027	PRESURGICAL INFANT MAXILLARY ARCH REPOSITIONING including supply of appliances and all adjustments of appliances and supervision WHERE 2 APPLIANCES ARE USED **Fee:** $822.90	**Benefit:** 75% = $617.20	85% = $743.40

DENTITION TREATMENT

75030	MAXILLARY ARCH EXPANSION not being a service associated with a service to which item 75039, 75042, 75045 or 75048 applies, including supply of appliances, all adjustments of the appliances, removal of the appliances and retention **Fee:** $732.70	**Benefit:** 75% = $549.55	85% = $653.20
75033	MIXED DENTITION TREATMENT - incisor alignment using fixed appliances in maxillary arch, including supply of appliances, all adjustments of appliances, removal of the appliances and retention **Fee:** $1,200.95	**Benefit:** 75% = $900.75	85% = $1,121.45

75034	MIXED DENTITION TREATMENT - incisor alignment with or without lateral arch expansion using a removable appliance in the maxillary arch, including supply of appliances, associated adjustments and retention **Fee:** $611.25 **Benefit:** 75% = $458.45 85% = $531.75
75036	MIXED DENTITION TREATMENT - lateral arch expansion and incisor alignment using fixed appliances in maxillary arch, including supply of appliances, all adjustments of appliances, removal of appliances and retention **Fee:** $1,658.75 **Benefit:** 75% = $1,244.10 85% = $1,579.25
75037	MIXED DENTITION TREATMENT - lateral arch expansion and incisor correction - 2 arch (maxillary and mandibular) using fixed appliances in both maxillary and mandibular arches, including supply of appliances, all adjustments of appliances, removal of appliances and retention **Fee:** $2,089.15 **Benefit:** 75% = $1,566.90 85% = $2,009.65
75039	PERMANENT DENTITION TREATMENT SINGLE ARCH (mandibular or maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - initial 3 months of active treatment **Fee:** $555.25 **Benefit:** 75% = $416.45 85% = $475.75
75042	PERMANENT DENTITION TREATMENT - SINGLE ARCH (mandibular or maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - each 3 months of active treatment (including all adjustments and maintenance and removal of the appliances) after the first for a maximum of a further 33 months **Fee:** $207.55 **Benefit:** 75% = $155.70 85% = $176.45
75045	PERMANENT DENTITION TREATMENT 2 ARCH (mandibular and maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - initial 3 months of active treatment **Fee:** $1,111.55 **Benefit:** 75% = $833.70 85% = $1,032.05
75048	PERMANENT DENTITION TREATMENT - 2 ARCH (mandibular and maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - each subsequent 3 months of active treatment (including all adjustments and maintenance, and removal of the appliances) after the first for a maximum of a further 33 months **Fee:** $285.05 **Benefit:** 75% = $213.80 85% = $242.30
75049	RETENTION, FIXED OR REMOVABLE, single arch (mandibular or maxillary) - supply of retainer and supervision of retention **Fee:** $333.60 **Benefit:** 75% = $250.20 85% = $283.60
75050	RETENTION, FIXED OR REMOVABLE, 2-arch (mandibular and maxillary) - supply of retainers and supervision of retention **Fee:** $644.05 **Benefit:** 75% = $483.05 85% = $564.55
	JAW GROWTH GUIDANCE
75051	JAW GROWTH guidance using removable or functional appliances, including supply of appliances and all adjustments to appliances **Fee:** $988.65 **Benefit:** 75% = $741.50 85% = $909.15

GROUP C2 - ORAL AND MAXILLOFACIAL SERVICES

Note: (i) In this Group, benefit is only payable where the service has been rendered to a patient who has been referred by an eligible orthodontist.
(ii)While benefit is payable for simple extractions performed by a registered dental practitioner, benefit is only payable for surgical extractions and other surgical procedures where the service is rendered by a medical practitioner who is a specialist in the practice of his or her speciality of oral and maxillofacial surgery.

CONSULTATIONS

75150	INITIAL PROFESSIONAL attendance in a single course of treatment by an eligible oral and maxillofacial surgeon where the patient is referred to the surgeon by an eligible orthodontist (AOS) **Fee:** $85.55	**Benefit:** 75% = $64.20	85% = $72.75
75153	PROFESSIONAL ATTENDANCE by an eligible oral and maxillofacial surgeon subsequent to the first professional attendance by the surgeon in a single course of treatment where the patient is referred to the surgeon by an eligible orthodontist **Fee:** $43.00	**Benefit:** 75% = $32.25	85% = $36.55
75156	PRODUCTION OF DENTAL STUDY MODELS (not being a service associated with a service to which item 75153 applies) prior to provision of a service: (a) to which item 52321, 53212 or 75618 applies; or (b) to which an item in the series 52330 to 52382, 52600 to 52630, 53400 to 53409 or 53415 to 53429 applies; in a single course of treatment if the patient is referred by an eligible orthodontist (AOS) **Fee:** $76.25	**Benefit:** 75% = $57.20	85% = $64.85

SIMPLE EXTRACTIONS

75200	Removal of tooth or tooth fragment (other than treatment to which item 75400, 75403, 75406, 75409, 75412 or 75415 applies), if the patient is referred by an eligible orthodontist (AD) **Fee:** $54.90	**Benefit:** 75% = $41.20	85% = $46.70
75203	REMOVAL OF TOOTH OR TOOTH FRAGMENT under general anaesthesia, if the patient is referred by an eligible orthodontist (AD) **Fee:** $82.45	**Benefit:** 75% = $61.85	85% = $70.10
75206	Removal of each additional tooth or tooth fragment at the same attendance at which a service to which item 75200 or 75203 applies is rendered, if the patient is referred by an eligible orthodontist (AD) **Fee:** $27.35	**Benefit:** 75% = $20.55	85% = $23.25

SURGICAL EXTRACTIONS

75400	Surgical removal of erupted tooth, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $164.75	**Benefit:** 75% = $123.60	85% = $140.05
75403	Surgical removal of tooth with soft tissue impaction, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $189.25	**Benefit:** 75% = $141.95	85% = $160.90
75406	Surgical removal of tooth with partial bone impaction, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $215.65	**Benefit:** 75% = $161.75	85% = $183.35
75409	Surgical removal of tooth with complete bone impaction, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $244.25	**Benefit:** 75% = $183.20	85% = $207.65
75412	Surgical removal of tooth fragment requiring incision of soft tissue only, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $136.40	**Benefit:** 75% = $102.30	85% = $115.95
75415	Surgical removal of tooth fragment requiring removal of bone, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $164.75	**Benefit:** 75% = $123.60	85% = $140.05

OTHER SURGICAL PROCEDURES

75600	Surgical exposure, stimulation and packing of unerupted tooth, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $232.05	**Benefit:** 75% = $174.05	85% = $197.25

75603	Surgical exposure of unerupted tooth for the purpose of fitting a traction device, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $272.75 **Benefit:** 75% = $204.60 85% = $231.85
75606	Surgical repositioning of unerupted tooth, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $272.75 **Benefit:** 75% = $204.60 85% = $231.85
75609	Transplantation of tooth bud, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $407.15 **Benefit:** 75% = $305.40 85% = $346.10
75612	Surgical procedure for intra oral implantation of osseointegrated fixture (first stage), if the patient is referred by an eligible orthodontist (AOS) **Fee:** $503.85 **Benefit:** 75% = $377.90 85% = $428.30
75615	Surgical procedure for fixation of trans mucosal abutment (second stage of osseointegrated implant), if the patient is referred by an eligible orthodontist (AOS) **Fee:** $186.50 **Benefit:** 75% = $139.90 85% = $158.55
75618	Provision and fitting of a bite rising appliance or dental splint for the management of temporomandibular joint dysfunction syndrome, if the patient is referred by an eligible orthodontist (AOS) **Fee:** $231.60 **Benefit:** 75% = $173.70 85% = $196.90
75621	The provision and fitting of surgical template in conjunction with orthognathic surgical procedures in association with: (a) an item in the series: (i) 45720 to 45754; or (ii) 52342 to 52375; or (b) item 52380 or 52382; if the patient is referred by an eligible orthodontist (AOS) **Fee:** $231.60 **Benefit:** 75% = $173.70 85% = $196.90

GROUP C3 - GENERAL AND PROSTHODONTIC SERVICES

Note: Benefit is payable for services listed in this Group where they are rendered by a registered dental practitioner

CONSULTATIONS

75800	ATTENDANCE BY AN ELIGIBLE DENTAL PRACTITIONER involving consultation, preventive treatment and prophylaxis, of not less than 30 minutes' duration each attendance to a maximum of 3 attendances in any period of 12 months *(See para C7.6 of explanatory notes to this Category)* **Fee:** $82.45	**Benefit:** 75% = $61.85	85% = $70.10

PROSTHODONTIC

75803	PROVISION AND FITTING OF ACRYLIC BASE PARTIAL DENTURE, including retainers 1 TOOTH **Fee:** $329.75	**Benefit:** 75% = $247.35	85% = $280.30
75806	PROVISION AND FITTING OF ACRYLIC BASE PARTIAL DENTURE, including retainers 2 TEETH **Fee:** $386.75	**Benefit:** 75% = $290.10	85% = $328.75
75809	PROVISION AND FITTING OF ACRYLIC BASE PARTIAL DENTURE. including retainers 3 TEETH **Fee:** $457.95	**Benefit:** 75% = $343.50	85% = $389.30
75812	PROVISION AND FITTING OF ACRYLIC BASE PARTIAL DENTURE, including retainers 4 TEETH **Fee:** $508.85	**Benefit:** 75% = $381.65	85% = $432.55
75815	PROVISION AND FITTING OF ACRYLIC BASE PARTIAL DENTURE, including retainers 5 TO 9 TEETH **Fee:** $620.90	**Benefit:** 75% = $465.70	85% = $541.40
75818	PROVISION AND FITTING OF ACRYLIC BASE PARTIAL DENTURE, including retainers 10 TO 12 TEETH **Fee:** $732.70	**Benefit:** 75% = $549.55	85% = $653.20
75821	PROVISION AND FITTING OF CAST METAL BASE (cobalt chromium alloy) PARTIAL DENTURE including casting and retainers 1 TOOTH **Fee:** $590.15	**Benefit:** 75% = $442.65	85% = $510.65
75824	PROVISION AND FITTING OF CAST METAL BASE (cobalt chromium alloy) PARTIAL DENTURE including casting and retainers 2 TEETH **Fee:** $681.80	**Benefit:** 75% = $511.35	85% = $602.30
75827	PROVISION AND FITTING OF CAST METAL BASE (cobalt chromium alloy) PARTIAL DENTURE including casting and retainers 3 TEETH **Fee:** $783.75	**Benefit:** 75% = $587.85	85% = $704.25
75830	PROVISION AND FITTING OF CAST METAL BASE (cobalt chromium alloy) PARTIAL DENTURE including casting and retainers 4 TEETH **Fee:** $865.10	**Benefit:** 75% = $648.85	85% = $785.60
75833	PROVISION AND FITTING OF CAST METAL BASE (cobalt chromium alloy) PARTIAL DENTURE including casting and retainers 5 TO 9 TEETH **Fee:** $1,058.35	**Benefit:** 75% = $793.80	85% = $978.85
75836	PROVISION AND FITTING OF CAST METAL BASE (cobalt chromium alloy) PARTIAL DENTURE including casting and retainers 10 TO 12 TEETH **Fee:** $1,211.05	**Benefit:** 75% = $908.30	85% = $1,131.55
75839	PROVISION AND FITTING OF RETAINERS not being a service associated with a service to which item 75803, 75806, 75809, 75812, 75815, 75818, 75821, 75824, 75827, 75830, 75833 or 75836 applies each retainer **Fee:** $27.35	**Benefit:** 75% = $20.55	85% = $23.25
75842	ADJUSTMENT OF PARTIAL DENTURE not being a service associated with a service to which item 75803, 75806, 75809, 75812, 75815, 75818, 75821, 75824, 75827, 75830, 75833 or 75836 applies **Fee:** $40.75	**Benefit:** 75% = $30.60	85% = $34.65
75845	RELINING OF PARTIAL DENTURE by laboratory process and associated fitting **Fee:** $203.65	**Benefit:** 75% = $152.75	85% = $173.15

GENERAL AND PROSTHODONTIC		GENERAL AND PROSTHODONTIC
75848	REMODELLING AND FITTING OF PARTIAL DENTURE of more than 4 teeth **Fee:** $244.25 **Benefit:** 75% = $183.20 85% = $207.65	
75851	REPAIR TO CAST METAL BASE OF PARTIAL DENTURE 1 or more points **Fee:** $122.15 **Benefit:** 75% = $91.65 85% = $103.85	
75854	ADDITION OF A TOOTH OR TEETH to a partial denture to replace extracted tooth or teeth including taking of necessary impression **Fee:** $122.15 **Benefit:** 75% = $91.65 85% = $103.85	

MISCELLANEOUS SERVICES

CATEGORY 8

SUMMARY OF CHANGES FROM 1/1/2016

The 1/1/2016 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

There are no changes to this Category for 1 January 2016.

M.1.1. ADDITIONAL BULK BILLING PAYMENT FOR GENERAL MEDICAL SERVICES - (ITEMS 10990 AND 10991)

Item 10990 can only be claimed where all of the conditions set out in paragraphs (a) to (d) of item 10990 have been met.

Item 10991 can only be claimed where all of the conditions set out in paragraphs (a) to (e) of item 10991 have been met.

- Item 10991 can only be used where the service is provided at, or from, a practice location that is listed in item 10991. This includes all regional, rural and remote areas (RRMA 3 to 7 under the Rural Remote Metropolitan Areas classification system), all of Tasmania and those areas covered by a Statistical Subdivision (SSD) or Statistical Local Areas (SLA) listed in item 10991 (SSDs and SLAs are specified in the Australian Standard Geographical Classification (ASGC) 2002). If you are not sure whether your practice location is in an eligible area, you can call the Department of Human Services on 132 150.
- Practice location is the place associated with the medical practitioner's provider number from which the service has been provided. This includes services performed either at the medical practitioner's surgery, or those services performed away from the surgery using the provider number for that surgery (eg home visits or visits to aged care facilities).
- Where a medical practitioner has a practice location in both an eligible and ineligible area, item 10991 can only be claimed in respect of those services provided at, or from, the eligible practice location.

Item 10990 and item 10991 can only be used in conjunction with items in the General Medical Services Table of the MBS. There are similar items to be used in conjunction with diagnostic imaging services (item 64990 or 64991) or pathology services (item 74990 or 74991).

Item 10990 or item 10991 can be claimed for each item of service claimable under the MBS (other than diagnostic imaging services and pathology services), provided the conditions of the relevant item, 10990 or 10991, are satisfied. For example, item 10990 or 10991 can be claimed in conjunction with attendance items, procedural items (other than diagnostic imaging or pathology items) or services provided by a practice nurse on behalf of a medical practitioner (items 10983, 10984, 10986, 10987 and 10997). In some cases, this will mean that item 10990 or 10991 can be claimed more than once in respect of a patient visit.

Item 10990 or 10991 can not be claimed in conjunction with each other.

Where a Medicare benefit is not payable for a particular service (eg because the patient has exceeded the number of allowable services in a period of time), the additional bulk billing payment will not be paid for that service.

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

Commonwealth concession card holder means a person listed on a Pensioner Concession Card, Health Care Card or Commonwealth Seniors Health Card issued by either Centrelink or the Department of Veterans' Affairs. Gold or White Cards issued by the Department of Veterans' Affairs do not attract the additional bulk billing payment. However, if a Gold or White Card holder also holds a recognised Commonwealth concession card and chooses to be treated under the Medicare arrangements, then that patient is an eligible concession card holder.

Unreferred service means a medical service provided to a patient by, or on behalf of, a medical practitioner, being a service that has not been referred to that practitioner by another medical practitioner or person with referring rights.

The Department of Human Services will undertake regular post payment auditing to ensure that the additional bulk billing payment is being claimed correctly. Centrelink data will be used to verify concessional status and Medicare records will be used to confirm patient age.

M.1.2. AFTER-HOURS SERVICES PROVIDED IN AREAS ELIGIBLE FOR THE HIGHER BULK BILLING PAYMENT - (ITEM 10992)

Item 10992 can only be claimed where all of the conditions set out in paragraphs (a) to (g) of item 10992 have been met:

- Item 10992 must be claimed in conjunction with one of the items 597, 598, 599, 600, 5003, 5010, 5023, 5028, 5043, 5049, 5063, 5067, 5220, 5223, 5227, 5228, 5260, 5263 5265, or 5267. These items are for services provided after-hours outside of consulting rooms or hospital.

- Item 10992 can only be used where the service is provided in one of the eligible areas listed in item 10992 by a medical practitioner whose practice location (i.e. the location associated with the medical practitioner's provider number) is not in one of these areas.

Medical practitioners whose practice location is inside one of these listed locations should claim item 10991 for eligible services.

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

From 1 May to 30 June 2010, item 10985 was the higher bulk billing payment that could be claimed in conjunction items 597, 598, 599 or 600. On 1 July 2010, item 10985 ceased and item 10992 became the higher bulk billing payment item to be claimed in conjunction with items 597, 598, 599 and 600.

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

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

Commonwealth concession card holder means a person listed on a Pensioner Concession Card, Health Care Card or Commonwealth Seniors Health Card issued by either Centrelink or the Department of Veterans' Affairs. Gold or White Cards issued by the Department of Veterans' Affairs do not attract the additional bulk billing payment. However, if a Gold or White Card holder also holds a recognised Commonwealth concession card and chooses to be treated under the Medicare arrangements, then that patient is an eligible concession card holder.

Unreferred service means a medical service provided to a patient by, or on behalf of, a medical practitioner, being a service that has not been referred to that practitioner by another medical practitioner or person with referring rights.

The Department of Human Services will undertake regular post payment auditing to ensure that the additional bulk billing payment is being claimed correctly. Centrelink data will be used to verify concessional status and Medicare records will be used to confirm patient age.

M.3.1. INDIVIDUAL ALLIED HEALTH SERVICES (ITEMS 10950 TO 10970) FOR CHRONIC DISEASE MANAGEMENT - ELIGIBLE PATIENTS

ELIGIBLE PATIENTS

Medicare benefits are available for certain services provided by eligible allied health professionals to people with chronic conditions and complex care needs who are being managed by a GP using certain Chronic Disease Management (CDM) Medicare items. The allied health services must be recommended in the patient's plan as part of the management of their chronic condition.

Chronic medical conditions and complex care needs

A chronic medical condition is one that has been or is likely to be present for at least six months, e.g. asthma, cancer, cardiovascular illness, diabetes mellitus, musculoskeletal conditions.and stroke. A patient is considered to have complex care needs if they require ongoing care from a multidisciplinary team consisting of their GP and at least two other health or care providers.

Prerequisite CDM services

Patients must have received the following MBS CDM services:

- GP Management Plan - MBS item 721(or review item 732 for a review of a GPMP); and
- Team Care Arrangements - MBS item 723 (or review item 732 for a review of TCAs)

Alternatively, for patients who are permanent residents of an aged care facility, their GP must have contributed to, or contributed to a review of, a multidisciplinary care plan prepared for them by the aged care facility (MBS item 731).

For more information on the CDM planning items, refer to the explanatory notes for these items.

Allied health membership of a TCAs team

The allied health professional providing the service may be a member of the TCAs team convened by the GP to manage a patient's chronic condition and complex care needs. However, the service may also be provided by an allied health professional who is not a member of the TCAs team, provided that the service has been identified as necessary by the patient's GP and recommended in the patient's care plan/s.

Group services

In addition to individual services, patients who have type 2 diabetes may also access MBS items 81100 to 81125 which provide group allied health services. Patients only need to have MBS item 721 or 723 in place to be eligible for the group services.

M.3.2. INDIVIDUAL ALLIED HEALTH SERVICES (ITEMS 10950 TO 10970) FOR CHRONIC DISEASE MANAGEMENT - REFERRAL REQUIREMENTS

Referral form
For Medicare benefits to be payable, the patient must be referred to an eligible allied health professional by their GP using a referral form that has been issued by the Australian Government Department of Health or a form that contains all the components of this form.

The form issued by the department is available at http://www.health.gov.au/mbsprimarycareitems (click on the link for allied health individual services).

GPs are encouraged to attach a copy of the relevant part of the patient's care plan to the referral form.

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

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

It is recommended that allied health professionals retain the referral form for 24 months from the date the service was rendered (for the Department of Human Services auditing purposes).

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

Completed forms do not have to be sent to the Department of Health.

Referral validity
Medicare benefits are available for up to five allied health services per patient per calendar year. Where a patient receives more than the limit of five services in a calendar year, the additional service/s will not attract a Medicare benefit and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.

If a patient has not used all of their allied health services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of five services for which the patient is eligible in that calendar year.

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

It is not necessary to have a new CDM plan/s prepared each calendar year in order to access a new referral/s for eligible allied health services. Patients continue to be eligible for rebates for allied health services while they are being managed under the prerequisite CDM items as long as the need for eligible services continues to be recommended in their plan. However, regular reviews using MBS item 732 are encouraged.

M.3.3. INDIVIDUAL ALLIED HEALTH SERVICES - (ITEMS 10950 TO 10970) FOR CHRONIC DISEASE MANAGEMENT - ELIGIBLE PROVIDERS AND SERVICES

Eligible allied health providers
The following allied health professionals are eligible to provide services under Medicare for patients with a chronic or terminal medical condition and complex care needs when they meet the provider eligibility requirements set out the next section and are registered with the Department of Human Services.

- Aboriginal and Torres Strait Islander health practitioners
- Aboriginal health workers
- Audiologists
- Chiropractors
- Diabetes educators
- Dietitians
- Exercise physiologists

- Mental health workers
- Occupational therapists
- Osteopaths
- Physiotherapists
- Podiatrists
- Psychologists
- Speech pathologists

Number of services per year
Medicare benefits are available for up to five allied health services per eligible patient, per calendar year. The five allied health services can be made up of one type of service (e.g. five physiotherapy services) or a combination of different types of services (e.g. one dietetic and four podiatry services). Five services per calendar year are the legal maximum per patient and exemptions to this are not possible.

Checking patient eligibility for allied health services
Patients seeking Medicare rebates for allied health services will need to have a valid referral form. If there is any doubt about a patient's eligibility, the Department of Human Services will be able to confirm the number of allied health services already claimed by the patient during the calendar year. The allied health professional or the patient can call the Department of Human Services to check this information (132 150 for provider enquiries; 132 011 for public enquiries).

Service length and type
Individual allied health services under Medicare for patients with a chronic medical condition and complex care needs (items 10950 to 10970) must be of at least 20 minutes duration and provided to an individual patient, not to a group. The allied health professional must personally attend the patient.

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

Where an allied health professional provides *multiple services* to the same patient under the one referral, they must provide a written report back to the referring GP after the first and last service only, or more often if clinically necessary. Written reports should include:
- any investigations, tests, and/or assessments carried out on the patient;
- any treatment provided; and
- future management of the patient's condition or problem.

Out-of-pocket expenses and Medicare Safety Net
Allied health professionals can determine their own fees for the professional service. Charges in excess of the Medicare benefit are the responsibility of the patient. However, out-of-pocket costs will count toward the Medicare Safety Net for that patient. Allied health services in excess of five in a calendar year will not attract a Medicare benefit and the Safety Net arrangements will not apply to costs incurred by the patient for such services.

Publicly funded services
Items 10950 to 10970 do not apply for services that are provided by any Commonwealth or state funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or state/territory government health clinic, items 10950 to 10970 can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, the service or health clinic. All requirements of the relevant item must be met, including registration of the allied health professional with the Department of Human Services. Medicare services provided under a subsection 19(2) exemption must be bulk billed (i.e. the Medicare rebate is accepted as full payment for services).

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

The Department of Human Services (DHS) has developed a Health Practitioner Guideline to substantiate that valid individual Allied Health services were provided (for allied health professionals) which is located on the DHS website.

M.3.4. INDIVIDUAL ALLIED HEALTH SERVICES - (ITEMS 10950 TO 10970) FOR CHRONIC DISEASE MANAGEMENT - PROFESSIONAL ELIGIBILITY

The individual allied health items (10950 to 10970) can only be claimed for services provided by eligible allied health professionals who are registered with the Department of Human Services. To be eligible to register with the Department

of Human Services to provide these services, allied health professionals must meet the specific eligibility requirements detailed below.

Aboriginal and Torres Strait Islander health practitioners must be registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. Aboriginal and Torres Strait Islander health practitioners may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioners; Aboriginal and Torres Strait Islander health practitioners; or Torres Strait Islander health practitioners.

Aboriginal health workers in a State or Territory other than the Northern Territory must have been awarded either:

a. a Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care (or an equivalent or higher qualification) by a registered training organisation; or
b. a Certificate III in Aboriginal and Torres Strait Islander Health (or an equivalent or higher qualification) by a registered training organisation before 1 July 2012.

Note: Where individuals consider their qualification to be equivalent to or higher than the qualifications listed above, they will need to contact a registered training organisation in their State or Territory to have the qualification assessed as such before they can register with the Department of Human Services. In the Northern Territory, a practitioner must be registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia.

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

Diabetes educators must be a Credentialled Diabetes Educator (CDE) as credentialled by the Australian Diabetes Educators Association (ADEA).

Chiropractors must be registered with the Chiropractic Board of Australia.

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

Exercise physiologists must be an 'Accredited Exercise Physiologist' as accredited by Exercise and Sports Science Australia (ESSA).

Mental health workers

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

- psychologists;
- mental health nurses;
- occupational therapists;
- social workers;
- Aboriginal and Torres Strait Islander health practitioners; and
- Aboriginal health workers.

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

Mental health nurses must be a credentialled mental health nurse, as certified by the Australian College of Mental Health Nurses.

Mental health nurses who were registered in the ACT or Tasmania prior to the introduction of the National Registration and Accreditation Scheme (NRAS) on 1 July 2010, will have until 31 December 2010 to be certified by the Australian College of Mental Health Nurses.

Social workers must be a 'Member' of the Australian Association of Social Workers (AASW) and be certified by AASW as meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers' as in force on 8 November 2008.

Occupational therapists must be registered with the Occupational Therapy Board of Australia.

Osteopaths must be registered with the Osteopathy Board of Australia.

Physiotherapists must be registered with the Physiotherapy Board of Australia.

Podiatrists must be registered with the Podiatry Board of Australia.

Psychologists must hold general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided.

Speech pathologists must be a 'Practising Member' of Speech Pathology Australia.

Registering with the Department of Human Services
Provider registration forms may be obtained from the Department of Human Services on 132 150 or at the Department of Human Services website.

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

Changes to provider details
Allied health providers must notify the Department of Human Services in writing of all changes to mailing details to ensure that they continue to receive information about Medicare rebateable allied health services.
The individual allied health items (10950 to 10970) can only be claimed for services provided by eligible allied health professionals who are registered with the Department of Human Services. To be eligible to register with the Department of Human Services to provide these services, allied health professionals must meet the specific eligibility requirements detailed below.

M.3.5. Individual Allied Health Services (10950 to 10970) for Chronic Disease Management - Further Information

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

M.6.1. Provision of Psychological Therapy Services by Clinical Psychologists - (Items 80000 to 80020)

OVERVIEW
The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative commenced on 1 November 2006. Under the Better Access initiative MBS items provide Medicare benefits for the following allied mental health services:

- psychological therapy (items 80000 to 80020) – provided by eligible clinical psychologists; and
- focussed psychological strategies – allied mental health (items 80100 to 80170) – provided by eligible psychologists, occupational therapists and social workers.

M.6.2. Psychological Therapy Services Attracting Medicare Rebates

Eligible psychological therapy services
There are five MBS items for the provision of psychological therapy services to eligible patients by a clinical psychologist. Clinical psychologists must meet the provider eligibility requirements set out below and be registered with the Department of Human Services.

In these notes, 'GP' means a medical practitioner, including a general practitioner, but not including a specialist or consultant physician.

Referrals and Referral Validity
Services provided under the Psychological Therapy items will not attract a Medicare rebate unless:

- a referral has been made by a GP who is managing the patient under a GP Mental Health Treatment Plan (items 2700, 2701, 2715 or 2717);
- a referral has been made by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or
- a referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see Referral Requirements for further details regarding psychiatrist and paediatrician referrals).

Number of services per year
Medicare rebates are available for up to ten allied mental health services in a calendar year. The ten services may consist of: GP focussed psychological strategies services (items 2721 to 2727); and/or psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165).

In addition, the referring practitioner may consider that in exceptional circumstances the patient may require an additional six services above those already provided (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012).

Note: Patients will be able to receive an additional six individual allied mental health services under exceptional circumstances from 1 March 2012 to 31 December 2012. From 1 January 2013 the number of individual allied mental health services for which a person can receive a Medicare rebate will be ten services per calendar year.

Exceptional circumstances are defined as a significant change in the patient's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services.

It is up to the referring practitioner (e.g GP) to determine that the patient meets these requirements.
In these cases a new referral should be provided, and exceptional circumstances noted in that referral. Invoices for services provided under exceptional circumstances must state that exceptional circumstances apply.

Referrals should be provided, as required, for an initial course of treatment (a maximum of six services but may be less depending on the referral and patient need) to a maximum of ten services per calendar year (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply). For the purposes of these services, a course of treatment will consist of the number of services stated in the patient's referral (up to a maximum of six in any one referral).

Patients will also be eligible to claim up to ten separate services within a calendar year for group therapy services involving 6-10 patients to which items 80020 (psychological therapy – clinical psychologist), 80120 (focussed psychological strategies – psychologist), 80145 (focussed psychological strategies – occupational therapist) and 80170 (focussed psychological strategies - social worker) apply. These group services are separate from the individual services and do not count towards the ten individual services per calendar year maximum associated with those items.

Services provided under the Access to Allied Psychological Services (ATAPS) should not be used in addition to the ten (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) psychological therapy services (items 80000 to 80020), focussed psychological services-allied mental health services (items 80100 to 80170 or GP focussed psychological strategies services (items 2721 to 2727) available under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative per calendar year. Psychologists delivering services under the ATAPS program should refer to the ATAPS Operational Guidelines.

Service length and type
Services provided by eligible clinical psychologists under these items must be within the specified time period within the item descriptor. The clinical psychologist must personally attend the patient.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

In addition to psycho-education, it is recommended that cognitive-behaviour therapy be provided. However, other evidence-based therapies ─ such as interpersonal therapy ─ may be used if considered clinically relevant.

Course of treatment and reporting back to the referring medical practitioner
Patients are eligible to receive up to ten individual services (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) and up to ten group sessions in a calendar year.

Within this maximum service allocation, the clinical psychologist can provide one or more courses of treatment. For the purposes of these services, a course of treatment consists of the number of services stated in the patient's referral (up to a maximum of six in any one referral). This enables the referring medical practitioner to consider a report from the clinical psychologist on the services provided to the patient, and the need for further treatment.

On completion of the initial course of treatment, the clinical psychologist must provide a written report to the referring medical practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder.

A written report must also be provided to the referring medical practitioner at the completion of any subsequent course(s) of treatment provided to the patient.

Out of pocket expenses and Medicare safety net
Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Psychological therapy services and/or focussed psychological strategies – allied mental health services in excess of ten individual services (apart from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) and ten group sessions in a calendar year will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients
Items 80000 to 80020 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a GP who is managing the patient under a GP Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717), or under a referred psychiatrist assessment and management plan (item 291); or on referral from an eligible psychiatrist or paediatrician.

The conditions classified as mental disorders for the purposes of these services are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of these items, dementia, delirium, tobacco use disorder and mental retardation are not regarded as a mental disorder.

Checking patient eligibility for psychological therapy services
Patients seeking Medicare rebates for psychological therapy services will need to have a referral from a GP, psychiatrist or paediatrician. If there is any doubt about a patient's eligibility, the Department of Human Services will be able to confirm whether a GP Mental Health Treatment Plan; and/or a psychiatrist assessment and management plan is in place and claimed; or an eligible psychiatric or paediatric service has been claimed, as well as the number of allied mental health services already claimed by the patient during the calendar year.

Clinical psychologists can call the Department of Human Services on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011.

The patient will not be eligible if they have not been appropriately referred and a relevant Medicare service provided to them. If the referring service has not yet been claimed, the Department of Human Services will not be aware of the patient's eligibility. In this case the clinical psychologist should, with the patient's permission, contact the referring practitioner to ensure the relevant service has been provided to the patient.

Publicly funded services
Psychological therapy items 80000 to 80020 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory clinic, the items apply for services that are provided by eligible clinical psychologists salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with the Department of Human Services. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

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

M.6.3. Referral Requirements (GPs, Psychiatrists or Paediatricians to Clinical Psychologists for Psychological Therapy)

Referrals
Patients must be referred for psychological therapy services by a GP managing the patient under a GP Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717), or a referred psychiatrist assessment and management plan (item 291); or on referral from a psychiatrist or a paediatrician.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

Referring practitioners are **not** required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible clinical psychologist signed and dated by the referring practitioner.

The clinical psychologist must be in receipt of the referral at the first allied mental health consultation. It is recommended that the clinical psychologist retain the referral for 24 months from the date the service was rendered (for the Department of Human Services auditing purposes).

Referral validity
Medicare benefits are available for up to ten individual (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) and/or ten group psychological therapy services and/or focussed psychological strategies services per patient per calendar year.

Referrals should be provided, as required, for an initial course of treatment (a maximum of six services but may be less depending on the referral and the patient's clinical need) to a maximum of ten services per calendar year (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply). For the purposes of these services, a course of treatment will consist of the number of services stated in the patient's referral (up to a maximum of six in any one referral).

If a patient has not used all of their psychological therapy services and/or focussed psychological strategies services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of ten services for which the patient is eligible in that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from the referring practitioner if they are eligible for further services. Where the patient's care is being managed by a GP, the GP may choose to use this visit to undertake a review of the patient's GP Mental Health Treatment Plan and/or psychiatrist assessment and management plan.

It is not necessary to have a new GP Mental Health Treatment Plan and/or psychiatrist assessment and management plan prepared each calendar year in order to access a new referral(s) for eligible psychological therapy services and/or focussed psychological strategies services. Patients continue to be eligible for rebates for psychological therapy services and/or focussed psychological strategies services while they are being managed under a GP Mental Health Treatment Plan and/or a psychiatrist assessment and management plan as long as the need for eligible services continues to be recommended in their plan.

M.6.4. CLINICAL PSYCHOLOGIST PROFESSIONAL ELIGIBILITY

Eligible clinical psychologists
A person is an allied health professional in relation to the provision of a psychological therapy health service if the person:

(a) holds general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided; and
(b) is endorsed by the Psychology Board of Australia to practice in clinical psychology.

Until 31 October 2015, a person is also an allied health professional in relation to the provision of a psychological therapy health service if the person:

(a) holds general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided; and
(b) on 31 October 2014 was an allied health professional in relation to the provision of a psychological therapy health service because the person:
    (i) was a member of the College of Clinical Psychologists of the Australian Psychological Society; or
    (ii) had been assessed by the College of Clinical Psychologists of the Australian Psychological Society as meeting the requirements for membership of that College.

The clinical psychologist must be registered with the Department of Human Services.

Registering with the Department of Human Services
Advice about registering with the Department of Human Services to provide psychological therapy services using items 80000-80020 inclusive is available from the Department of Human Services provider inquiry line on 132 150.

Further information
For further information about Medicare Benefits Schedule items, please go to the Department of Health's website at www.health.gov.au/mbsonline.

For providers, further information is also available for providers from the Department of Human Services provider inquiry line
on 132 150

M.7.1. PROVISION OF FOCUSSED PSYCHOLOGICAL STRATEGIES SERVICES BY ALLIED HEALTH PROVIDERS - (ITEMS 80100 TO 80170)

OVERVIEW

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative commenced on 1 November 2006. Under the Better Access initiative MBS items provide Medicare benefits for the following allied mental health services:

- psychological therapy (items 80000 to 80020) – provided by eligible clinical psychologists; and
- focussed psychological strategies – allied mental health (items 80100 to 80170) – provided by eligible psychologists, occupational therapists and social workers.

FOCUSSED PSYCHOLOGICAL STRATEGIES – ALLIED MENTAL HEALTH SERVICES ATTRACTING MEDICARE REBATES

Eligible focussed psychological strategies services

There are fifteen MBS items for the provision of focussed psychological strategies (FPS) – allied mental health services to eligible patients by allied health professionals:

- 80100, 80105, 80110, 80115 and 80120 for provision of FPS services by a psychologist;
- 80125, 80130, 80135, 80140 and 80145 for provision of FPS services by an occupational therapist; and
- 80150, 80155, 80160, 80165 and 80170 for provision of FPS services by a social worker.

The allied health professional must meet the provider eligibility requirements set out below and be registered with the Department of Human Services.

In these notes, 'GP' means a medical practitioner, including a general practitioner, but not including a specialist or consultant physician.

Services provided under the focussed psychological strategies – allied mental health items will not attract a Medicare rebate unless:

- A referral has been made by a GP who is managing the patient under a GP Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717);
- A referral has been made by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or
- A referral has been made by a psychiatrist or paediatrician from an eligible psychiatric or paediatric service (see Referral Requirements for further details regarding psychiatrist and paediatrician referrals).

Number of services per year

Medicare rebates for up to ten individual allied mental health services in a calendar year. These ten services may consist of: GP focussed psychological strategies services (items 2721 to 2727); and/or psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165.

In addition, the referring practitioner may consider that in exceptional circumstances the patient may require an additional six services above those already provided (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012).

Note: Patients will be able to receive an additional six individual allied mental health services under exceptional circumstances from 1 March 2012 to 31 December 2012. From 1 January 2013 the number of individual allied mental health services for which a person can receive a Medicare rebate will be ten services per calendar year.

Exceptional circumstances are defined as a significant change in the patient's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services.

It is up to the referring practitioner to determine that the patient meets these requirements. In these cases a new referral should be provided, and exceptional circumstances noted in that referral. Invoices for services provided under exceptional circumstances must state that exceptional circumstances apply.

Referrals should be provided, as required, for an initial course of treatment (a maximum of six services but may be less depending on the referral and patient need) to a maximum of ten services per calendar year (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply). For the purposes of these services, a course of treatment will consist of the number of services stated in the patient's referral (up to a maximum of six in any one referral).

Patients will also be eligible to claim up to ten separate services within a calendar year for group therapy services involving 6-10 patients to which items 80020 (psychological therapy – clinical psychologist), 80120 (focussed psychological strategies – psychologist), 80145 (focussed psychological strategies – occupational therapist) and 80170 (focussed psychological strategies - social worker) apply. These group services are separate from the individual services and do not count towards the ten individual service calendar year maximum associated with those items.

After an initial group of up to six services, the allied mental health professional must provide a report to the referring practitioner. Following receipt of this report, the referring practitioner will consider the need for further treatment, before further allied mental health services may be provided.

Services provided under the Access to Allied Psychological Services (ATAPS) should not be used in addition to the ten (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) psychological therapy services (items 80000 to 80020), focussed psychological services-allied mental health services (items 80100 to 80170) or GP focussed psychological strategies services (items 2721 to 2727) available under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative per calendar year. Allied mental health professionals delivering services under the ATAPS program should refer to the ATAPS Operational Guidelines.

Service length and type
Services provided by eligible allied health professionals under these items must be within the specified time period within the item descriptor. The allied mental health professional must personally attend the patient.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

A range of acceptable strategies has been approved for use by allied mental health professionals utilising the FPS items.

These are:

1. **Psycho-education**
   (including motivational interviewing)
2. **Cognitive-behavioural Therapy including:**
   - **Behavioural interventions**
     - Behaviour modification
     - Exposure techniques
     - Activity scheduling
   - **Cognitive interventions**
     - Cognitive therapy
3. **Relaxation strategies**
     - Progressive muscle relaxation
     - Controlled breathing
4. **Skills training**
     - Problem solving skills and training
     - Anger management
     - Social skills training
     - Communication training
     - Stress management
     - Parent management training
5. **Interpersonal Therapy** (especially for depression)
6. **Narrative therapy (for Aboriginal and Torres Strait Islander people).**

Course of treatment and reporting back to the referring medical practitioner
Patients are eligible to receive up to ten individual services (up to 16 services from 1 March 2012 to 31 December 2012 when exceptional circumstances apply) and up to ten group sessions in a calendar year.

Within this maximum service allocation the allied mental health professional can provide one or more courses of treatment. For the purposes of these services, a course of treatment consist of the number of services stated in the patient's

referral (up to a maximum of six services in any one referral). This enables the referring medical practitioner to consider a report from the allied mental health professional on the services provided to the patient, and the need for further treatment.

On completion of the initial course of treatment, the allied mental health professional must provide a written report to the referring medical practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder.

A written report must also be provided to the referring medical practitioner at the completion of any subsequent course(s) of treatment provided to the patient.

Out of pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Psychological therapy services and/or focussed psychological strategies services in excess of the maximum annual allowance of ten individual (apart from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) and ten group sessions in a calendar year will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Eligible patients

Items 80100 to 80170 (inclusive) apply to people with an assessed mental disorder and where the patient is referred by a GP who is managing the patient under a GP Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717), referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or from an eligible psychiatrist or paediatrician.

The conditions classified as mental disorders for the purposes of these services are informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of these items, dementia, delirium, tobacco use disorder and mental retardation are not regarded as a mental disorder.

Checking patient eligibility for focussed psychological strategies – allied mental health services

Patients seeking Medicare rebates for focussed psychological strategies – allied mental health services will need to have a referral from a GP, psychiatrist or paediatrician. If there is any doubt about a patient's eligibility, the Department of Human Services will be able to confirm whether a GP Mental Health Treatment Plan; and/or a psychiatrist assessment and management plan is in place and claimed; or an eligible psychiatric or paediatric service has been claimed, as well as the number of allied health services already claimed by the patient during the calendar year.

Allied Mental Health Professionals can call the Department of Human Services on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011.

The patient will not be eligible if they have not been appropriately referred and a relevant Medicare service provided to them. If the referring service has not yet been claimed, the Department of Human Services will not be aware of the patient's eligibility. In this case the clinical psychologist should, with the patient's permission, contact the referring practitioner to ensure the relevant service has been provided to the patient.

Publicly funded services

Focussed psychological strategies (FPS) services items 80100 to 80170 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory clinic, the FPS services items apply for services that are provided by eligible allied mental health professionals salaried by, or contracted to, the service as long as all requirements of the items are met, including registration with the Department of Human Services. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

Private health insurance

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

REFERRAL REQUIREMENTS (GPs, PSYCHIATRISTS OR PAEDIATRICIANS TO ALLIED MENTAL HEALTH PROFESSIONALS)

Referrals

Patients must be referred for focussed psychological strategies – allied mental health services by either a GP managing the patient under a GP Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717), or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan (item 291); or on referral from a psychiatrist or a paediatrician.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

Referring practitioners are **not** required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied mental health professional signed and dated by the referring practitioner.

The allied mental health professional must be in receipt of the referral at the first allied mental health consultation. It is recommended that the allied health professional retain the referral for 24 months from the date the service was rendered (for the Department of Human Services auditing purposes).

Referral validity

Medicare benefits are available for up to ten individual (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply) and ten group psychological therapy services and/or focussed psychological strategies services per patient per calendar year.

Referrals should be provided, as required, for an initial course of treatment (a maximum of six services but may be less depending on the referral and patient's clinical need) to a maximum of ten services per calendar year (up to 16 services from 1 March 2012 to 31 December 2012 where exceptional circumstances apply). For the purposes of these services, a course of treatment will consist of the number of services stated in the patient's referral (up to a maximum of six in any one referral).

If a patient has not used all of their psychological therapy services and/or focussed psychological strategies services under a referral in a calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total of ten services for which the patient is eligible in that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from the referring practitioner if they are eligible for further services. Where the patient's care is being managed by a GP, the GP may choose to use this visit to undertake a review of the patient's GP Mental Health Treatment Plan and/or psychiatrist assessment and management plan.

It is not necessary to have a new GP Mental Health Treatment Plan and/or psychiatrist assessment and management plan prepared each calendar year in order to access a new referral(s) for eligible psychological therapy services and/or focussed psychological strategies services. Patients continue to be eligible for rebates for psychological therapy services and/or focussed psychological strategies services while they are being managed under a GP Mental Health Treatment Plan and/or a psychiatrist assessment and management plan as long as the need for eligible services continues to be recommended in their plan.

ALLIED MENTAL HEALTH PROFESSIONAL ELIGIBILITY

Eligible allied health professionals
A person is an allied health professional in relation to the provision of a FPS service if the person meets one of the following requirements:

a) the person is a psychologist who holds general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided;
b) the person is a member of the Australian Association of Social Workers (AASW) and certified by AASW as the meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers', as in force on 8 November 2008;
c) the person:
    i) is an occupational therapist who is registered as a person who may provide that kind of service under the applicable law in force in the State or Territory in which the service is provided; and
    ii) is accredited by Occupational Therapy Australia as:
        - having a minimum of two years experience in mental health; and
        - having undertaken to observe the standards set out in the document published by Occupational Therapy Australia 'Australian Competency Standards for Occupational Therapists in Mental Health' as in force on 1 November 2006.

Continuing professional development (CPD) for Occupational Therapists and Social Workers providing focussed psychological strategies (FPS) services

Occupational Therapists and Social Workers providing FPS services are required to have completed 10 hours FPS CPD.

A CPD year for the purposes of these items is from 1 July to 30 June annually.

Part-time allied mental health professionals are required to have 10 hours of FPS related CPD, the same as full-time allied mental health professionals.

Occupational Therapists and Social Workers who are registered during the course of the CPD year, their obligation to undertake CPD will be on a pro-rata basis. The amount of units will be calculated from the 1st of the month immediately succeeding the month they obtained initial registration. The obligation will be one-twelfth of the yearly requirement for each month.

CPD activities must be relevant to delivering FPS services. Acceptable CPD activities where the content is related to FPS can include formal postgraduate education, workshops, seminars, lectures, journal reading, writing papers, receipt of supervision and peer consultation, and online training.

There is flexibility in the CPD activities that can be undertaken to meet individual professional needs and their practice/client base and client needs. For example, activities could also include assessment and treatment of specific disorders and client types such as youth, or different modalities and delivery such as working with groups.

Registering with the Department of Human Services
Advice about registering with the Department of Human Services to provide focussed psychological strategies – allied mental health services using items 80100-80170 inclusive is available from the Department of Human Services provider inquiry line on 132 150.

Further information
For further information about Medicare Benefits Schedule items, please go to the Department of Health's website at www.health.gov.au/mbsonline

For providers, further information is also available for providers from the Department of Human Services provider inquiry line on 132 150.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline to substantiate that a valid Allied Mental Health service has been provided (for allied health professionals)which is located on the DHS website.

M.8.1. PREGNANCY SUPPORT COUNSELLING - ELIGIBLE PATIENTS - (ITEMS 81000 TO 81010)

Medicare benefits are available for non-directive pregnancy support counselling services provided to a person who is pregnant or who has been pregnant in the 12 months preceding the first service to which item 81000, 81005 or 81010 applies in relation to that pregnancy. Services can be provided either by an eligible GP or by an eligible psychologist, social worker or mental health nurse on referral from a GP.

The term 'GP' is used hereafter as a generic reference to medical practitioners (including a general practitioner, but not including a specialist or consultant physician).

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

M.8.2. PREGNANCY SUPPORT COUNSELLING - ELIGIBLE SERVICES - (ITEMS 81000 TO 81010)

There are four MBS items for the provision of non-directive pregnancy support counselling services:
Item 4001 – services provided by an eligible GP;
Item 81000 – services provided by an eligible psychologist;
Item 81005 – services provided by an eligible social worker; and
Item 81010 – services provided by an eligible mental health nurse.

These notes relate to items 81000-81010. Each individual allied health professional must meet the provider eligibility requirements set out below and be registered with the Department of Human Services.

Service length and type
Non-directive pregnancy support counselling services provided by eligible psychologists, social workers and mental health nurses using items 81000-81010 inclusive must be of at least 30 minutes duration and provided to an individual patient. The allied health professional must personally attend the patient.

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

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

Number of services per year
Medicare benefits are available for up to three (3) eligible non-directive pregnancy support counselling services per patient, per pregnancy, provided using items 81000, 81005, 81010 and 4001.

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

Out-of-pocket expenses and Medicare Safety Net
Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Non-directive pregnancy support counselling services in excess of three (3) per pregnancy will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Publicly funded services
Items 81000, 81005 and 81010 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital.

However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory clinic, items 81000, 81005 and 81010 can be claimed for services provided by an eligible psychologist, social worker or mental health nurse salaried by or contracted to the service, where all requirements of the relevant item are met, including registration with the Department of Human Services. These services must be direct billed (that is, the Medicare rebate is accepted as full payment for services).

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

M.8.3. PREGNANCY SUPPORT COUNSELLING - REFERRAL REQUIREMENTS - (ITEMS 81000 TO 81010)

Patients must be referred for non-directive pregnancy support counselling services by a GP. GPs are **not** required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring GP.

Patients may be referred by a GP to more than one eligible allied health professional for eligible non-directive pregnancy support counselling services (for example, where a patient does not wish to continue receiving services from the provider they were referred to in the first instance). However, Medicare benefits are only available for a maximum of three (3) non-directive pregnancy support counselling services to which items 4001, 81000, 81005 and 81010 apply, per patient, per pregnancy.

Where the patient is unsure of the number of Medicare rebated non-directive pregnancy support counselling services they have already accessed, the patient may check with the Department of Human Services on 132 011. Alternatively, the psychologist, social worker or mental health nurse may check with the Department of Human Services.

The relevant allied health professional must be in receipt of the referral at the first non-directive pregnancy support counselling service and must retain the referral for 2 years from the date the service was rendered, for the Department of Human Services auditing purposes.

A copy of the referral is **not** required to accompany Medicare claims. However, referral details are required to be included on patients' itemised accounts/receipts or Medicare assignment of benefit forms.

Referral validity
The referral is valid for up to three (3) non-directive pregnancy support counselling services, per patient, per pregnancy.

Subsequent Referrals
A new referral is required where the patient seeks to access non-directive pregnancy support counselling in relation to a different pregnancy or where the patient wishes to be referred to a different allied health professional than the one they were referred to in the first instance.

M.8.4. PREGNANCY SUPPORT COUNSELLING - ALLIED HEALTH PROFESSIONAL ELIGIBILITY -(ITEMS 81000 TO 81010)

Eligible allied health professionals
Items 81000, 81005 and 81010 can only be claimed for services provided by psychologists, social workers and mental health nurses who meet the following specific eligibility requirements, and are registered with the Department of Human Services.

To be eligible to provide services using MBS Item 81000, a psychologist must hold general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided and be certified by the Australian Psychological Society as appropriately trained in non-directive pregnancy counselling.

To be eligible to provide services using MBS Item 81005, a social worker must be a 'Member' of the Australian Association of Social Workers (AASW), be certified by AASW either as meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers' as in force on 8 November 2008 or as an Accredited Social Worker, and have completed appropriate non-directive pregnancy counselling training;

To be eligible to provide services using MBS Item 81010, a mental health nurse must be a 'Credentialled Mental Health Nurse' as certified by the Australian College of Mental Health Nurses, and have completed appropriate non-directive pregnancy counselling training.

REGISTERING WITH THE DEPARTMENT OF HUMAN SERVICES
Advice about registering with the Department of Human Services to provide non-directive pregnancy support counselling services using items 81000-81010 inclusive is available from the Department of Human Services provider inquiry line on 132 150.

Further information
A copy of the Medicare Allied Health Supplement can be accessed from www.health.gov.au/mbsonline. The Supplement includes more information about Medicare, including how to make a claim from Medicare.

Further information is also available for providers from the Department of Human Services provider inquiry line on 132 150.

M.9.1. GROUP ALLIED HEALTH SERVICES (ITEMS 81100 TO 81125) FOR PEOPLE WITH TYPE 2 DIABETES - ELIGIBLE PATIENTS -

MBS items (81100 to 81125) are available for group allied health services for patients with type 2 diabetes. These items apply to services provided by eligible diabetes educators, exercise physiologists and dietitians, on referral from a GP.

Services available under these items are in addition to the five individual allied health services available to patients each calendar year (refer to items 10950 to 10970).

To be eligible for these services, the patient must have in place one of the following:

- a GP Management Plan (GPMP) (item 721); OR
- for a resident of a residential aged care facility, the GP must have contributed to, or contributed to a review of, a care plan prepared for them by the facility (item 731). [Note: Generally, residents of an aged care facility rely on the facility for assistance to manage their type 2 diabetes. Therefore, the resident may not need to be referred for group allied health services under these items, as the self-management approach offered in group services may not be appropriate.]

Unlike the individual allied health services under items 10950 to 10970, there is no additional requirement for a Team Care Arrangement (item 723) in order for the patient to be referred for group allied health services.

Once the patient has been referred by their GP, a diabetes educator, exercise physiologist or dietitian will conduct an individual assessment (under items 81100, 81110 or 81120). A maximum of one (1) assessment service is available per calendar year. After assessment, the patient may receive up to eight (8) group services per calendar year from an eligible diabetes educator, exercise physiologist and/or dietitian (under items 81105, 81115 and 81125). A collaborative approach, where diabetes educators, exercise physiologists and dietitians work together to develop group service programs in their local area, is encouraged.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline to substantiate the MBS requirements for patients with type 2 diabetes which is located on the DHS website.

M.9.2. Group Allied Health Services (Items 81100 to 81125) for People with Type 2 Diabetes - GP Referral Requirements

Patients must be referred by their GP to an eligible allied health professional (diabetes educator, exercise physiologist or dietitian) who will undertake an individual assessment of their suitability for a group services program (under item 81100, 81110 or 81120).

When referring patients, **GPs** must use a referral form that has been issued by the Australian Government Department of Health or a form that contains all the components of this form. The form issued by the department is available at http://www.health.gov.au/mbsprimarycareitems (click on the link for group allied health services).

GPs are also encouraged to provide a copy of the relevant part of the patient's care plan to the allied health professional.

M.9.3. Group Allied Health Services (Items 81100 to 81125) for People with Type 2 Diabetes - Eligible Allied Health Professionals

Items 81100 to 81125 only apply to services provided by eligible diabetes educators, exercise physiologists and dietitians who are registered with the Department of Human Services. If providers are already registered with the Department of Human Services to use item 10951, 10953 or 10954, they do not need to register separately for items 81100 to 81125. Eligibility criteria are as follows:

Diabetes educator: must be a 'credentialed diabetes educator' (CDE) as credentialed by the Australian Diabetes Educators Association (ADEA).

Exercise physiologist: must be an 'accredited exercise physiologist' as accredited by Exercise and Sports Science Australia (ESSA).

Dietitian: must be an 'accredited practising dietitian' as recognised by the Dietitians Association of Australia (DAA).

The Department of Human Services registration forms may be obtained from the Department of Human Services on 132 150 or at the Department of Human Services' website.

M.9.4. Assessment for Group Allied Health Services (Items 81100, 81110 and 81120) for People with Type 2 Diabetes

An assessment service is provided by a diabetes educator (item 81100), an exercise physiologist (item 81110) or a dietitian (item 81120), on referral from a GP.

The purpose of this service is to undertake an individual assessment and determine the patient's suitability for a group services program. It involves taking a comprehensive patient history and identification of individual goals. This may also provide an opportunity to identify any patient who is likely to be unsuitable for group services.

Number of services per year
Patients are eligible for a maximum of one assessment for group services (item 81100 **or** 81110 **or** 81120) per calendar year. If more than one assessment service is provided in a calendar year, the subsequent service/s will not attract a Medicare rebate and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.

If there is any doubt about a patient's eligibility for items 81100, 81110 or 81120, the allied health professional should contact the Department of Human Services to confirm the number of assessment services already claimed by the patient in the calendar year. Allied health professionals can call the Department of Human Services on 132 150 to check this information.

Referral form
The GP must refer the patient using the *Referral form for group allied health services under Medicare for patients with type 2 diabetes* or a form that contains all the components of this form. The form issued by the department is available at http://www.health.gov.au/mbsprimarycareitems (click on the link for group allied health services).

The allied health professional undertaking the assessment service will need to complete Part B of this form, and the patient will then need to present this form to the provider/s of group services.

Length of service
This service must be of at least 45 minutes duration and provided to an individual patient. The allied health professional must personally attend the patient.

Reporting requirements
On completion of the assessment service, the allied health professional must provide a written report back to the referring GP outlining the assessment undertaken, whether the patient is suitable for group services and, if so, the nature of the group services to be delivered.

M.9.5. GROUP ALLIED HEALTH SERVICES (ITEMS 81105, 81115 AND 81125) FOR PEOPLE WITH TYPE 2 DIABETES - SERVICE REQUIREMENTS AND REFERRAL FORMS

These services are provided in a group setting to assist with the management of type 2 diabetes.

Number of services per year
Patients are eligible for up to eight group allied health services in total (items 81105, 81115 and 81125 inclusive) per calendar year. Each separate group service must be provided to the patient by only one type of allied health professional (i.e. by a diabetes educator, or by an exercise physiologist or by a dietitian). However, the overall group services program provided for the patient could be comprised of one type of service only (e.g. eight diabetes education services) or a combination of services (e.g. three diabetes education services, three dietitian services and two exercise physiology services). An eligible allied health professional with more than one Medicare provider number (e.g. for the provision of diabetes education and dietetics) may provide separate services under each of these provider numbers.

Group allied health service providers are strongly encouraged to deliver multidisciplinary group services programs that allow patients to benefit from a range of interventions designed to assist in the management of their type 2 diabetes.

Where a patient receives more than the limit of eight group services in a calendar year, the additional service/s will not attract a Medicare benefit and the MBS Safety Net arrangements will not apply to costs incurred by the patient for the service/s.

If there is any doubt about a patient's eligibility for group services, the allied health professional should contact the Department of Human Services to confirm the number of group services already claimed by the patient in the calendar year. Allied health professionals can call the Department of Human Services on 132 150 to check this information.

Multiple services on the same day
Where clinically relevant, up to two group services may be provided consecutively on the same day by the same allied health professional.

Referral form
The allied health professional/s undertaking the group services will need to receive the *Referral form for group allied health services under Medicare for patients with type 2 diabetes* issued by the Department of Health or a form that contains all the components of this form, with Part B completed by the provider who has undertaken the assessment

service. The form issued by the department is available at http://www.health.gov.au/mbsprimarycareitems (click on the link for group allied health services).

Group size
The service must be provided to a person who is part of a group of between two and 12 persons.

Length of service
Each group service must be of at least 60 minutes duration.

Reporting requirements
On completion of the group services program, each allied health professional must provide, or contribute to, a written report back to the referring GP in respect of each patient. The report should describe the group services provided for the patient and indicate the outcomes achieved. While each allied health professional is required to provide feedback to the GP in relation to the group services that they provide to the patient, allied health professionals involved in the provision of a multidisciplinary program are encouraged to combine feedback into a single report to the referring GP.

M.9.6. Group Allied Health Services (Items 81100 to 81125) for People with Type 2 Diabetes - Additional Requirements

Retention of Referral Form for the Department of Human Services Audit Purposes

It is recommended that Allied health professionals retain a copy of the referral form for 24 months from the date the service was rendered (for the Department of Human Services auditing purposes).

Publicly funded services
Items 81100 – 81125 do not apply for services that are provided by any other Commonwealth or state-funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or a state/territory government health clinic, items 81100-81125 can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, service or health clinic. All requirements of the relevant item must be met, including registration of the allied health professional with the Department of Human Services. These services must also be bulk billed.

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

Out-of-pocket expenses and Medicare Safety Net
Allied health professionals are free to determine their own fees for the professional service. Charges in excess of the Medicare benefit for the allied health items are the responsibility of the patient. However, such out of pocket costs will count toward the Medicare Safety Net for that patient.

M.9.7. Group Allied Health Services (Items 81100 to 81125) for People with Type 2 Diabetes - Further Information

Further information about these items is available on the Department of Health's website at www.health.gov.au/mbsprimarycareitems

M.10.1. Provision of Autism, Pervasive Developmental Disorder or Disability Services by Allied Health Professionals - (Items 82000 to 82035)

Eligible patients

MBS items 82000 to 82035 provide Medicare-rebateable allied health services to children with autism or any other pervasive developmental disorder (PDD) through the Helping Children with Autism program, and to children with an eligible disability through the Better Start for Children with Disability program. Children with both autism/PDD and an eligible disability can access either program, but not both.

The conditions classified as PDD in 2008 for the purposes of these services were informed by the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), Washington, DC, American Psychiatric Association, 2000.

'Eligible disabilities' for the purpose of these services means any of the following conditions:

(a) sight impairment that results in vision of less than or equal to 6/18 vision or equivalent field loss in the better eye, with correction.
(b) hearing impairment that results in:
  (iii) a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or
  (iv) permanent conductive hearing loss and auditory neuropathy.
(c) deafblindness
(d) cerebral palsy
(e) Down syndrome
(f) Fragile X syndrome
(g) Prader-Willi syndrome
(h) Williams syndrome
(i) Angelman syndrome
(j) Kabuki syndrome
(k) Smith-Magenis syndrome
(l) CHARGE syndrome
(m) Cri du Chat syndrome
(n) Cornelia de Lange syndrome
(o) microcephaly if a child has:
  (iii) a head circumference less than the third percentile for age and sex; and
  (iv) a functional level at or below 2 standard deviations below the mean for age on a standard developmental test, or an IQ score of less than 70 on a standardised test of intelligence.
(p) Rett's disorder

"standard developmental test" refers to the Bayley Scales of Infant Development or the Griffiths Mental Development Scales; "standardised test of intelligence" means the Wechsler Intelligence Scale for Children (WISC) or the Wechsler Preschool and Primary Scale of Intelligence (WPPSI). It is up to the clinical judgement of the diagnosing practitioner if other tests are appropriate to be used.

Allied health services available under Medicare

Items are available for **assessment/diagnosis** services, the results of which can contribute to development of a treatment and management plan by the referring medical practitioner, and for **treatment** services.

The **assessment/diagnosis** items (82000, 82005, 82010, 82030) can be accessed when:

- a child with autism/PDD is aged under 13 years and referred by an eligible consultant psychiatrist or paediatrician; or
- a child with an eligible disability is aged under 13 years and referred by a specialist, consultant physician or GP.

The **treatmen**t items (82015, 82020, 82025 and 82035) can be accessed when:

- A child with autism/PDD is aged under 15 years and a treatment and management plan has been put in place for them before their 13th birthday, and they have been referred by an eligible consultant psychiatrist or paediatrician.
- A child with an eligible disability is aged under 15 years and a treatment and management plan has been put in place for them before their 13th birthday, and they have been referred by a specialist, consultant physician or GP.

The allied health assessment and treatment services can be provided by eligible audiologists, occupational therapists, optometrists, orthoptists, physiotherapists, psychologists and speech pathologists.

Number of assessment services
Medicare rebates are available for up to four services in total per eligible child, to assist with assessment and diagnosis and development of a treatment plan. The four services may consist of any combination of items 82000, 82005, 82010 and 82030. It is the responsibility of the referring practitioner to allocate these services in keeping with the child's individual needs and to refer the child to appropriate allied health professional(s) accordingly.

These services will not attract a Medicare rebate unless a referral has been made by a consultant psychiatrist (using items 296-370) or paediatrician (using items 110-131) for a child with autism/PDD, or by a specialist or consultant physician (using items 104-131 or 296-370 excluding item 359) or GP (using items 3-51) for a child with a disability.

Number of treatment services
Medicare rebates are available for up to twenty allied health treatment services in total per eligible child. The twenty services may consist of any combination of items 82015, 82020, 82025 and 82035. It is the responsibility of the referring

practitioner to allocate these services in keeping with the child's individual treatment needs and to refer the child to appropriate allied health professional(s) accordingly.

These services will not attract a Medicare rebate unless referral has been made by a consultant psychiatrist (using item 289) or paediatrician (using item 135) for children with autism/PDD, or by a specialist or consultant physician (using item 137) or a GP for disability (using item 139) for children with disability.

Service length and type
Services under these items must be for the time period specified within the item descriptor. The allied health professional must personally attend the child.

A child may receive up to four Medicare eligible services from an allied health professional on the same day.
It is anticipated that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

It is also expected that participating allied health providers will deliver treatment under these items that is consistent with the autism/PDD or disability treatment plan prepared by the medical practitioner, and is in keeping with commonly established autism/PDD or disability interventions as practised by their profession and appropriate for the age and particular needs of the child being treated.

Eligible allied health professionals
Allied health professionals providing services under these items must be registered with the Department of Human Services. To register with the Department of Human Services to provide these services, an allied health professional must meet the specific eligibility requirements detailed below:

- **Audiologist** must be either a 'Full Member' of the Audiological Society of Australia Inc (ASA), who holds a 'Certificate of Clinical Practice' issued by the ASA; or an 'Ordinary Member - Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).
- **Occupational Therapist** must be registered with the Occupational Therapy Board of Australia.
- **Optometrist** must be registered as an optometrist or optician under a law of a State or an internal Territory that provides for the registration of optometrists or opticians, and be a participating optometrist.
- **Orthoptist** must be registered with the Australian Orthoptic Board and have a Certificate of Currency; and be a member of Orthoptics Australia.
- **Physiotherapist** must be registered with the Physiotherapy Board of Australia.
- **Psychologist** must hold General Registration with the Psychology Board of Australia.
- **Speech Pathologist** must be a 'Practising Member' of Speech Pathology Australia.

In addition to meeting the above mentioned credentialing requirements, it is expected that eligible providers will "self-select" for the autism/PDD and disability items (i.e. possess the skills and experience appropriate for provision of these services and be oriented to work with children with autism/PDD or disability).

Referral requirements
An allied health professional wanting to provide any of the items 82000-82035 must be in receipt of a current referral provided by an eligible medical practitioner. Referrals are only valid when prerequisite MBS services have been provided.

An eligible allied health professional can provide assessment items (82000, 82005, 82010 and 82030) to a child under the Helping Children with Autism program when:

- the child has previously been provided with any MBS service covering items 110 through 131 inclusive by a consultant paediatrician; or
- the child has previously been provided with any MBS service covering items 296 through 370 (excluding item 359) inclusive by a consultant psychiatrist.

An eligible allied health professional can provide assessment items (82000, 82005, 82010 and 82030) to a child under the Better Start for Children with Disability program when:

- the child has previously been provided with any MBS service covering items 104 through 131 inclusive, or items 296 through 370 (excluding item 359) inclusive by a specialist or consultant physician; or
- the child has previously been provided with any MBS service covering items 3 through 51 by a GP.

An eligible allied health professional can provide treatment items (82015-82025 and 82035) to a child under the Helping Children with Autism program when:

- the child has previously been provided with a treatment plan (item 135) by a consultant paediatrician; or

- the child has previously been provided with a treatment plan (item 289) by a consultant psychiatrist.

An eligible allied health professional can provide treatment items (82015-82025 and 82035) to a child under the Better Start for Children with Disability program when:

- the child has previously been provided with a treatment plan (MBS item 137) by a specialist or consultant physician; or
- the child has previously been provided with a treatment plan (MBS item 139) by a GP.

If the referring service has not yet been claimed, the Department of Human Services (DHS) will not be aware of the child's eligibility and Medicare benefits cannot be paid. DHS will be able to confirm whether a relevant MBS service has been claimed and/or the number of allied health services already claimed by the child. Allied health professionals can call the DHS provider line on 132 150. Parents and carers can call the patient information line on 132 011.

It is recommended that allied health professionals retain the referral for 24 months from the date the service was rendered for Medicare auditing purposes.

Referring medical practitioners are not required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring practitioner.

Referral validity
Medicare benefits are available for up to four allied health assessment and diagnosis services and up to twenty allied health treatment services per patient in total.

Patients will require a separate referral for each allied health professional they are referred to and they will also need new referrals for each new course of treatment.

A course of treatment for the allied health treatment services consists of the number of allied health services stated on the child's referral. This enables the referring practitioner to consider a report from the allied health professional(s) about the services provided to the child, and the need for further treatment.

Within the maximum service allocation of twenty services for the treatment items, the allied health professional(s) can provide one or more courses of treatment. Up to 4 services may be provided to the same child on the same day.

Reporting requirements
A written report must be provided to the referring medical practitioner by the allied health professional(s) after having provided the assessment and diagnosis and development of a treatment plan service(s) to the child.

On completion of a course of treatment, the eligible audiologist, occupational therapist, optometrist, orthoptist, physiotherapist, psychologist and speech pathologist must provide a written report to the referring medical practitioner which includes information on:

- treatment provided;
- recommendations on future management of the child's disorder; and
- any advice provided to third parties (e.g. parents, schools).

A written report must also be provided to the referring medical practitioner at the completion of any subsequent course(s) of treatment provided to the child.

Further information
For more information refer to the MBS online website or the MBS Primary Care Items information page. information page.

M.11.1. Follow-up Allied Health Services for people of Aboriginal or Torres Strait Islander descent (Items 81300 to 81360)

Eligible Patients
A person who is of Aboriginal or Torres Strait Islander descent may be referred by their GP for follow-up allied health services under items 81300 to 81360 when the GP has undertaken a health assessment and identified a need for follow-up allied health services.

These items are similar to the individual allied health items (items 10950 to 10970) available to patients who have a chronic or terminal medical condition and complex care needs and have a GP Management Plan and Team Care Arrangements prepared by their GP. However items 81300 to 81360 provide an alternative referral pathway for Aboriginal

or Torres Strait Islander people to access allied health services. If a patient meets the eligibility criteria for individual allied health services under the Chronic Disease Management items and for follow-up allied health services, they can access both sets of services and are eligible for up to ten allied health services under Medicare per calendar year.

A practice nurse/Aboriginal and Torres Strait Islander health practitioner item (10987) is also available for Indigenous Australians who have received a health check. This item enables Aboriginal or Torres Strait Islander people to receive follow-up services from a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a GP. More detail on this item is provided at explanatory note M.12.4 of the Medicare Benefits Schedule.

Eligible Allied Health Services

The following allied health professionals are eligible to provide services under these items:

- Aboriginal and Torres Strait Islander health practitioners
- Aboriginal Health Workers
- Audiologists
- Chiropractors
- Diabetes Educators
- Dietitians
- Exercise Physiologists
- Mental Health Workers
- Occupational Therapists
- Osteopaths
- Physiotherapists
- Podiatrists
- Psychologists
- Speech Pathologists

Publicly funded services

Items 81300 to 81360 do not apply for services that are provided by any Commonwealth or state or territory government funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or state/territory government health clinic, items 81300 to 81360 can be claimed for services provided by eligible allied health professionals salaried by, or contracted to, the service or health clinic. All requirements of the relevant item must be met, including registration of the allied health professional with the Department of Human Services. Medicare services provided under a subsection 19(2) exemption must be bulk billed (i.e. the Medicare rebate is accepted as full payment for services).

Number of services per year

Medicare benefits are available for up to five follow-up allied health services per eligible patient, per calendar year. The five allied health services can be made up of one type of service (e.g. five physiotherapy services) or a combination of different types of services (e.g. one dietetic, two podiatry and two physiotherapy services).

The annual limit of five allied health services per patient under items 81300 to 81360 is in addition to the individual allied health services for patients with a chronic or terminal medical condition and complex care needs (items 10950 to 10970).

Checking patient eligibility for items 81300 to 81360

If there is any doubt about a patient's eligibility, the Department of Human Services will be able to confirm the number of allied health services already claimed by the patient during the calendar year. Allied health professionals can call the Department of Human Services on 132 150 and patients can call the Department of Human Services on 132 011 or alternatively the Indigenous Access Line for the Department of Human Services on 1800 556 955.

Service length and type

Services provided by eligible allied health professionals under these items must meet the specific requirements set out in the item descriptors. These requirements include that:

- the service is of at least 20 minutes duration;
- the service is provided to the person individually (i.e. not as part of a group service) and in person (i.e. the allied health professional must personally attend the patient);
- the person is not an admitted patient of a hospital;
- the allied health professional must provide a written report to the GP; and
- if the patient has private health insurance, he/she cannot use their private health insurance ancillary cover to 'top up' the Medicare rebate paid for these services.

Private health insurance

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

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

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

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

Out-of-pocket expenses and Medicare safety net
Allied health professionals can determine their own fees for the professional service, except where the service is provided under a subsection 19(2) exemption. Charges in excess of the Medicare benefit for the allied health items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Allied health services in excess of five in a calendar year will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Referral Requirements
Referral form
For Medicare benefits to be payable, the patient must be referred to an eligible allied health professional by their GP using a referral form that has been issued by the Australian Government Department of Health or a form that contains all the components of this form.

The form issued by the department is available at the MBS Primary Care Items information page (click on the link for follow-up allied health services).

GPs are encouraged to attach a copy of the relevant part of the patient's care plan to the referral form.

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

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

It is recommended that allied health professionals retain the referral form for 24 months from the date the service was rendered (for the Department of Human Services auditing purposes). A copy of the referral form is not required to accompany Medicare claims, and allied health professionals do not need to attach a signed copy of the form to patients' itemised accounts/receipts or assignment of benefit forms.

Completed forms do not have to be sent to the Department of Health.

Referral validity
A referral is valid for the stated number of services. If all services are not used during the calendar year in which the patient was referred, the unused services can be used in the next calendar year. However, those services will be counted as part of the five rebates for allied health services available to the patient during that calendar year.

When patients have used all of their referred services they will need to obtain a new referral from their GP.

Allied health Professional Eligibility
Items 81300 to 81360 can only be claimed for services provided by eligible allied health professionals who are registered with the Department of Human Services. Allied health professionals already registered with Medicare (e.g. for items 10950 to 10970) do not need to register again to claim these items.

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

Aboriginal and Torres Strait Islander health practitioners must be registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. Aboriginal and Torres Strait Islander health practitioners may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioners; Aboriginal and Torres Strait Islander health practitioners; or Torres Strait Islander health practitioners.

Aboriginal health workers in a State or Territory other than the Northern Territory must have been awarded either:

a. a Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care (or an equivalent or higher qualification) by a registered training organisation; or
b. a Certificate III in Aboriginal and Torres Strait Islander Health (or an equivalent or higher qualification) by a registered training organisation before 1 July 2012.

Note: Where individuals consider their qualification to be equivalent to or higher than the qualifications listed above, they will need to contact a registered training organisation in their State or Territory to have the qualification assessed as such before they can register with the Department of Human Services. In the Northern Territory, a practitioner must be registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia.

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

Chiropractors must be registered with the Chiropractic Board of Australia.

Diabetes educators must be a Credentialled Diabetes Educator (CDE) as credentialled by the Australian Diabetes Educators Association (ADEA).

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

Exercise physiologists must be an 'Accredited Exercise Physiologist' as accredited by Exercise and Sports Science Australia (ESSA).

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

- psychologists;
- mental health nurses;
- occupational therapists;
- social workers;
- Aboriginal and Torres Strait Islander health practitioners; and
- Aboriginal health workers.

Psychologists, occupational therapists, Aboriginal and Torres Strait Islander health practitioners and **Aboriginal health workers** are eligible in separate categories for these items.

Mental health nurses must be a credentialled mental health nurse, as certified by the Australian College of Mental Health Nurses.

Mental health nurses who were registered in the ACT or Tasmania prior to the introduction of the National Registration and Accreditation Scheme (NRAS) on 1 July 2010, will have until 31 December 2010 to be certified by the Australian College of Mental Health Nurses.

Social workers must be a 'Member' of the Australian Association of Social Workers (AASW); and be certified by AASW as meeting the standards for mental health set out in the document published by AASW titled 'Practice Standards for Mental Health Social Workers' as in force on 8 November 2008.

Occupational therapists must be registered with the Occupational Therapy Board of Australia.

Osteopaths must be registered with the Osteopathy Board of Australia.

Physiotherapists must be registered with the Physiotherapy Board of Australia.

Podiatrists must be registered with the Podiatry Board of Australia.

Psychologists must hold general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided.

Speech pathologists must be a 'Practising Member' of Speech Pathology Australia.

Registering with the Department of Human Services

Provider registration forms may be obtained from the Department of Human Services on 132 150 or by visiting the Department of Human Services website and then searching for "allied health application".

Further information
Further information about these items, including a fact sheet and the referral form, is available on the Department of Health's MBS Primary Care Items information page. For providers, information is also available from the Department of Human Services provider inquiry line on 132 150. The Indigenous Access Line for the Department of Human Services on 1800 556 955 is also a useful source of information.

M.12.1. IMMUNISATION SERVICES PROVIDED BY AN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER - (ITEM 10988)

Item 10988 can only be claimed by a medical practitioner where an immunisation is provided to a patient by an Aboriginal and Torres Strait Islander health practitioner on behalf of the medical practitioner.

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

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

The Aboriginal and Torres Strait Islander health practitioner must be appropriately qualified and trained to provide immunisations. This includes compliance with any territory requirements.

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

Supervision may include distance supervision where the medical practitioner does not have to be physically present at the time that the service is provided by the Aboriginal and Torres Strait Islander health practitioner, but should be able to be contacted for advice if required.

The immunisation must be performed by the Aboriginal and Torres Strait Islander health practitioner in accordance with the current edition of the Australian Immunisation Handbook and the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual.

Immunisation means the administration of a registered vaccine to a patient for any purpose other than as part of a mass immunisation of persons.

A registered vaccine means a vaccine that is included on the Australian Register of Therapeutic Goods. This includes all vaccines on the Australian Standard Vaccination Schedule and vaccines covered in the current edition of the Australian Immunisation Handbook. The following substances cannot be claimed under this item: vaccines used experimentally; homeopathic substances; immunotherapy for allergies (eg de-sensitisation preparations); and other substances that are not vaccines. There may also be territory limitations on the administration of some vaccines, such as those for tuberculosis, yellow fever and Q-fever.

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

Where the medical practitioner provides a professional attendance to the patient (in addition to the immunisation service provided by the Aboriginal and Torres Strait Islander health practitioner), the medical practitioner may also claim for the professional attendance they provide to the patient.

Item 10991 can also be claimed in conjunction with item 10988 provided the conditions of both items are satisfied.

Related Items: 10988

M.12.2. WOUND MANAGEMENT SERVICES PROVIDED BY AN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER (ITEM 10989)

Item 10989 can only be claimed by a medical practitioner where wound management (other than normal aftercare) is provided to a patient by an Aboriginal and Torres Strait Islander health practitioner on behalf of the medical practitioner.

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

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or 806 retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

The Aboriginal and Torres Strait Islander health practitioner must be appropriately qualified and trained to treat wounds. This includes compliance with any territory requirements.

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

Supervision may include distance supervision where the medical practitioner does not have to be physically present at the time that the service is provided by the Aboriginal and Torres Strait Islander health practitioner, but should be able to be contacted for advice if required.

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

Where an Aboriginal and Torres Strait Islander health practitioner provides ongoing wound management, the medical practitioner is not required to give instruction or see the patient during each subsequent visit.

M.12.3. HEALTHY KIDS CHECK PROVIDED BY A PRACTICE NURSE OR AN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER (ITEM 10986)

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

A health assessment must include the following elements:

(a) information collection, including taking a patient history and undertaking examinations and investigations as required;

(b) making an overall assessment of the patient;

(c) recommending appropriate interventions;

(d) providing advice and information to the patient;

(e) keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and

(f) offering the patient’s carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

MBS item 10986 may be provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner, but may only be claimed by a medical practitioner (including a general practitioner but not including a specialist or consultant physician).

A health assessment should not take the form of a health screening service (see General Explanatory Notes G.13.1).

The practice nurse or Aboriginal and Torres Strait Islander health practitioner is required to note if a copy of the Department's publication ‘Get Set 4 Life – habits for healthy kids’ has been provided to the patient’s parents/guardian.

The practice nurse or Aboriginal and Torres Strait Islander health practitioner is also required to note that the four year-old immunisation has been given (including evidence provided).

The practice nurse is a registered or enrolled nurse who is employed by, or whose services are otherwise retained by a general practice.

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

Should the practice nurse or Aboriginal and Torres Strait Islander health practitioner identify any health concerns that require medical intervention, the patient must be reviewed by the patient's 'usual doctor' who will arrange referrals and follow-up as clinically required.

In all cases, the medical practitioner under whose supervision the health check is being provided retains responsibility for the health, safety and clinical outcomes of the patient. The medical practitioner must be satisfied that the practice nurse or Aboriginal and Torres Strait Islander health practitioner is appropriately qualified and trained to provide the service.

General practices and Aboriginal Community Controlled Health Services and State/Territory health clinics that are exempt under subsection 19(2) of the *Health Insurance Act 1973* that utilise nurses and Aboriginal and Torres Strait Islander health practitioners to provide the Healthy Kids Check must also have a written clinical risk management strategy.

Where the medical practitioner and practice nurse or Aboriginal and Torres Strait Islander health practitioner are at the same location, the medical practitioner is not required to be present while the Healthy Kids Check is undertaken. The medical practitioner must decide whether he or she needs to see the patient.

Item 10988 (immunisation by Aboriginal and Torres Strait Islander health practitioner) can be claimed in conjunction with the Healthy Kids Check health assessment, provided the conditions of item 10988 are satisfied.

The Healthy Kids Check must include the following basic physical examinations and assessments:

(a) Height and weight (plot and interpret growth curve/calculate BMI)
(b) Eyesight
(c) Hearing
(d) Oral health (teeth and gums)
(e) Toileting
(f) Allergies

Item 10986 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, item 10986 can be claimed for services provided by nurses or Aboriginal and Torres Strait Islander health practitioners salaried by or contracted to, the Service or health clinic. All other requirements of the item must be met.

The Healthy Kids Check provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner (item 10986) may only be claimed once by an eligible patient and only if the patient has not already claimed a Healthy Kids Check service under items 701, 703, 705 or 707.

M.12.4. FOLLOW UP SERVICE PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER, ON BEHALF OF A MEDICAL PRACTITIONER, FOR AN INDIGENOUS PERSON WHO HAS RECEIVED A HEALTH ASSESSMENT (ITEM 10987)

Item 10987 may be claimed by a medical practitioner, where a follow up service is provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of that medical practitioner for an Indigenous person who has received a health check.

All GPs whether vocationally registered or not are eligible to claim this item. District Medical Officers (DMOs) employed by state/territory health Departments are also eligible to claim this item. The term 'GP' is used in these notes as a generic reference to medical practitioners able to claim this item.

Item 10987 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government Health clinic, item 10987 can be claimed for services provided by practice nurses or Aboriginal and Torres Strait Islander health practitioner salaried or contracted to, the Service or Health clinic. All requirements of the item must be met.

Item 10987 will assist Indigenous patients who have received a health check which has identified a need for follow up services which can be provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner between further consultations with the patient's GP.

Item 10987 may be used to provide:

- Examinations/interventions as indicated by the health check;
- Education regarding medication compliance and associated monitoring;
- Checks on clinical progress and service access;
- Education, monitoring and counselling activities and lifestyle advice;
- Taking a medical history; and
- Prevention advice for chronic conditions, and associated follow up.

Item 10987 may be claimed up to a maximum of 10 times per patient per calendar year.

Item 10987 may be accessed by an Indigenous patient who has received the Aboriginal and Torres Strait Islander Peoples Health Assessment (item 715), which is available to:
a) children between the ages of 0 and 14 years;
b) adults between the ages of 15 and 54 years; and
c) older people over the age of 55 years.

The item can also be accessed by a child who has received a health check as part of the Northern Territory Emergency Response (NTER).

Patients whose condition is unstable/deteriorating should be referred to their GP for further treatment.

A practice nurse means a registered or enrolled nurse who is employed by, or whose services are otherwise retained by a general practice or by a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the *Health Insurance Act 1973*.

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

In all cases, the GP under whose supervision the health check follow-up is being provided retains responsibility for the health, safety and clinical outcomes of the patient. The GP must be satisfied that the practice nurse or Aboriginal and Torres Strait Islander health practitioner is appropriately qualified and trained to provide the relevant follow up for the patient. GPs are advised to consult their insurer concerning indemnity coverage for services provided on their behalf.

General practices where nurses or Aboriginal and Torres Strait Islander health practitioners provide follow up for Indigenous people who have received a health check, should also have a written clinical risk management strategy covering issues like clinical roles, patient follow up and patient consent.

Continuing professional development is recommended for all nurses and an Aboriginal and Torres Strait Islander health practitioners providing follow up services for Indigenous people who have received a health check.

Supervision of the practice nurse/Aboriginal and Torres Strait Islander health practitioner by the GP at a distance is recognised as an acceptable form of supervision. This means that the claiming GP does not have to be physically present at the time the service is provided. However the GP should be able to be contacted if required.

Where the GP and practice nurse/Aboriginal and Torres Strait Islander health practitioner are at the same location, the GP is not required to be present while the health check follow up is undertaken. It is up to the GP to decide whether they need to see the patient. Where the GP has a consultation with the patient, then the GP is entitled to claim a Medicare item for the time and complexity of their personal attendance on the patient. The time the patient spends receiving a service from the practice nurse or Aboriginal and Torres Strait Islander health practitioner is itemised separately under item 10987 and should not be counted as part of the Medicare items claimed for time spent with the GP. Where the practice nurse or Aboriginal and Torres Strait Islander health practitioner provides another service (eg immunisation, Pap smear) on the same day, the GP is able to claim for all practice nurse/ Aboriginal and Torres Strait Islander health practitioner services provided.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with item 10987 provided the conditions of item 10990 or 10991 are satisfied.

M.12.5. PROVISION OF MONITORING AND SUPPORT FOR A PERSON WITH A CHRONIC DISEASE BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER (ITEM 10997)

Item 10997 may be claimed by a medical practitioner, where a monitoring and support service for a person with a chronic disease care plan is provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of that medical practitioner.

All GPs whether vocationally registered or not are eligible to claim this item. The term 'GP' is used in these notes as a generic reference to medical practitioners able to claim this item.

Item 10997 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, item 10997 can be claimed for services provided by practice nurses or Aboriginal and Torres Strait Islander health practitioners salaried by or contracted to, the Service or health clinic. All requirements of the item must be met.

Item 10997 will assist patients who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the patient's usual GP.

Item 10997 may be used to provide:
- checks on clinical progress;
- monitoring medication compliance;
- self management advice, and;
- collection of information to support GP reviews of Care Plans.

The services provided by the practice nurse or Aboriginal and Torres Strait Islander health practitioner should be consistent with the scope of the GP Management Plan, Team Care Arrangements, or Multidisciplinary Care Plan.

Item 10997 may be claimed up to a maximum of 5 times per patient per calendar year.

Item 10997 may only be accessed by a patient with a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan (items 721, 723, 729, 731 and 732).

Patients whose condition is unstable/deteriorating should be referred to their GP for further treatment.

A practice nurse means a registered or enrolled nurse or Nurse Practitioner who is employed by, or whose services are otherwise retained by a general practice.

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

In all cases, the GP under whose supervision the chronic disease monitoring and support is being provided retains responsibility for the health, safety and clinical outcomes of the patient. The GP must be satisfied that the practice nurse is

appropriately qualified and trained to provide chronic disease support and monitoring. GPs are advised to consult their insurer concerning indemnity coverage for services performed on their behalf.

General practices where nurses or Aboriginal and Torres Strait Islander health practitioner provide chronic disease support and monitoring, should also have a written clinical risk management strategy covering issues like clinical roles, patient follow up and patient consent.

Continuing professional development is recommended for all nurses and Aboriginal and Torres Strait Islander health practitioners providing chronic disease monitoring and support.

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

Where the GP and practice nurse/ Aboriginal and Torres Strait Islander health practitioner are at the same location, the GP is not required to be present while the chronic disease monitoring and support is undertaken. It is up to the GP to decide whether they need to see the patient. Where the GP has a consultation with the patient, then the GP is entitled to claim a Medicare item for the time and complexity of their personal attendance on the patient. The time the patient spends receiving a service from the practice nurse or Aboriginal and Torres Strait Islander health practitioner is itemised separately under item 10997 and should not be counted as part of the Medicare item claimed for time spent with the GP. Where the practice nurse or Aboriginal and Torres Strait Islander health practitioner provides another service (eg immunisation) on the same day, the GP is able to claim for both practice nurse/ Aboriginal and Torres Strait Islander health practitioner items.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with item 10997 provided the conditions of item 10990 or 10991 are satisfied (see explanatory note M.1).

M.12.6. TELEHEALTH SUPPORT SERVICES BY HEALTH PROFESSIONALS

These notes provide information on the telehealth MBS attendance items for health professionals to provide clinical support to their patients during video consultations with a specialist, consultant physicians and psychiatrists under items 10945 to 10948 in Group A10 which are available for participating optometrists, items 82150, 82151 and 82152 in Group M13 which are available for participating midwives, items 82220 to 82225 in Group M14 for participating nurse practitioners and items 10983 and 10984 in Group M12 for practice nurses, Aboriginal and Torres Strait Islander health practitioners or Aboriginal health workers for services provided for and on behalf of a medical practitioner.

Telehealth patient-end support services can only be claimed where:
- a Medicare eligible specialist service is claimed;
- the service is rendered in Australia; and
- where this is necessary for the provision of the specialist service.

The above patient-end support services provide for attendances in various settings including eligible residential aged care services, eligible Aboriginal Medical Service or Aboriginal Community Controlled Health Service to which a 19(2) direction under the *Health Insurance Act 1973* applies.

Clinical indications
The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist, consultant physician or psychiatrist.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Collaborative Consultation
The practitioner, who provides assistance to the patient where this is necessary for the provision of the specialist service, may seek assistance from a health professional (e.g. a practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker) but only one item is billable for the patient-end support service. The practitioner must be present during part or all of the consultation in order to bill an appropriate time-tiered MBS item. Any time spent by another health professional called to assist with the consultation may not be counted against the overall time taken to complete the video consultation.

Restrictions
The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations. In order to fulfill the item descriptor

there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Eligible Geographical Areas
Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website.

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in a residential care service; or at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service for which a direction, made under subsection 19(2) of the *Health Insurance Act 1973*, as these patients are to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at the MBS Online website.

Record Keeping
Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Multiple attendances on the same day
In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Aftercare Rule
Video consultations are subject to the same aftercare rules as face to face consultations.

Referrals
The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements
In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

Bulk billing
Bulk bill incentive items 10990 or 10991 may be billed in conjunction with the telehealth items 2100, 2122, 2125, 2126, 2137, 2138, 2143, 2147, 2179, 2195, 2199 and 2220.

Duration of attendance
The practitioner attending at the patient end of the video consultation does not need to be present for the entire consultation, only as long as is clinically relevant - this can be established in consultation with the specialist. The MBS fee payable for the supporting practitioner will be determined by the total time spent assisting the patient. This time does not need to be continuous.

Aboriginal health workers
For the purpose of items 10983 and 10984 an Aboriginal health worker means a person who:
a) holds a Certificate III in Aboriginal or Torres Strait Islander Health Worker Primary Health Care (Clinical) or other appropriate qualifications; or
b) is registered, and holds a current registration issued by a State or Territory regulatory authority, as an Aboriginal health worker; and
c) is employed by, or whose services are otherwise retained by a medical practitioner or their practice. This includes health service in relation to which a direction made under subsection 19(2) of the Act applies.

Aboriginal and Torres Strait Islander health practitioners
For the purpose of items 10983 and 10984 an Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the *Health Insurance Act 1973*.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

Practice Nurse
For the purpose of items 10983 and 10984 a practice nurse means a registered or enrolled nurse who is employed by, or whose services are otherwise retained by a medical practitioner or their practice. This includes a health service in relation to which a direction made under subsection 19(2) of the *Health Insurance Act 1973* applies.

M.13.1. Maternity Services by Participating Midwives - Overview

As at 1 November 2010, Medicare benefits are payable for antenatal, intrapartum and postnatal care for the first 6 weeks after the delivery, provided by eligible privately practising midwives. Eligible midwives can also request certain pathology and diagnostic imaging services for their patients and refer patients to obstetricians and paediatricians, as the clinical need arises. Each service that attracts a Medicare benefit is identified in the Medicare Benefits Schedule (MBS) by an item number. Each item describes the service that the item covers.

M.13.2. Participating Midwives

To provide services under Medicare, the legislation requires that a midwife be a participating midwife. A participating midwife is an eligible midwife who provides services in a collaborative arrangement or collaborative arrangements with one or more medical practitioners, of a kind or kinds specified in the regulations.

For more details on collaborative arrangements required under the regulations see Point M.13.5.

M.13.3. Eligible Midwives

Under the legislation, to be an eligible midwife the midwife must be registered or authorised (however described) under State and Territory law to practice midwifery. The midwife must also demonstrate that he or she has the appropriate qualifications and experience to meet the registration standard developed by the Nursing and Midwifery Board of Australia

Information regarding eligibility can be found on the Nursing and Midwifery Board of Australia (NMBA) site of the Australian Health Practitioner Regulatory Agency (AHPRA) website at:
http://www.nursingmidwiferyboard.gov.au/.

M.13.4. Midwife Professional Indemnity Insurance

Under National Law, which governs the National Registration and Accreditation Scheme (NRAS), it is a requirement for midwives to have appropriate professional indemnity insurance. All privately practising midwives who wish to provide private midwifery services in must have appropriate professional indemnity insurance from the date the State or Territory in which they were registered enacted National Law.

Further information about professional indemnity insurance for midwives can be found at:
http://www.health.gov.au/internet/main/publishing.nsf/Content/Maternity+Services+Review-Q&A-PIMI

M.13.5. Collaborative Arrangements

To provide Medicare rebate-able services an eligible midwife must have a collaborative arrangement in place that must provide for consultation, referral or transfer of care as clinical needs dictate, to ensure safe, high quality maternity care.

Under the legislation a collaborative arrangement can be with the following "specified" medical practitioners:

1) an obstetrician;
2) a medical practitioner who provides obstetric services; or
3) a medical practitioner employed or engaged by a hospital authority and authorised by the hospital authority to participate in a collaborative arrangement.

The types of practitioners listed 1) and 2) are defined in the Regulations as "obstetric specified medical practitioners".

Collaborative arrangement can be established in the following ways:

a) where the midwife:
    I. is employed or engaged by 1 or more obstetric specified medical practitioners or by an entity that employs or engages 1 or more obstetric specified medical practitioners; **or**
    II. has an agreement, in writing, with an entity, other than a hospital, that employs or engages one or more obstetric specified medical practitioners, OR
b) receiving patients by referral in writing to the midwife for midwifery treatment from a specified medical practitioner, **OR**
c) having a signed written agreement with one or more specified medical practitioners, **OR**
d) having an arrangement with *and acknowledged* by at least one specified medical practitioner
    I. an arrangement requires that the eligible midwife must record the following in the midwife's written records:-
        i. The name of at least one specified medical practitioner who is, or will be, collaborating with the midwife in the patient's care (a **named medical practitioner**);
        ii. That the midwife has told the patient that the midwife will be providing midwifery services to the patient in collaboration with one or more specified medical practitioners;
        iii. Acknowledgement by a named medical practitioner that the practitioner will be collaborating in the patient's care;
        iv. Plans for the circumstances in which the midwife will do any of the following:
            1. consult with an obstetric specified medical practitioner;
            2. refer the patient to a specified medical practitioner;
            3. transfer the patient's care to an obstetric specified medical practitioner.
    II. The midwife must also record the following in the midwife's written records:
        i. Any consultation or other communication between the midwife and an obstetric specified medical practitioner about the patient's care;
        ii. Any referral of the patient by the midwife to a specified medical practitioner;
        iii. Any transfer by the midwife of the patient's care to an obstetric specified medical practitioner;
        iv. When the midwife gives a copy of the hospital booking letter for the patient to a named medical practitioner – acknowledgement that the named medical practitioner has received the copy;
        v. When the midwife gives a copy of the patient's maternity care plan prepared by the midwife to a named medical practitioner – acknowledgement that the named medical practitioner has received the copy;
        vi. If the midwife requests diagnostic imaging or pathology services for the patient – when the midwife gives the results of the services to a named medical practitioner;
        vii. That the midwife has given a discharge summary at the end of the midwife's care for the patient to:
            1. a named medical practitioner; and
            2. the patient's usual general practitioner, OR
e) In relation to a hospital, the midwife is:
    I. credentialed to provide midwifery services after successfully completing a formal process to assess the midwife's competence, performance and professional suitability; and
    II. given clinical privileges for a defined scope of clinical practice for the hospital; and

III. permitted to provide midwifery care to his or her own patients at the hospital.

The legislation requires that collaborative arrangements must be in place at the time the participating midwife provides the service.

a) Being employed or engaged by a medical practice or an entity or having a written agreement with an entity
An entity may refer to, for example, a community health centre or a medical practice. For a midwife to have a collaborative arrangement in these circumstances, that midwife must be employed or engaged by or have a written agreement with an entity that also employs or engages 1 or more obstetric specified medical practitioners.

The terms *employ* or *engage* covers both employees and contractors. This will cover an eligible midwife who is employed or engaged by a medical practice so long as that medical practice employs or engages at least one obstetrician or medical practitioner that provides obstetric services.

There must be at least one obstetric specified medical practitioner employed or engaged by the entity each time the midwife renders a service/performs treatment. However, there is no requirement that the consultation, referral or transfer of care must always be to the medical practitioner(s) employed/engaged by the entity.

b) Referral from a medical practitioner
A participating midwife's patient will be able to access the MBS and PBS if a patient has been referred in writing to the midwife by a specified medical practitioner. The arrangement must provide for consultation, referral and transfer of care should the clinical need arise.

c) Written agreement with a medical practitioner
A participating midwife's patient will be able to access the MBS and PBS if the nurse practitioner has a written agreement in place with one or more specified medical practitioners. The agreement must be signed by the nurse practitioner and doctor. The arrangement must provide for consultation, referral and transfer of care.

d) Arrangement with, acknowledged by a medical practitioner
Evidence of 'acknowledgement' by an obstetrician/GP obstetrician for each woman for whom the midwife provides care is a requirement to ensure that the medical practitioner being named understands and accepts the collaborative arrangement.

The acknowledgement does not have to be obtained on an individual patient basis. This means that, for example, a midwife could obtain an acknowledgement from a specified medical practitioner that he or she will be the collaborating medical practitioner for some or all of the midwife's patients. Arrangements to collaborate could be obtained in a number of ways including signing of documents, email or fax confirmation, or verbal acknowledgement which the midwife documents in their written records.

The midwife is required to record in written records communications in regard to consultations, referral and transfer of the woman's care with the medical practitioner, including information that has been forwarded to the medical practitioner. The midwife is also required to send a copy of all pathology and diagnostic imaging results to a named medical practitioner and to record in the midwife's written records when this occurs (however, there is no requirement that the midwife consult with a medical practitioner in relation to every test result). The purpose of sharing records with the collaborating medical practitioner is to prevent duplication of services and to ensure continuity of care.

e) Collaborative arrangement with a hospital
This type of collaborative arrangement applies where an eligible midwife is credentialed for a hospital, having successfully completed a formal assessment of his or her qualifications, skills, experience and professional standing. It is expected that the assessment would involve an appropriately qualified medical practitioner/s. The midwife is also required to have a defined scope of clinical practice at the hospital and be eligible to treat his or her own patients at the hospital. The hospital must employ or engage at least one obstetric specified medical practitioner. It is expected that the hospital will have a formal written agreement with such midwives, addressing consultation, referral and transfer of care, relevant clinical guidelines and locally determined policies.

M.13.6. PROVIDER NUMBERS

To access the Medicare arrangements, eligible midwives will need to apply to the Department of Human Services for a provider number. A separate provider number is required for each location at which a midwife practices.

Advice about registering with the Department of Human Services to provide midwifery services using items 82100 to 82140 inclusive, is available from the Department of Human Services provider inquiry line on 132 150.

Medicare provider application forms for midwives can be downloaded from the following site:
www.medicareaustralia.gov.au

M.13.7. SCHEDULE FEES AND MEDICARE BENEFITS

Each midwifery service is identified in the MBS by an item number. The fee set for any item in the MBS is known as the "Schedule fee". The Schedule fee and Medicare benefit for each service is listed in the item description.

There are two levels of benefit payable for midwifery services:
75% of the Schedule fee for midwifery services rendered to privately insured patients as part of an episode of hospital treatment (other than for public patients); or
85% of the Schedule fee for antenatal and postnatal services rendered to non-admitted patients.

M.13.8. SAFETY NETS

Where practitioners charge more than the Medicare benefit, the resultant out-of-pocket costs are the responsibility of the patient.

Assistance is provided to families and singles for out-of-pocket costs for out-of-hospital services through the "original" and "extended" Medicare safety nets:

- the original safety net provides that once the threshold is met, the Medicare benefit increases to 100 per cent of the Schedule fee. The threshold in 2015 is $440.80; and

- under the extended Medicare safety net (EMSN), once certain thresholds are met, Medicare reimburses 80 per cent of the out-of-pocket costs. 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.

In 2015, the annual EMSN threshold for concession cardholders and people who receive Family Tax Benefits (Part A) is $638.40. For all other singles and families the annual threshold is $2000. These amounts are indexed by Consumer Price Index on 1 January each year.

M.13.9. SAFETY NET CAPPING FOR MIDWIFERY ITEMS

Midwifery services will be subject to a benefit limit or cap under the EMSN. This is in line with obstetric services which are also subject to a safety net cap. The caps that apply to midwifery services are outlined below:

Item	Maximum increase ($)
82100	21.70
82105	16.30
82110	21.70
82115	54.10
82130	16.30
82135	21.70
82140	16.30

M.13.10. WHERE MEDICARE BENEFITS ARE NOT PAYABLE

Medicare benefits are not available:

a. for services listed in the MBS, where the service rendered does *not* meet the item description and associated requirements;
b. where the midwifery service is *not* personally performed by the participating midwife;
c. for MBS services that are time based, the inclusion of any time period in the consultation periods when the patient is *not* receiving active attention e.g. the time the provider may take to travel to the patient's home or where the patient is resting between blood pressure readings; and
d. services provided where the patient is not in attendance, such as the issuing of repeat prescriptions;
e. for telephone attendances;
f. group sessions; and
g. The issuing of repeat prescriptioins, updating patient notes or telephone consultations.

The fee charged under Medicare must not include the cost of services that are not part of the MBS service being claimed. Medicare benefits are not payable for good or appliances associated with the service, such as bandages or other skin dressings
Unless the Minister otherwise directs, Medicare benefits are not payable where funding has already been provided under an arrangement with the Commonwealth, state or a local governing body.

M.13.11. BILLING OF PATIENT

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

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

(a) Patient's name;

(b) The date on which the professional service was rendered;

(c) An item number or a description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment is provided in a hospital "admitted patient" immediately preceding the description of the service or an asterisk "*" directly after an item number where used;

(d) The name and practice address and provider number of the participating midwife who actually rendered the service; (where the participating midwife has more than one practice location recorded with the Department of Human Services, the provider number used should be that which is applicable to the practice location at or from which the service was given).

Only one original itemised account should be issued in respect of any one service and any duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

M.13.12. ASSIGNMENT OF BENEFITS (DIRECT-BILLING) ARRANGEMENTS

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

If a participating midwife direct-bills, the participating midwife undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:-

- The patient's Medicare card number must be quoted on all direct-bill forms for that patient.
- The basic forms provided are loose leaf to enable the patient details to be imprinted from the Medicare card.
- The forms include information required by Regulations under Subsection 19(6) of the Health Insurance Act.
- The practitioner must include the particulars relating to the professional service out on the assignment form before the patient signs the form and ensure that the patient to receive a copy of the form as soon as practicable after the patient signs it.
- Where a patient is unable to sign the assignment form the signature of the patient's parent, guardian or other responsible person (other than the practitioner, practitioner's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable. The reason the patient is unable to sign should also be stated.

The administration of the direct-billing arrangements under Medicare as well as the payment of Medicare benefits on patient claims is the responsibility of **the Department of Human Services**. Any enquiries in regard to these matters should therefore be directed to Medicare offices or enquiry points.

M.13.13. ASSIGNMENT OF BENEFIT FORMS

Participating midwives wishing to direct-bill are required to use a specific form available from the Department of Human Services. This stationary is available from the Department of Human Services. Note that these forms are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of the Department of Human Services. Further information about direct-billing stationary can be obtained by telephoning **132150**.

M.13.14. TIME LIMITS APPLICABLE TO LODGEMENT OF CLAIMS FOR ASSIGNED BENEFITS

A time limit of two years applies to the lodgement of claims with Medicare under the direct-billing (assignment of benefit) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than two years earlier than the date the claim was lodged with Medicare.

Provision exists whereby in certain circumstances (e.g. hardship cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

M.13.15. OVERVIEW OF THE MATERNITY ITEMS

Antenatal, intrapartum and postnatal care provided by participating midwives are covered by MBS items 82100, 82105, 82110, 82115, 82120, 82125, 82130, 82135, 82140. These items cover nine specific types of service that allow the participating midwife to:

- undertake an initial antenatal attendance of more than 40 minutes duration (item 82100)
- provide a short antenatal attendance of up to 40 minutes duration (item 82105)
- provide a long antenatal attendance of more than 40 minutes duration (item 82110);
- make an assessment of and prepare a maternity care plan for a woman across a pregnancy that has progressed beyond 20 weeks (item 82115);

- undertake management of a confinement for up to 12 hours, including delivery (item 82120);
- undertake management of a confinement in excess of 12 hours including delivery (item 82125);
- provide a short postnatal attendance of up to 40 minutes duration (item 82130);
- provide long postnatal attendance of at least 40 minutes duration (item 82135); and
- provide a comprehensive postnatal check to a woman six weeks after the birth of her baby (item 82140).

M.13.16. MATERNITY SERVICES ATTRACTING MEDICARE REBATES

Medicare Benefits are only payable for clinically relevant services. ***Clinically relevant*** in relation to midwifery care means a service generally accepted by the midwifery profession as necessary to the appropriate treatment of the patient's clinical condition.

Medicare benefits are only payable where the participating midwife provides care to not more than one patient on the one occasion.

Antenatal Care
Eligible maternity care plan service
There is one MBS item available for eligible midwife practitioners to undertake a comprehensive assessment of and prepare a written maternity care plan for a woman, who is not an admitted patient of a hospital, across a pregnancy that has progressed beyond 20 weeks. It is expected that the care plan would be agreed with the woman and detail such things as agreed expectation, health problems and care needs and appropriate referrals, medication and diagnostic tests.

Number of services
Only one (1) midwifery care plan is payable in any pregnancy.

Antenatal Attendances
Medicare benefits are payable for an antenatal service where a midwife provides a clinically relevant service in respect of a miscarriage. Medicare benefits are not payable for an antenatal attendance associated with the confinement. The confinement items 82120 and 82125 include all associated attendances.

Any clinically relevant indication that requires an antenatal attendance by a midwife on an admitted patient in hospital, but that is not associated with the confinement, will attract a Medicare benefit.

Number of services
Only one (1) initial antenatal attendance under item 82100 is payable in any pregnancy.

There is no limit attached to long and short antenatal attendances by a participating midwife. However, only clinically relevant attendances should be itemised under Medicare and services provided by participating midwives will be subject to Medicare Audit and Professional Review Processes.

Management of Confinement
The MBS includes two items for management of confinement by a participating midwife; 82120 for a confinement of up to 12 hours, and 82125 for a confinement where labour is in excess of 12 hours, and the woman's care has been transferred to another participating midwife.

Medicare benefits are payable under items 82120 and 82125 whether or not the participating midwife undertakes the delivery i.e. including where the woman's care is escalated to an obstetrician during labour or for the delivery.

Medicare benefits are only payable where the service is provided to a woman who is an admitted patient of a hospital, including a hospital birthing centre. For Medicare benefit purposes a confinement is taken to commence when the participating midwife attends a patient that is in labour and who has been admitted to the hospital for confinement and delivery The time period for these items is the period for which the midwife is in exclusive and continuous attendance on the woman for labour, and delivery where performed.

Medicare benefits are only payable for management of confinement where the participating midwife undertaking the service has provided the patient's antenatal care or who is a member of a practice that provided the patient's antenatal care.

It is not intended that these items be claimed routinely by midwives who do not intend to undertake the delivery i.e where the midwife has arranged beforehand for a medical practitioner to undertake the delivery. Where the midwife does not undertake the delivery it is because:

- care was transferred to a second midwife for management of labour which had exceeded 12 hours; or
- there was a clinical need to escalate care to an obstetrician or medical practitioner who provides obstetric services; or
- the patient's care was transferred from the first midwife to another participating midwife in exceptional circumstances.

Number of services
Only one (1) confinement item 82120 is payable in any pregnancy, except where exceptional circumstances have required the patient's care to be transferred from the first midwife to another participating midwife. In these circumstances, both midwives may bill an item 82120 service.

Medicare rebates are only payable for (1) confinement item 82125.

Postnatal Care
In addition to the long and short antenatal attendance items for postnatal care in the first 6 weeks post delivery the MBS provides for a 6 week postnatal check, after which the woman would be referred back to her usual GP.

Number of services
Only one (1) postnatal check by a participating midwife is payable in any pregnancy.

There is no limit attached to long and short postnatal attendances by a participating midwife. However, only clinically relevant attendances should be itemised under Medicare and services provided by participating midwives will be subject to Medicare Audit and Professional Review Processes.

M.13.17. CONDITIONS GOVERNING THE PROVISION AND CLAIMING OF ITEMS

Service length and type
Services under these items must be for the time period specified within the item descriptor.

Professional attendance for MBS items 82100, 82105, 82110, 82115, 82130, 82135, 82140 may be provided in an appropriate setting that includes but is not limited to: the woman's home, a midwifery group practice, a midwife practitioner's rooms or a medical practice.

M.13.18. REFERRAL REQUIREMENTS

A participating midwife will be able to refer women to specialist obstetricians and paediatricians as clinical services dictate.

This measure does not include referral by a midwife for allied health care. If a participating midwife refers a patient to an allied health practitioner, no benefits would be payable for that service.

Medicare benefits are not payable specifically for services provided by a lactation consultant at this time. Medicare benefits would be payable for breast feeding support provide as part of the postnatal care by the participating midwife.

A referral is valid for 12 months to cover the confinement (antenatal, birthing and postnatal care for 6 weeks post delivery). Should there be a new pregnancy in that period, a new referral will be required.

A new pregnancy represents a new episode of care.

A referral to a specialist must be in writing in the form of a letter or a note to the specialist and must be signed and dated by the referring midwife. The referral must contain any information relevant to the patient and the specialist must have received the referral on or prior to providing a specialist consultation.

If a specialist provides a consultation without a referral, the specialist's consultation would not attract Medicare benefits at the specialist rate.

There are exemptions from this requirement in an emergency if the specialist considers the patient's condition requires immediate attention without a referral. In that situation, the specialist is taken to be the referring practitioner.

If a referral is lost, stolen or destroyed, the midwife would need to provide a replacement referral as soon as is practicable after the service is provided.

If the woman is a privately admitted patient of a hospital a letter or note is not required. The referring midwife would make a notation in the woman's hospital, which he or she would sign, approving the referral.

A referral is not required to transfer a woman's care during the intra-partum period under items 16527 and 16528. The midwife would make a signed notation in the woman's clinical record approving the transfer of care

A referral is not required to refer the woman back to her GP after the 6 week postnatal period. The midwife would provide a discharge summary to the GP outlining her maternity history and any relevant clinical issues, which would also be recorded on the patient's notes.

M.13.19. REQUESTING REQUIREMENTS

Pathology Services

Determination of Necessity of Service
The participating midwife requesting a pathology service for a woman must determine that the pathology service is necessary.

Request for Service
The service may only be provided in response to a request from the treating practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days).

Pathology Services approved for participating midwives

• FBC (item 65070)	• vaginal /anal swab/GBS (69312)* • varicella 69384 - 69401 (antibody test) • parvo virus 69384 - 69401
• Hb (item 65060)	• rubella titre } • syphilis } • Hep B/C } items 69405, 69408, 69411, 69413 or 69415 • HIV }
• Group and antibodies (items 65090, 65093, 65096)	• Serum Bilirubin (SBR); 66500

• glucose load (items 66545, 66548)	
• Downs Syndrome/ Spina Bifida (items 66743, 66750, 66751)	• Direct Coombs; 65114
• eye swab (69303)	• Blood glucose level (item 66500);
• skin swab (69306)	• Cord PH and gases cord (O2 and CO2) (Item 66566)
• skin scrapings (69309)	• Group and Hold (item 65099)
• Chlamydia (item 69316)	• Coagulation Studies (items 65129, 65070)
• Gonorrhea (item 69317)	• Mid stream urine (item 69324)
• Cervical Pap tests (item 73053)	• HCG (item 73529)

Diagnostic Imaging Services

Determination of Necessity of Service
The participating midwife requesting a diagnostic imaging service for a woman must determine that the diagnostic imaging service is necessary for the appropriate professional care of the patient.

Request for Service
The service may only be provided in response to a request from the treating practitioner, and the request must be in writing, signed and dated.

The request does not have to be in a particular form. However, legislation provides that a request must be in writing and contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item/s of service requested. This includes, where relevant, noting on the request the clinical indication(s) for the requested service. The provision of additional relevant clinical information can often assist the service provider, and enhance the overall service provided to the patient.

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.

A single request may be used to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within seven days after rendering the first service.

Ultrasound:

➢ Routine morphology scan (item 55706)	➢ Nuchal Translucency (item 55707)
➢ Early dating scan (item 55700)	➢ Post 22 weeks scan (item 55718)
➢ Scan at 12-16 weeks (item 55704)	

M.14.1. PARTICIPATING NURSE PRACTITIONERS SERVICES - OVERVIEW

As at 1 November 2010, Medicare benefits are payable for services provided by privately practising participating nurse practitioners in collaboration with other health care providers. Participating nurse practitioners can also request certain

pathology and diagnostic imaging services for their patients and refer patients to specialist, as the clinical need arises. The nurse practitioner services that attract a Medicare benefit are identified in the Medicare Benefits Schedule (MBS) by an item number and the each item describes the service requirements and schedule fee.

M.14.2. ELIGIBLE NURSE PRACTITIONERS

Under the legislation, to be an eligible nurse practitioner the nurse practitioner must be registered or authorised (however described) under State and Territory law. The nurse practitioner must also demonstrate that he or she has the appropriate qualifications and experience to meet the registration standard developed by the Nursing and Midwifery Board of Australia (NMBA).

This standard was developed for the purposes of the National Registration and Accreditation Scheme (NRAS), a single regulation and accreditation scheme for health professionals, including nurse practitioners. Additional information is available at the Australian Health Practitioners Regulation Agency (AHPRA) website at:
http://www.ahpra.gov.au/index.php

M.14.3. PROVIDER NUMBERS

To access the Medicare arrangements, eligible nurse practitioners will need to apply to the Department of Human Services for a provider number. A separate provider number is required for each location at which a nurse practitioner practices.

Advice about registering with the Department of Human Services to provide nurse practitioner services using items 82200 to 82215 inclusive, is available from the Department of Human Services provider inquiry line on 132 150.

Medicare provider application forms for nurse practitioners can be downloaded from the Department of Human Services' website.

M.14.4. PARTICIPATING NURSE PRACTITIONERS

To provide services under Medicare, the legislation requires that a nurse practitioner be a participating nurse practitioner. A participating nurse practitioner is an eligible nurse practitioner who has a Medicare provider number and who provides Medicare services in a collaborative arrangement or collaborative arrangements with one or more medical practitioners, of a kind or kinds specified in the regulations.

M.14.5. COLLABORATIVE ARRANGEMENTS

Under the Medicare program collaboration is having arrangements in place with a medical practitioner/s to consult, refer or transfer care as clinical needs dictate, to ensure safe, high quality maternity care. Under Medicare a collaborative arrangement can be with any medical practitioner.

Collaborative arrangement can be established in the following ways:
a) being employed or engaged by 1 or more specified medical practitioners or by an entity that employs or engages 1 or more specified medical practitioners; OR
b) receiving patients by referral in writing to the nurse practitioner for treatment from a specified medical practitioner, OR
c) having a signed written agreement with one or more specified medical practitioners, OR
d) having an arrangement with and acknowledged by at least one specified medical practitioners. This includes keeping comprehensive notes on all instances of consultation, referral and transfer of care, diagnostic tests requested and the test results and providing the collaborating practitioner/s with those results.

The legislation requires that collaborative arrangements must be in place at the time the participating nurse practitioner provides the service. The legislation requires that for each kind of collaborative arrangement, at least one medical practitioner is needed; it is not possible for the nurse practitioner to have a collaborative arrangement with an entity such as a health service.

a) Being employed or engaged by a medical practice or an entity
An entity may refer to a hospital or community health centre. For a nurse practitioner to have a collaborative arrangement in these circumstances, that nurse practitioner must be employed or engaged by an entity that also employs or engages 1 or more specified medical practitioners.

The terms employ or engage covers both employees and contractors. This will cover an eligible nurse practitioner who is employed or engaged by a medical practice so long as that medical practice employs or engages at least one medical practitioner.

There must be at least one specified medical practitioner employed or engaged by the entity each time the nurse practitioner renders a service/performs treatment. However, there is no requirement that the consultation, referral or transfer of care must always be to the medical practitioner(s) employed/engaged by the entity.

b) Referral from a medical practitioner

A participating nurse practitioner's patient will be able to access the MBS and PBS if a patient has been referred in writing to the nurse practitioner by a specified medical practitioner. The arrangement must provide for consultation, referral and transfer of care should the clinical need arise.

c) Written agreement with a medical practitioner

A nurse practitioner's patient will be able to access the MBS and PBS if the nurse practitioner has a written agreement in place with one or more doctors. The agreement must be signed by the nurse practitioner and a doctor. The arrangement must deal with consultation, referral and transfer to a doctor.

d) Arrangement with, acknowledged by a medical practitioner.

Evidence of 'acknowledgement' by a medical practitioner for each patient for whom the nurse practitioner provides care is a requirement to ensure that the medical practitioner being named understands and accepts the collaborative arrangement.

The acknowledgement does not have to be obtained on an individual patient basis. This means that, for example, a nurse practitioner could obtain an acknowledgement from a specified medical practitioner that he or she will be the collaborating medical practitioner for some or all of the nurse practitioner's patients. Arrangements to collaborate could be obtained in a number of ways including signing of documents, email or fax confirmation, or verbal acknowledgement which the nurse practitioner documents in their written records.

The nurse practitioner is required to record in written records any communications in regard to consultations, referral and transfer of the patient's care with the medical practitioner, including information that has been forwarded to the medical practitioner. The nurse practitioner is also required to send a copy of all pathology and diagnostic imaging results to a named medical practitioner and to record in the nurse practitioner's written records when this occurs (however, there is no requirement that the nurse practitioner consult with a medical practitioner in relation to every test result). The purpose of sharing records with the collaborating medical practitioner is to prevent duplication of services and to ensure continuity of care.

Arrangements to collaborate could be obtained in a number of ways including signing of documents, email or fax confirmation, or verbal acknowledgement which the nurse practitioner documents in their written records.

M.14.6. SCHEDULE FEES AND MEDICARE BENEFITS

Each nurse practitioner service is identified in the MBS by an item number. The fee set for any item in the MBS is known as the "Schedule fee". The Schedule fee and Medicare benefit for each service is listed in the item description. The Medicare benefit for nurse practitioner services rendered to non-admitted patients is 85% of the Schedule fee.

M.14.7. WHERE MEDICARE BENEFITS ARE NOT PAYABLE

Medicare benefits are not available:

a. where the service rendered does not meet the item description and associated requirements;
b. where the nurse practitioner service is not personally performed by the participating nurse practitioner;
c. for any time period in the consultation periods when the patient is not receiving active attention e.g. the time the provider may take to travel to the patient's home or where the patient is resting between blood pressure readings;
d. services provided where the patient is not in attendance, such as the issuing of repeat prescriptions;
e. for telephone attendances; and
f. group sessions.

The fee charged under Medicare must not include the cost of services that are not part of the MBS service being claimed. Medicare benefits are not payable for good or appliances associated with the service, such as bandages or other skin dressings.

Unless the Minister otherwise directs, Medicare benefits are not payable where funding has already been provided under an arrangement with the Commonwealth, state or a local governing body.

M.14.8. BILLING OF THE PATIENT

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

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

(a) Patient's name;

(b) The date on which the professional service was rendered;

(c) An item number or a description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment is provided in a hospital "admitted patient" immediately preceding the description of the service or an asterisk "*" directly after an item number where used;

(d) The name and practice address and provider number of the participating nurse practitioner who actually rendered the service; (where the participating nurse practitioner has more than one practice location recorded with the Department of Human Services, the provider number used should be that which is applicable to the practice location at or from which the service was given).

Only one original itemised account should be issued in respect of any one service and any duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

M.14.9. ASSIGNMENT OF BENEFITS (DIRECT-BILLING ARRANGEMENTS

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

If a participating nurse practitioner direct-bills, the participating nurse practitioner undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient.

Under these arrangements:

The patient's Medicare card number must be quoted on all direct bill forms for that patient.

The basic forms provided are loose leaf to enable the patient details to be imprinted from the Medicare card.

The forms include information required by Regulations under Subsection 19(6) of the Health Insurance Act.

The nurse practitioner must include the particulars relating to the professional service out on the assignment form before the patient signs the form and ensure that the patient to receive a copy of the form as soon as practicable after the patient signs it.

Where a patient is unable to sign the assignment form the signature of the patient's parent, guardian or other responsible person (other than the nurse practitioner, nurse practitioner's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable. The reason the patient is unable to sign should also be stated.

The administration of the direct billing arrangements under Medicare as well as the payment of Medicare benefits on patient claims is the responsibility of the Department of Human Services. Any enquiries in regard to these matters should therefore be directed to Medicare offices or enquiry points.

M.14.10. ASSIGNMENT OF BENEFIT FORMS

Participating nurse practitioners wishing to direct-bill are required to use a specific form available from the Department of Human Services. This stationary is available from the Department of Human Services. Note that these forms are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of the Department of Human Services. Further information about direct-billing stationary can be obtained by telephoning 132150.

M.14.11. TIME LIMITS APPLICABLE TO LODGEMENT OF CLAIMS FOR ASSIGNED BENEFITS

A time limit of two years applies to the lodgement of claims with Medicare under the direct billing (assignment of benefit) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than two years earlier than the date the claim was lodged with Medicare.

Provision exists whereby in certain circumstances (e.g. hardship cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

M.14.12. OVERVIEW OF THE NURSE PRACTITIONER ITEMS

Services provided by participating nurse practitioners are covered by MBS items 82200, 82205, 82210, 82215. These items cover four time-tiered specific types of service that allow the participating nurse practitioner to perform a:

professional attendance for an obvious problem, straight forward in nature, with limited examination and management required (82200)

professional attendance for a patient presenting with clinical signs and symptoms with an easily identifiable underlying cause following a short consultation lasting less than 20 minutes duration (item 82205)

professional attendance for a patient presenting with clinical signs and symptoms with no obvious underlying cause requiring a more detailed consultation lasting at least than 20 minutes duration (item 82210);

professional attendance for a patient presenting with multiple clinical signs and symptoms with the possibility of multiple causes and outcomes requiring an extensive consultation of at least 40 minutes (item 82215);

M.14.13. NURSE PRACTITIONER SERVICES ATTRACTING MEDICARE REBATES

Medicare Benefits are only payable for clinically relevant services. Clinically relevant in relation to nurse practitioner care means a service generally accepted by the nursing profession as necessary to the appropriate treatment of the patient's clinical condition.

Medicare benefits are only payable where the participating nurse practitioner provides care to not more than one patient on one occasion.

M.14.14. CONDITIONS GOVERNING THE PROVISION AND CLAIMING OF ITEMS

Service length and type
Services under these items must be for the time period specified within the item descriptor.

Professional attendance for MBS items 82200, 82205, 82210, 82215, may be provided in an appropriate setting that includes but is not limited to: the patient's home, a nurse practitioner group practice, a nurse practitioner's rooms or a medical practice.

M.14.15. REFERRAL REQUIREMENTS

A participating nurse practitioner will be able to refer private patients to a specialist and consultant physician as clinical services dictate.

This measure does not include referral by a nurse practitioner for allied health care. If a participating nurse practitioner refers a patient to an allied health practitioner, no benefits would be payable for that service provided by the allied health professional.

A referral given by a participating nurse practitioner is valid until 12 months after the first service given in accordance with the referral.

If the referral is lost, stolen or destroyed, the nurse practitioner would need to provide a replacement referral as soon as is practicable after the service is provided.

A referral to a specialist must be in writing in the form of a letter or a note to the specialist and must be signed and dated by the referring nurse practitioner. The referral must contain any information relevant to the patient and the specialist must have received the referral on or prior to providing a specialist consultation.

There are exemptions from this requirement in an emergency if the specialist considers the patient's condition requires immediate attention without a referral. In that situation, the specialist is taken to be the referring practitioner.

M.14.16. REQUESTING REQUIREMENTS

Pathology Services

Determination of Necessity of Service
The participating nurse practitioner requesting a pathology service for a patient must determine that the pathology service is necessary.

Request for Service
The service may only be provided in response to a request from the treating practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days).

Pathology Services approved for participating nurse practitioners
Nurse practitioners may request MBS pathology items 65060 – 73810 (inclusive). Requesting pathology services must be within the nurse practitioner's scope of practice.

Further information
For further information about Medicare Benefits Schedule items, please go to the Department of Health's website at www.health.gov.au/mbsonline.

Diagnostic Imaging Services

Determination of Necessity of Service
The participating nurse practitioner requesting a diagnostic imaging service for a patient must determine that the diagnostic imaging service is necessary for the appropriate professional care of the patient.

Request for Service
The service may only be provided in response to a request from the treating nurse practitioner, and the request must be in writing, signed and dated. The legislation provides that a request must be in writing and contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item/s of service requested. This includes, where relevant, noting on the request the clinical indication(s) for the requested service. The provision of additional relevant clinical information can often assist the service provider, and enhance the overall service provided to the patient.

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.

A single request may be used to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within seven days after rendering the first service.

Ultrasound:

Subgroup 1: General Ultrasound
MBS item: 55036 (abdomen)
MBS items: 55070, 55076 (breast)

Subgroup 4: Urological
MBS item: 55600 (prostate)

Subgroup 5: Obstetric and Gynaecological
MBS item: 55768

Subgroup 6: Musculoskeletal
MBS items: 55800, 55804, 55808, 55812, 55816, 55820, 55824, 55828, 55832, 55836, 55840, 55844, 55848, 55850, 55852

X-ray:

Subgroup 1: Radiographic examination of the extremities
MBS items: 57509, 57515, 57521

subgroup 6: Radiographic examination of the thoracic region
MBS items: 58503 – 58527 (inclusive)

M.15.1. BRAIN STEM EVOKED RESPONSE AUDIOMETRY - (ITEM 82300)

Item 82300 can be claimed for the programming of a cochlear speech processor.

M.15.2. NON-DETERMINATE AUDIOMETRY - (ITEM 82306)

This refers to audiometry covering those services, one or more, referred to in Items 82309-82318 when not performed under the conditions set out in paragraph M15.3.

M.15.3. CONDITIONS FOR AUDIOLOGY SERVICES - (ITEMS 82309 TO 82318)

A service specified in Items 82309 to 82318 shall be taken to be a service for the purposes of payment of benefits if, and only if, it is rendered:

(a) in conditions that allow the establishment of determinate thresholds;
(b) in a sound attenuated environment with background noise conditions that comply with Australian Standard AS/NZS 1269.3-2005; and
(c) using calibrated equipment that complies with Australian Standard AS IEC 60645.1-22002, AS IEC 60645.2-2002 and AS IEC 60645.3-2002.

M.15.4. OTO-ACOUSTIC EMISSION AUDIOMETRY - (ITEM 82332)

Medicare benefits are not payable under Item 82332 for routine screening of infants. The equipment used to provide this service must be capable of displaying the recorded emission and not just a pass/fail indicator.

M.15.5. PROVISION OF DIAGNOSTIC AUDIOLOGY SERVICES BY AUDIOLOGISTS - (ITEMS 82300 TO 82332)

OVERVIEW

The diagnostic audiology services available through MBS items 82300 to 82332 enable an eligible audiologist to perform diagnostic tests upon written request from an Ear, Nose and Throat (ENT) specialist (a specialist in the specialty of otolaryngology head and neck surgery); or for some services, a written request from a neurologist (a specialist or consultant physician in the specialty of neurology).

These diagnostic audiology services assist ENT specialists and neurologists in their medical diagnosis and/or treatment and/or management of ear disease or related disorders. The new diagnostic audiology items supplement the existing Otolaryngology items for services delivered by, or on behalf of medical practitioners (MBS items 11300 to 11339, excluding 11304).

Requesting arrangements

Medicare benefits are payable only under the following circumstances:

- For items 82300 and 82306, the written request must be made by an eligible practitioner who is a specialist in the specialty of otolaryngology head and neck surgery;
- For items 82309 to 82332, the written request must be made by an eligible practitioner who is a specialist in the specialty of otolaryngology head and neck surgery or a specialist or consultant physician in the specialty of neurology.

The written request must be in writing and must contain:

(a) the date of the request; and
(b) the name of the eligible practitioner who requested the service and either the address of his or her place of practice or the provider number in respect of his or her place of practice; and
(c) a description of the service which provides sufficient information to identify the service as relating to a particular item (but need not specify the item number).

Written requests should, where possible, note the clinical indication/s for the requested service/s.

A request may be for the performance of more than one diagnostic audiology service making up a single audiological assessment, but cannot be for more than one audiological assessment. This means that for Medicare benefits to be payable, any re-evaluation of the patient should be made at the discretion of the ENT specialist or neurologist through a separate request.

Audiologists do not have the discretion to self-determine diagnostic tests under items 82300 to 82332. If a written request is incomplete or requires clarification, the audiologist should contact the requesting ENT specialist or neurologist for further information. If an audiologist considers that additional tests may be necessary, the audiologist should contact the requesting ENT specialist or neurologist to discuss the need and if the requesting practitioner determines that additional tests are necessary, an amended or separate written request must be arranged.

It is recommended that audiologists retain the written request for 24 months from the date the service was rendered (for Medicare auditing purposes). A copy of the written request is not required to accompany Medicare claims or be attached to patients' itemised accounts/receipts or assignment of benefit forms.

Eligibility requirements for audiologists

The diagnostic audiology items (82300 to 82332) can only be claimed by audiologists who are registered with the Department of Human Services. To be eligible to register with the Department of Human Services to provide these services, audiologists must meet the following requirements:

Audiologists must be either:

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

Registering with the Department of Human Services

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

Changes to provider details
Audiologists must notify the Department of Human Services in writing of all changes to mailing details to ensure that they continue to receive information about Medicare services.

Reporting requirements
Where an audiologist provides diagnostic audiology service/s to the patient under a written request, they must provide a copy of the results of the service/s performed together with relevant written comments on those results to the requesting ENT specialist or neurologist. It is recommended that these be provided within 7 days of the date the service was performed.

Out-of-pocket expenses and Medicare Safety Net
Audiologists can determine their own fees for the professional service. Charges in excess of the Medicare benefit are the responsibility of the patient. However, out-of-pocket costs will count toward the Medicare Safety Net for that patient.

Publicly funded services
Items 82300 to 82332 do not apply for services that are provided by any Commonwealth or state funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or state/territory government health clinic, items 82300 to 82332 can be claimed for services provided by audiologists salaried by, or contracted to, the service or health clinic. All requirements of the relevant item must be met, including registration of the audiologist with the Department of Human Services. Medicare services provided under a subsection 19(2) exemption must be bulk billed (i.e. the Medicare rebate is accepted as full payment for services).

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

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.

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

Higher rates of benefits are also provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons).

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.

GROUP M3 - ALLIED HEALTH SERVICES

10950	**ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH SERVICE** Aboriginal or Torres Strait Islander health service provided to a person by an eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner if: (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year *(See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95 **Extended Medicare Safety Net Cap:** $186.75
10951	**DIABETES EDUCATION SERVICE** Diabetes education health service provided to a person by an eligible diabetes educator if: (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible diabetes educator by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year *(See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95 **Extended Medicare Safety Net Cap:** $186.75

	AUDIOLOGY Audiology health service provided to a person by an eligible audiologist if: (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible audiologist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible audiologist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year *(See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95
10952	**Extended Medicare Safety Net Cap:** $186.75
	EXERCISE PHYSIOLOGY Exercise physiology service provided to a person by an eligible exercise physiologist if: (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible exercise physiologist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year *(See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95
10953	**Extended Medicare Safety Net Cap:** $186.75

	DIETETICS SERVICES Dietetics health service provided to a person by an eligible dietician if: (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible dietician by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible dietician gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year *(See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95
10954	**Extended Medicare Safety Net Cap:** $186.75
	MENTAL HEALTH SERVICE Mental health service provided to a person by an eligible mental health worker if: (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible mental health worker by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible mental health worker gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year *(See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95
10956	**Extended Medicare Safety Net Cap:** $186.75

	OCCUPATIONAL THERAPY Occupational therapy health service provided to a person by an eligible occupational therapist if: (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible occupational therapist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible occupational therapist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year *(See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95
10958	**Extended Medicare Safety Net Cap:** $186.75
	PHYSIOTHERAPY Physiotherapy health service provided to a person by an eligible physiotherapist if: (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible physiotherapist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible physiotherapist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year *(See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95
10960	**Extended Medicare Safety Net Cap:** $186.75

	PODIATRY Podiatry health service provided to a person by an eligible podiatrist if: (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible podiatrist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible podiatrist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year *(See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95
10962	**Extended Medicare Safety Net Cap:** $186.75
	CHIROPRACTIC SERVICE Chiropractic health service provided to a person by an eligible chiropractor if: (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible chiropractor by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible chiropractor gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year *(See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95
10964	**Extended Medicare Safety Net Cap:** $186.75

	OSTEOPATHY Osteopathy health service provided to a person by an eligible osteopath if: (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible osteopath by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible osteopath gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year *(See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95
10966	**Extended Medicare Safety Net Cap:** $186.75
	PSYCHOLOGY Psychology health service provided to a person by an eligible psychologist if: (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible psychologist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible psychologist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year *(See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95
10968	**Extended Medicare Safety Net Cap:** $186.75

	SPEECH PATHOLOGY Speech pathology health service provided to a person by an eligible speech pathologist if: (a) the service is provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under both a GP Management Plan and Team Care Arrangements or, if the person is a resident of an aged care facility, the person's medical practitioner has contributed to a multidisciplinary care plan; and (b) the service is recommended in the person's Team Care Arrangements or multidisciplinary care plan as part of the management of the person's chronic condition and complex care needs; and (c) the person is referred to the eligible speech pathologist by the medical practitioner using a referral form that has been issued by the Department or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 20 minutes duration; and (g) after the service, the eligible speech pathologist gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral - in relation to that service; or (ii) if the service is the first or the last service under the referral - in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of - in relation to those matters; and (h) for a service for which a private health insurance benefit is payable - the person who incurred the medical expenses for the service has elected to claim the Medicare benefit for the service, and not the private health insurance benefit; - to a maximum of five services (including any services to which items 10950 to 10970 apply) in a calendar year *(See para M3.1 and M3.2 and M3.3 and M3.4 and M3.5 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95
10970	**Extended Medicare Safety Net Cap:** $186.75

GROUP M12 - SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER

SUBGROUP 1 - TELEHEALTH SUPPORT SERVICE ON BEHALF OF A MEDICAL PRACTITIONER

Attendance by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner, to provide clinical support to a patient who:
(a) is participating in a video conferencing consultation with a specialist, consultant physician or psychiatrist; and
(b) is not an admitted patient; and
(c) either:
(i) is located both:
(A) within a telehealth eligible area; and
(B) at the time of the attendance—at least 15 kms by road from the specialist, physician or psychiatrist mentioned in paragraph (a); or
(ii) is a patient of:
(A) an Aboriginal Medical Service; or
(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies

(See para M12.6 of explanatory notes to this Category)
Fee: $32.40 **Benefit:** 100% = $32.40
10983 **Extended Medicare Safety Net Cap:** $97.20

SUBGROUP 2 - TELEHEALTH SUPPORT SERVICE ON BEHALF OF A MEDICAL PRACTITIONER AT A RESIDENTIAL AGED CARE FACILITY

Service by a practice nurse or Aboriginal health worker or Aboriginal and Torres Strait Islander health practitioner provided on behalf of, and under the supervision of, a medical practitioner that requires the provision of clinical support to a patient who is:
a) a care recipient receiving care in a residential aged care service (other than a self-contained unit); or
b) at consulting rooms situated within such a complex if the patient is a care recipient receiving care in a residential aged care service (excluding accommodation in a self-contained unit);
and who is participating in a video consultation with a specialist or consultant physician.

(See para M12.6 of explanatory notes to this Category)
Fee: $32.40 **Benefit:** 100% = $32.40
10984 **Extended Medicare Safety Net Cap:** $97.20

SUBGROUP 3 - SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER

Follow up service provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health assessment if:
a) The service is provided on behalf of and under the supervision of a
medical practitioner; and
b) the person is not an admitted patient of a hospital; and
c) the service is consistent with the needs identified through the health assessment;
- to a maximum of 10 services per patient in a calendar year
(See para M12.4 of explanatory notes to this Category)
Fee: $24.00 **Benefit:** 100% = $24.00
10987 **Extended Medicare Safety Net Cap:** $72.00

Immunisation provided to a person by an Aboriginal and Torres Strait Islander health practitioner if:
(a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner; and
(b) the person is not an admitted patient of a hospital.
(See para M12.1 of explanatory notes to this Category)
Fee: $12.00 **Benefit:** 100% = $12.00
10988 **Extended Medicare Safety Net Cap:** $36.00

Treatment of a person's wound (other than normal aftercare) provided by an Aboriginal and Torres Strait Islander health practitioner if:
(a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner; and
(b) the person is not an admitted patient of a hospital.
(See para M12.2 of explanatory notes to this Category)
Fee: $12.00 **Benefit:** 100% = $12.00
10989 **Extended Medicare Safety Net Cap:** $36.00

GROUP M1 - MANAGEMENT OF BULK-BILLED SERVICES

A medical service to which an item in this table (other than this item or item 10991) applies if:
(a) the service is an unreferred service; and
(b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and
(c) the person is not an admitted patient of a hospital; and
(d) the service is bulk-billed in respect of the fees for:
(i) this item; and
(ii) the other item in this table applying to the service
(See para M1.1 of explanatory notes to this Category)

10990 **Fee:** $7.20 **Benefit:** 85% = $6.15

A medical service to which an item in this table (other than this item or item 10990) applies if:
(a) the service is an unreferred service; and
(b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and
(c) the person is not an admitted patient of a hospital; and
(d) the service is bulk-billed in respect of the fees for:
(i) this item; and
(ii) the other item in this table applying to the service: and
(e) the service is provided at, or from, a practice location in:
(i) a regional, rural or remote area; or
(ii) Tasmania; or
(iii) A geographical area included in any of the following SSD spatial units:
(A) Beaudesert Shire Part A
(B) Belconnen
(C) Darwin City
(D) Eastern Outer Melbourne
(E) East Metropolitan, Perth
(F) Frankston City
(G) Gosford-Wyong
(H) Greater Geelong City Part A
(I) Gungahlin-Hall
(J) Ipswich City (part in BSD)
(K) Litchfield Shire
(L) Melton-Wyndham
(M) Mornington Peninsula Shire
(N) Newcastle
(O) North Canberra
(P) Palmerston-East Arm
(Q) Pine Rivers Shire
(R) Queanbeyan
(S) South Canberra
(T) South Eastern Outer Melbourne
(U) Southern Adelaide
(V) South West Metropolitan, Perth
(W) Thuringowa City Part A
(X) Townsville City Part A
(Y) Tuggeranong
(Z) Weston Creek-Stromlo
(ZA) Woden Valley
(ZB) Yarra Ranges Shire Part A; or
(iv) the geographical area included in the SLA spatial unit of Palm Island (AC)
(See para M1.1 of explanatory notes to this Category)

10991 **Fee:** $10.85 **Benefit:** 85% = $9.25

	A medical service to which item 597. 598, 599, 600, 5003, 5010, 5023, 5028, 5043, 5049, 5063, 5067, 5220, 5223, 5227, 5228, 5260, 5263, 5265 or 5267 applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is not provided in consulting rooms; and (e) the service is provided in one of the following eligible areas: (i) a regional, rural or remote area; or (ii) Tasmania; or (iii) A geographical area included in any of the following SSD spatial units: (A) Beaudesert Shire Part A (B) Belconnen (C) Darwin City (D) Eastern Outer Melbourne (E) East Metropolitan, Perth (F) Frankston City (G) Gosford-Wyong (H) Greater Geelong City Part A (I) Gungahlin-Hall (J) Ipswich City (part in BSD) (K) Litchfield Shire (L) Melton-Wyndham (M) Mornington Peninsula Shire (N) Newcastle (O) North Canberra (P) Palmerston-East Arm (Q) Pine Rivers Shire (R) Queanbeyan (S) South Canberra (T) South Eastern Outer Melbourne (U) Southern Adelaide (V) South West Metropolitan, Perth (W) Thuringowa City Part A (X) Townsville City Part A (Y) Tuggeranong (Z) Weston Creek-Stromlo (ZA) Woden Valley (ZB) Yarra Ranges Shire Part A; or (iv) the geographical area included in the SLA spatial unit of Palm Island (AC) (f) the service is provided by, or on behalf of, a medical practitioner whose practice location is not in an eligible area; and (g) the service is bulk billed in respect of the fees for: (i) this item; and (ii) the other item in this table applying to the service. *(See para M1.2 of explanatory notes to this Category)*
10992	**Fee:** $10.85 **Benefit:** 85% = $9.25

	GROUP M12 - SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER
	SUBGROUP 3 - SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER
10997	Service provided to a person with a chronic disease by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the person is not an admitted patient of a hospital; and (c) the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place; and (d) the service is consistent with the GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan to a maximum of 5 services per patient in a calendar year *(See para M12.5 of explanatory notes to this Category)* **Fee:** $12.00 **Benefit:** 100% = $12.00 **Extended Medicare Safety Net Cap:** $36.00

GROUP M6 - PSYCHOLOGICAL THERAPY SERVICES

80000	Professional attendance for the purpose of providing psychological assessment and therapy for a mental disorder by a **clinical psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting more than 30 minutes but less than 50 minutes, where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012). (Professional attendance at consulting rooms) *(See para M6.1 of explanatory notes to this Category)* **Fee:** $99.75 **Benefit:** 85% = $84.80 **Extended Medicare Safety Net Cap:** $299.25
80005	Professional attendance at a place other than consulting rooms. As per the service requirements outlined for item 80000. *(See para M6.1 of explanatory notes to this Category)* **Fee:** $124.65 **Benefit:** 85% = $106.00 **Extended Medicare Safety Net Cap:** $373.95
80010	Professional attendance for the purpose of providing psychological assessment and therapy for a mental disorder by a **clinical psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting at least 50 minutes, where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012). (Professional attendance at consulting rooms) *(See para M6.1 of explanatory notes to this Category)* **Fee:** $146.45 **Benefit:** 85% = $124.50 **Extended Medicare Safety Net Cap:** $439.35
80015	Professional attendance at a place other than consulting rooms As per the service requirements outlined for item 80010. *(See para M6.1 of explanatory notes to this Category)* **Fee:** $171.35 **Benefit:** 85% = $145.65 **Extended Medicare Safety Net Cap:** $500.00
80020	Professional attendance for the purpose of providing psychological therapy for a mental disorder by a **clinical psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80120, 80145 and 80170 apply). - GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT *(See para M6.1 of explanatory notes to this Category)* **Fee:** $37.20 **Benefit:** 85% = $31.65 **Extended Medicare Safety Net Cap:** $111.60

GROUP M7 - FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)

80100

Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

These services are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply).

Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012).

(Professional attendance at consulting rooms)
(See para M7.1 of explanatory notes to this Category)
Fee: $70.65 **Benefit:** 85% = $60.10
Extended Medicare Safety Net Cap: $211.95

80105

Professional attendance at a place other than consulting rooms.

As per the psychologist service requirements outlined for item 80100.
(See para M7.1 of explanatory notes to this Category)
Fee: $96.15 **Benefit:** 85% = $81.75
Extended Medicare Safety Net Cap: $288.45

80110

Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

These services are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply).

Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012).

(Professional attendance at consulting rooms)
(See para M7.1 of explanatory notes to this Category)
Fee: $99.75 **Benefit:** 85% = $84.80
Extended Medicare Safety Net Cap: $299.25

80115

Professional attendance at a place other than consulting rooms.

As per the psychologist service requirements outlined for item 80110.
(See para M7.1 of explanatory notes to this Category)
Fee: $125.30 **Benefit:** 85% = $106.55
Extended Medicare Safety Net Cap: $375.90

80120

Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **psychologist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80020, 80145 and 80170 apply).

GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT
(See para M7.1 of explanatory notes to this Category)
Fee: $25.45 **Benefit:** 85% = $21.65
Extended Medicare Safety Net Cap: $76.35

80125	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an **occupational therapist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012). (Professional services at consulting rooms) *(See para M7.1 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95 **Extended Medicare Safety Net Cap:** $186.75
80130	Professional attendance at a place other than consulting rooms. As per the occupational therapist service requirements outlined for item 80125. *(See para M7.1 of explanatory notes to this Category)* **Fee:** $87.70 **Benefit:** 85% = $74.55 **Extended Medicare Safety Net Cap:** $263.10
80135	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an **occupational therapist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012). (Professional attendance at consulting rooms) *(See para M7.1 of explanatory notes to this Category)* **Fee:** $87.95 **Benefit:** 85% = $74.80 **Extended Medicare Safety Net Cap:** $263.85
80140	Professional attendance at a place other than consulting rooms. As per the occupational therapist service requirements outlined for item 80135. *(See para M7.1 of explanatory notes to this Category)* **Fee:** $113.35 **Benefit:** 85% = $96.35 **Extended Medicare Safety Net Cap:** $340.05
80145	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by an **occupational therapist** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80020, 80120 and 80170 apply). GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT *(See para M7.1 of explanatory notes to this Category)* **Fee:** $22.35 **Benefit:** 85% = $19.00 **Extended Medicare Safety Net Cap:** $67.05

80150	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **social worker** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012). (Professional attendance at consulting rooms) *(See para M7.1 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95 **Extended Medicare Safety Net Cap:** $186.75
80155	Professional attendance at a place other than consulting rooms. As per the social worker service requirements outlined for item 80150. *(See para M7.1 of explanatory notes to this Category)* **Fee:** $87.70 **Benefit:** 85% = $74.55 **Extended Medicare Safety Net Cap:** $263.10
80160	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **social worker** registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These services are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 2721 to 2727; 80000 to 80015; 80100 to 80115; 80125 to 80140; 80150 to 80165 apply). Claims for this service may exceed this maximum session limit, however, where exceptional circumstances apply (to a maximum total of 16 individual services per patient from 1 March 2012 to 31 December 2012). (Professional attendance at consulting rooms) *(See para M7.1 of explanatory notes to this Category)* **Fee:** $87.95 **Benefit:** 85% = $74.80 **Extended Medicare Safety Net Cap:** $263.85
80165	Professional attendance at a place other than consulting rooms. As per the social worker service requirements outlined for item 80160. *(See para M7.1 of explanatory notes to this Category)* **Fee:** $113.35 **Benefit:** 85% = $96.35 **Extended Medicare Safety Net Cap:** $340.05
80170	Professional attendance for the purpose of providing focussed psychological strategies services for an assessed mental disorder by a **social worker** registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics. These therapies are time limited, being deliverable in up to ten planned sessions in a calendar year (including services to which items 80020, 80120 and 80145 apply*)*. GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT *(See para M7.1 of explanatory notes to this Category)* **Fee:** $22.35 **Benefit:** 85% = $19.00 **Extended Medicare Safety Net Cap:** $67.05

GROUP M8 - PREGNANCY SUPPORT COUNSELLING

81000

Provision of a non-directive pregnancy support counselling service to a person who is currently pregnant or who has been pregnant in the preceding 12 months, by an eligible psychologist, where the patient is referred to the psychologist by a medical practitioner (including a general practitioner, but not a specialist or consultant physician), and lasting at least 30 minutes. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

This service may be provided by a psychologist who is registered with Medicare Australia as meeting the credentialling requirements for provision of this service. It may not be provided by a psychologist who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.

To a maximum of three non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items –81000, 81005, 81010 and 4001
(See para M8.1 and M8.2 and M8.3 and M8.4 of explanatory notes to this Category)
Fee: $73.15 **Benefit:** 85% = $62.20
Extended Medicare Safety Net Cap: $219.45

81005

Provision of a non-directive pregnancy support counselling service to a person who is currently pregnant or who has been pregnant in the preceding 12 months, by an eligible social worker, where the patient is referred to the social worker by a medical practitioner (including a general practitioner, but not a specialist or consultant physician), and lasting at least 30 minutes. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

This service may be provided by a social worker who is registered with Medicare Australia as meeting the credentialling requirements for provision of this service. It may not be provided by a social worker who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.

To a maximum of three non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items –81000, 81005, 81010 and 4001
(See para M8.1 and M8.2 and M8.3 and M8.4 of explanatory notes to this Category)
Fee: $73.15 **Benefit:** 85% = $62.20
Extended Medicare Safety Net Cap: $219.45

81010

Provision of a non-directive pregnancy support counselling service to a person who is currently pregnant or who has been pregnant in the preceding 12 months, by an eligible mental health nurse, where the patient is referred to the mental health nurse by a medical practitioner (including a general practitioner, but not a specialist or consultant physician), and lasting at least 30 minutes. The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

This service may be provided by a mental health nurse who is registered with Medicare Australia as meeting the credentialling requirements for provision of this service. It may not be provided by a mental health nurse who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.

To a maximum of three non-directive pregnancy support counselling services per patient, per pregnancy from any of the following items - 81000, 81005, 81010 and 4001
(See para M8.1 and M8.2 and M8.3 and M8.4 of explanatory notes to this Category)
Fee: $73.15 **Benefit:** 85% = $62.20
Extended Medicare Safety Net Cap: $219.45

GROUP M9 - ALLIED HEALTH GROUP SERVICES

DIABETES EDUCATION SERVICE – ASSESSMENT FOR GROUP SERVICES

Diabetes education health service provided to a person by an eligible diabetes educator for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if:

(a) the service is provided to a person who has type 2 diabetes; and
(b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan [ie item 721 or 732], or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and
(c) the person is referred to an eligible diabetes educator by the medical practitioner using a referral form that has been issued by the Department of Health, or a referral form that contains all the components of the form issued by the Department; and
(d) the person is not an admitted patient of a hospital; and
(e) the service is provided to the person individually and in person; and
(f) the service is of at least 45 minutes duration; and
(g) after the service, the eligible diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (c); and
(h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit.

Benefits are payable **once** only in a calendar year for this or any other Assessment for Group Services item (including services to which items 81100, 81110 and 81120 apply).

(See para M9.1 and M9.2 and M9.3 and M9.4 and M9.6 and M9.7 of explanatory notes to this Category)

Fee: $79.85 **Benefit:** 85% = $67.90

81100 **Extended Medicare Safety Net Cap:** $239.55

DIABETES EDUCATION SERVICE – GROUP SERVICE

Diabetes education health service provided to a person by an eligible diabetes educator, as a GROUP SERVICE for the management of type 2 diabetes if:

(a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120; and
(b) the service is provided to a person who is part of a group of between 2 and 12 patients inclusive; and
(c) the person is not an admitted patient of a hospital; and
(d) the service is provided to a person involving the personal attendance by an eligible diabetes educator; and
(e) the service is of at least 60 minutes duration; and
(f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible diabetes educator prepares, or contribute to, a written report to be provided to the referring medical practitioner; and
(g) an attendance record for the group is maintained by the eligible diabetes educator; and
(h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit;

- to a maximum of eight GROUP SERVICES (including services to which items 81105, 81115 and 81125 apply) in a calendar year.

(See para M9.1 and M9.2 and M9.3 and M9.5 and M9.6 and M9.7 of explanatory notes to this Category)

Fee: $19.90 **Benefit:** 85% = $16.95

81105 **Extended Medicare Safety Net Cap:** $59.70

	EXERCISE PHYSIOLOGY SERVICE – ASSESSMENT FOR GROUP SERVICES Exercise physiology health service provided to a person by an eligible exercise physiologist for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if: (a) the service is provided to a person who has type 2 diabetes; and (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan [ie item 721 or 732, or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and (c) the person is referred to an eligible exercise physiologist by the medical practitioner using a referral form that has been issued by the Department of Health, or a referral form that contains all the components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 45 minutes duration; and (g) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (c); and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit. Benefits are payable **once** only in a calendar year for this or any other Assessment for Group Services item (including services to which items 81100, 81110 and 81120 apply). *(See para M9.1 and M9.2 and M9.3 and M9.4 and M9.6 and M9.7 of explanatory notes to this Category)* **Fee:** $79.85 **Benefit:** 85% = $67.90
81110	**Extended Medicare Safety Net Cap:** $239.55
	EXERCISE PHYSIOLOGY SERVICE – GROUP SERVICE Exercise physiology health service provided to a person by an eligible exercise physiologist, as a GROUP SERVICE for the management of type 2 diabetes if: (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120; and (b) the service is provided to a person who is part of a group of between 2 and 12 patients inclusive; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to a person involving the personal attendance by an eligible exercise physiologist; and (e) the service is of at least 60 minutes duration; and (f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible exercise physiologist prepares, or contribute to, a written report to be provided to the referring medical practitioner; and (g) an attendance record for the group is maintained by the eligible exercise physiologist; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of eight GROUP SERVICES (including services to which items 81105, 81115 and 81125 apply) in a calendar year. *(See para M9.1 and M9.2 and M9.3 and M9.5 and M9.6 and M9.7 of explanatory notes to this Category)* **Fee:** $19.90 **Benefit:** 85% = $16.95
81115	**Extended Medicare Safety Net Cap:** $59.70

	DIETETICS SERVICE – ASSESSMENT FOR GROUP SERVICES Dietetics health service provided to a person by an eligible dietitian for the purposes of ASSESSING a person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs, and preparing the person for the group services, if: (a) the service is provided to a person who has type 2 diabetes; and (b) the person is being managed by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) under a GP Management Plan [ie item 721 or 732], or if the person is a resident of an aged care facility, their medical practitioner has contributed to a multidisciplinary care plan [ie item 731]; and (c) the person is referred to an eligible dietitian by the medical practitioner using a referral form that has been issued by the Department of Health, or a referral form that contains all components of the form issued by the Department; and (d) the person is not an admitted patient of a hospital; and (e) the service is provided to the person individually and in person; and (f) the service is of at least 45 minutes duration; and (g) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c); and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit. Benefits are payable **once** only in a calendar year for this or any other Assessment for Group Services item (including services to which items 81100, 81110 and item 81120 apply). *(See para M9.1 and M9.2 and M9.3 and M9.4 and M9.6 and M9.7 of explanatory notes to this Category)* **Fee:** $79.85 **Benefit:** 85% = $67.90
81120	**Extended Medicare Safety Net Cap:** $239.55
	DIETETICS SERVICE – GROUP SERVICE Dietetics health service provided to a person by an eligible dietitian, as a GROUP SERVICE for the management of type 2 diabetes if: (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120; and (b) the service is provided to a person who is part of a group of between 2 and 12 patients inclusive; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to a person involving the personal attendance by an eligible dietitian; and (e) the service is of at least 60 minutes duration; and (f) after the last service in the group services program provided to the person under items 81105, 81115 or 81125, the eligible dietitian prepares, or contribute to, a written report to be provided to the referring medical practitioner; and (g) an attendance record for the group is maintained by the eligible dietitian; and (h) in the case of a service in respect of which a private health insurance benefit is payable - the person who incurred the medical expenses in respect of the service has elected to claim the Medicare benefit in respect of the service, and not the private health insurance benefit; - to a maximum of eight GROUP SERVICES (including services to which items 81105, 81115 and 81125 apply) in a calendar year. *(See para M9.1 and M9.2 and M9.3 and M9.5 and M9.6 and M9.7 of explanatory notes to this Category)* **Fee:** $19.90 **Benefit:** 85% = $16.95
81125	**Extended Medicare Safety Net Cap:** $59.70

GROUP M11 - ALLIED HEALTH SERVICES FOR INDIGENOUS AUSTRALIANS WHO HAVE HAD A HEALTH CHECK

81300

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH SERVICE provided to a person who is of Aboriginal and Torres Strait Islander descent by an eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner if:

(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and

(b) the person is referred to the eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and

(c) the person is not an admitted patient of a hospital; and

(d) the service is provided to the person individually and in person; and

(e) the service is of at least 20 minutes duration; and

(f) after the service, the eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (b):

(i) if the service is the only service under the referral – in relation to that service; or

(ii) if the service is the first or the last service under the referral – in relation to the service; or

(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters

- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year

(See para M11.1 of explanatory notes to this Category)

Fee: $62.25 **Benefit:** 85% = $52.95

Extended Medicare Safety Net Cap: $186.75

81305

DIABETES EDUCATION HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible diabetes educator if:

(a) a medical practitioner has identified a need for follow-up allied health services; and

(b) the person is referred to the eligible diabetes educator by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and

(c) the person is not an admitted patient of a hospital; and

(d) the service is provided to the person individually and in person; and

(e) the service is of at least 20 minutes duration; and

(f) after the service, the eligible diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (b):

(i) if the service is the only service under the referral – in relation to that service; or

(ii) if the service is the first or the last service under the referral – in relation to the service; or

(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters;

- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year

(See para M11.1 of explanatory notes to this Category)

Fee: $62.25 **Benefit:** 85% = $52.95

Extended Medicare Safety Net Cap: $186.75

81310

AUDIOLOGY HEALTH SERVICE provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible audiologist if:

(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and

(b) the person is referred to the eligible audiologist by the medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and

(c) the person is not an admitted patient of a hospital; and

(d) the service is provided to the person individually and in person; and

(e) the service is of at least 20 minutes duration; and

(f) after the service, the eligible audiologist gives a written report to the referring medical practitioner mentioned in paragraph (b):

(i) if the service is the only service under the referral – in relation to that service; or

(ii) if the service is the first or the last service under the referral – in relation to the service; or

(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters;

- to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year

(See para M11.1 of explanatory notes to this Category)

Fee: $62.25 **Benefit:** 85% = $52.95

Extended Medicare Safety Net Cap: $186.75

81315	**EXERCISE PHYSIOLOGY HEALTH SERVICE** provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible exercise physiologist if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible exercise physiologist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters; - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year *(See para M11.1 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95 **Extended Medicare Safety Net Cap:** $186.75
81320	**DIETETICS HEALTH SERVICE** provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible dietitian if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible dietitian by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year *(See para M11.1 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95 **Extended Medicare Safety Net Cap:** $186.75
81325	**MENTAL HEALTH SERVICE** provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible mental health worker if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible mental health worker by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible mental health worker gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year *(See para M11.1 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95 **Extended Medicare Safety Net Cap:** $186.75

81330	**OCCUPATIONAL THERAPY HEALTH SERVICE** provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible occupational therapist if (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible occupational therapist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible occupational therapist gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year *(See para M11.1 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95 **Extended Medicare Safety Net Cap:** $186.75
81335	**PHYSIOTHERAPY HEALTH SERVICE** provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible physiotherapist if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible physiotherapist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible physiotherapist gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year *(See para M11.1 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95 **Extended Medicare Safety Net Cap:** $186.75
81340	**PODIATRY HEALTH SERVICE** provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible podiatrist if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible podiatrist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible podiatrist gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year *(See para M11.1 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95 **Extended Medicare Safety Net Cap:** $186.75

81345	**CHIROPRACTIC HEALTH SERVICE** provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible chiropractor if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible chiropractor by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible chiropractor gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year *(See para M11.1 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95 **Extended Medicare Safety Net Cap:** $186.75
81350	**OSTEOPATHY HEALTH SERVICE** provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible osteopath if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible osteopath by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible osteopath gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year *(See para M11.1 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95 **Extended Medicare Safety Net Cap:** $186.75
81355	**PSYCHOLOGY HEALTH SERVICE** provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible psychologist if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible psychologist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible psychologist gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year *(See para M11.1 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95 **Extended Medicare Safety Net Cap:** $186.75

81360	**SPEECH PATHOLOGY HEALTH SERVICE** provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible speech pathologist if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; and (b) the person is referred to the eligible speech pathologist by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible speech pathologist gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral – in relation to that service; or (ii) if the service is the first or the last service under the referral – in relation to the service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of – in relation to those matters - to a maximum of five services (including services to which items 81300 to 81360 inclusive apply) in a calendar year *(See para M11.1 of explanatory notes to this Category)* **Fee:** $62.25 **Benefit:** 85% = $52.95 **Extended Medicare Safety Net Cap:** $186.75

GROUP M10 - AUTISM, PERVASIVE DEVELOPMENTAL DISORDER AND DISABILITY SERVICES

82000	**PSYCHOLOGY** Psychology health service provided to a child, aged under 13 years, by an eligible psychologist where: (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) or disability treatment plan, developed by the practitioner; and (c) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (d) the psychologist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. These items are limited to a maximum of four services per patient, consisting of any combination of the following items – 82000, 82005, 82010 and 82030 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $99.75 **Benefit:** 85% = $84.80 **Extended Medicare Safety Net Cap:** $299.25
82005	**SPEECH PATHOLOGY** Speech pathology health service provided to a child, aged under 13 years, by an eligible speech pathologist where: (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) or disability treatment plan, developed by the practitioner; and (c) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner: and (d) the speech pathologist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. These items are limited to a maximum of four services per patient, consisting of any combination of the following items – 82000, 82005, 82010 and 82030 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $87.95 **Benefit:** 85% = $74.80 **Extended Medicare Safety Net Cap:** $263.85
82010	**OCCUPATIONAL THERAPY** Occupational therapy health service provided to a child, aged under 13 years, by an eligible occupational therapist where: (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) or disability treatment plan, developed by the practitioner; and (c) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (d) the occupational therapist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. These items are limited to a maximum of four services per patient, consisting of any combination of the following items – 82000, 82005, 82010 and 82030 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $87.95 **Benefit:** 85% = $74.80 **Extended Medicare Safety Net Cap:** $263.85

82015	**PSYCHOLOGY** Psychology health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) or an eligible disability by an eligible psychologist where: (a) the child has been diagnosed with PDD or an eligible disability; and (b) the child has received a PDD or disability treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD or disability treatment plan; and (d) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (e) the psychologist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. These items are limited to a maximum of 20 services per patient, consisting of any combination of items ─ 82015, 82020, 82025 and 82035 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $99.75 **Benefit:** 85% = $84.80 **Extended Medicare Safety Net Cap:** $299.25
82020	**SPEECH PATHOLOGY** Speech pathology health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) or an eligible disability by an eligible speech pathologist where: (a) the child has been diagnosed with PDD or an eligible disability; and (b) the child has received a PDD or disability treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD or disability treatment plan; and (d) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (e) the speech pathologist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. These items are limited to a maximum of 20 services per patient, consisting of any combination of items ─ 82015, 82020, 82025 and 82035 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $87.95 **Benefit:** 85% = $74.80 **Extended Medicare Safety Net Cap:** $263.85

82025	**OCCUPATIONAL THERAPY** Occupational therapy health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) or an eligible disability by an eligible occupational therapist where: (a) the child has been diagnosed with PDD or an eligible disability; and (b) the child has received a PDD or disability treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD or disability treatment plan; and (d) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (e) the occupational therapist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. These items are limited to a maximum of 20 services per patient, consisting of any combination of items – 82015, 82020, 82025 and 82035 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $87.95 **Benefit:** 85% = $74.80 **Extended Medicare Safety Net Cap:** $263.85
82030	**AUDIOLOGY, OPTOMETRY, ORTHOPTIC OR PHYSIOTHERAPY** Audiology, optometry, orthoptic or physiotherapy health service provided to a child, aged under 13 years, by an eligible audiologist, optometrist, orthoptist or physiotherapist where: (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) or disability treatment plan, developed by the practitioner; and (c) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (d) the audiologist, optometrist, orthoptist or physiotherapist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. These items are limited to a maximum of four services per patient, consisting of any combination of the following items - 82000, 82005, 82010 and 82030 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $87.95 **Benefit:** 85% = $74.80 **Extended Medicare Safety Net Cap:** $263.85

	AUDIOLOGY, OPTOMETRY, ORTHOPTIC OR PHYSIOTHERAPY Audiology, optometry, orthoptic or physiotherapy health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) or eligible disability by an eligible audiologist, optometrist, orthoptist or physiotherapist where: (a) the child has been diagnosed with PDD or eligible disability; and (b) the child has received a PDD or disability treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD or disability treatment plan; and (d) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (e) the audiologist, optometrist, orthoptist or physiotherapist attending the child is registered with the Department of Human Services as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. These items are limited to a maximum of 20 services per patient, consisting of any combination of items - 82015, 82020, 82025 and 82035 *(See para M10.1 of explanatory notes to this Category)*
82035	**Fee:** $87.95 **Benefit:** 85% = $74.80 **Extended Medicare Safety Net Cap:** $263.85

GROUP M13 - MIDWIFERY SERVICES

SUBGROUP 1 - MBS ITEMS FOR PARTICIPATING MIDWIVES

82100

Initial antenatal professional attendance by a participating midwife, lasting at least 40 minutes, including all of the following:

(a) taking a detailed patient history;
(b) performing a comprehensive examination;
(c) performing a risk assessment;
(d) based on the risk assessment - arranging referral or transfer of the patient's care to an obstetrician;
(e) requesting pathology and diagnostic imaging services, when necessary;
(f) discussing with the patient the collaborative arrangements for her maternity care and recording the arrangements in the midwife's written records in accordance with section 2E of the Health Insurance Regulations 1975.

Payable once only for any pregnancy.
(See para M13.16 of explanatory notes to this Category)
Fee: $53.40 **Benefit:** 85% = $45.40
Extended Medicare Safety Net Cap: $21.70

82105

Short antenatal professional attendance by a participating midwife, lasting up to 40 minutes.
(See para M13.16 of explanatory notes to this Category)
Fee: $32.30 **Benefit:** 75% = $24.25 85% = $27.50
Extended Medicare Safety Net Cap: $16.30

82110

Long antenatal professional attendance by a participating midwife, lasting at least 40 minutes.
(See para M13.16 of explanatory notes to this Category)
Fee: $53.40 **Benefit:** 75% = $40.05 85% = $45.40
Extended Medicare Safety Net Cap: $21.70

82115

Professional attendance by a participating midwife, lasting at least 90 minutes, for assessment and preparation of a maternity care plan for a patient whose pregnancy has progressed beyond 20 weeks, if:

(a) the patient is not an admitted patient of a hospital; and
(b) the participating midwife undertakes a comprehensive assessment of the patient; and
(c) the participating midwife develops a written maternity care plan that contains:
- outcomes of the assessment; and
- details of agreed expectations for care during pregnancy, labour and delivery; and
- details of any health problems or care needs; and
- details of collaborative arrangements that apply for the patient; and
- details of any medication taken by the patient during the pregnancy, and any additional medication that may be required by the patient; and
- details of any referrals or requests for pathology services or diagnostic imaging services for the patient during the pregnancy, and any additional referrals or requests that may be required for the patient; and

(d) the maternity care plan is explained and agreed with the patient; and
(e) the fee does not include any amount for the management of the labour and delivery.

(Includes any antenatal attendance provided on the same occasion).

Payable once only for any pregnancy.
(See para M13.16 of explanatory notes to this Category)
Fee: $319.00 **Benefit:** 85% = $271.15
Extended Medicare Safety Net Cap: $54.10

82120

Management of confinement for up to 12 hours, including delivery (if undertaken), if:
(a) the patient is an admitted patient of a hospital; and
(b) the attendance is by a participating midwife who:
(i) provided the patient's antenatal care; or
(ii) is a member of a practice that provided the patient's antenatal care.

(Includes all attendances related to the confinement by the participating midwife)

Payable once only for any pregnancy
(See para M13.16 of explanatory notes to this Category)
Fee: $753.30 **Benefit:** 75% = $565.00
Extended Medicare Safety Net Cap: $500.00

82125	Management of confinement for in excess of 12 hours, including delivery where performed. Management of confinement, including delivery (if undertaken) when care is transferred from 1 participating midwife to another participating midwife (the second participating midwife), if: (a) the patient is an admitted patient of a hospital; and (b) the patient's confinement is for longer than 12 hours; (c) the second participating midwife: (i) has provided the patient's antenatal care; or (ii) is a member of a practice that has provided the patient's antenatal care. (Includes all attendances related to the confinement by the second participating midwife) Payable one only for any pregnancy. *(See para M13.16 of explanatory notes to this Category)* **Fee:** $753.30 **Benefit:** 75% = $565.00 **Extended Medicare Safety Net Cap:** $500.00
82130	**Short Postnatal Attendance** Short postnatal professional attendance by a participating midwife, lasting up to 40 minutes, within 6 weeks after delivery. *(See para M13.16 of explanatory notes to this Category)* **Fee:** $53.40 **Benefit:** 75% = $40.05 85% = $45.40 **Extended Medicare Safety Net Cap:** $16.30
82135	**Long Postnatal Attendance** Long postnatal professional attendance by a participating midwife, lasting at least 40 minutes, within 6 weeks after delivery. *(See para M13.16 of explanatory notes to this Category)* **Fee:** $78.50 **Benefit:** 75% = $58.90 85% = $66.75 **Extended Medicare Safety Net Cap:** $21.70
82140	Six Week Postnatal Attendance Postnatal professional attendance by a participating midwife on a patient not less than 6 weeks but not more than 7 weeks after delivery of a baby, including: (a) a comprehensive examination of patient and baby to ensure normal postnatal recovery; and (b) referral of the patient to a general practitioner for the ongoing care of the patient and baby Payable once only for any pregnancy. *(See para M13.16 of explanatory notes to this Category)* **Fee:** $53.40 **Benefit:** 85% = $45.40 **Extended Medicare Safety Net Cap:** $16.30
	SUBGROUP 2 - TELEHEALTH ATTENDANCES
82150	A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating midwife that requires the provision of clinical support to a patient who: a) is participating in a video consultation with a specialist practising in his or her speciality of obstetrics or a specialist or consultant physician practising in his or her speciality of paediatrics; and b) is not an admitted patient; and c) is located: (i) both: (A) within a telehealth eligible area; and (B) at the time of the attendance - at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or (ii) in Australia if the patient is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Act applies. *(See para M12.6 of explanatory notes to this Category)* **Fee:** $28.30 **Benefit:** 85% = $24.10 **Extended Medicare Safety Net Cap:** $84.90

82151	A professional attendance lasting at least 20 minutes (whether or not continuous) by a participating midwife that requires the provision of clinical support to a patient who: a) is participating in a video consultation with a specialist practising in his or her speciality of obstetrics or a specialist or consultant physician practising in his or her speciality of paediatrics; and b) is not an admitted patient; and c) is located: (i) both: (A) within a telehealth eligible area; and (B) at the time of the attendance - at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or (ii) in Australia if the patient is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Act applies. *(See para M12.6 of explanatory notes to this Category)* **Fee:** $53.70 **Benefit:** 85% = $45.65 **Extended Medicare Safety Net Cap:** $161.10
82152	A professional attendance lasting at least 40 minutes (whether or not continuous) by a participating midwife that requires the provision of clinical support to a patient who: a) is participating in a video consultation with a specialist practising in his or her speciality of obstetrics or a specialist or consultant physician practising in his or her speciality of paediatrics; and b) is not an admitted patient; and c) is located: (i) both: (A) within a telehealth eligible area; and (B) at the time of the attendance - at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or (ii) in Australia if the patient is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Act applies. *(See para M12.6 of explanatory notes to this Category)* **Fee:** $78.95 **Benefit:** 85% = $67.15 **Extended Medicare Safety Net Cap:** $236.85

GROUP M14 - NURSE PRACTITIONERS

SUBGROUP 1 - NURSE PRACTITIONERS

82200

Professional attendance by a participating nurse practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.
(See para M14.12 of explanatory notes to this Category)
Fee: $9.60 **Benefit:** 85% = $8.20
Extended Medicare Safety Net Cap: $28.80

82205

Professional attendance by a participating nurse practitioner lasting less than 20 minutes and including any of the following:
a) taking a history;
b) undertaking clinical examination;
c) arranging any necessary investigation;
d) implementing a management plan;
e) providing appropriate preventive health care,

for 1 or more health related issues, with appropriate documentation.
(See para M14.12 of explanatory notes to this Category)
Fee: $20.95 **Benefit:** 85% = $17.85
Extended Medicare Safety Net Cap: $62.85

82210

Professional attendance by a participating nurse practitioner lasting at least 20 minutes and including any of the following:
a) taking a detailed history;
b) undertaking clinical examination;
c) arranging any necessary investigation;
d) implementing a management plan;
e) providing appropriate preventive health care,

for 1 or more health related issues, with appropriate documentation.
(See para M14.12 of explanatory notes to this Category)
Fee: $39.75 **Benefit:** 85% = $33.80
Extended Medicare Safety Net Cap: $119.25

82215

Professional attendance by a participating nurse practitioner lasting at least 40 minutes and including any of the following:
a) taking an extensive history;
b) undertaking clinical examination;
c) arranging any necessary investigation;
d) implementing a management plan;
e) providing appropriate preventive health care,

for 1 or more health related issues, with appropriate documentation.
(See para M14.12 of explanatory notes to this Category)
Fee: $58.55 **Benefit:** 85% = $49.80
Extended Medicare Safety Net Cap: $175.65

	SUBGROUP 2 - TELEHEALTH ATTENDANCE
82220	A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who: a) is participating in a video consultation with a specialist or consultant physician; and b) is not an admitted patient; and c) is located: (i) both: (A) within a telehealth eligible area; and (B) at the time of the attendance - at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or (ii) in Australia if the patient is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Act applies. *(See para M12.6 of explanatory notes to this Category)* **Fee:** $28.30 **Benefit:** 85% = $24.10 **Extended Medicare Safety Net Cap:** $84.90
82221	A professional attendance lasting at least 20 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who: a) is participating in a video consultation with a specialist or consultant physician; and b) is not an admitted patient; and c) is located: (i) both: (A) within a telehealth eligible area; and (B) at the time of the attendance - at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or (ii) in Australia if the patient is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Act applies. *(See para M12.6 of explanatory notes to this Category)* **Fee:** $53.70 **Benefit:** 85% = $45.65 **Extended Medicare Safety Net Cap:** $161.10

82222	A professional attendance lasting at least 40 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who: a) is participating in a video consultation with a specialist or consultant physician; and b) is not an admitted patient; and c) is located: (i) both: (A) within a telehealth eligible area; and (B) at the time of the attendance - at least 15 kms by road from the specialist or consultant physician mentioned in paragraph (a); or (ii) in Australia if the patient is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Act applies. *(See para M12.6 of explanatory notes to this Category)* **Fee:** $78.95 **Benefit:** 85% = $67.15 **Extended Medicare Safety Net Cap:** $236.85
	SUBGROUP 3 - TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
82223	A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who: a) is participating in a video consultation with a specialist or consultant physician; and b) either: (i) is a care recipient receiving care in a residential care service; or (ii) is at consulting rooms situated within such a complex if the patient is a care recipient receiving care in a residential aged care service; and c) the professional attendance is not provided at a self-contained unit. *(See para M12.6 of explanatory notes to this Category)* **Fee:** $28.30 **Benefit:** 85% = $24.10 **Extended Medicare Safety Net Cap:** $84.90
82224	A professional attendance lasting at least 20 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who: a) is participating in a video consultation with a specialist or consultant physician; and b) either: (i) is a care recipient receiving care in a residential care service; or (ii) is at consulting rooms situated within such a complex if the patient is a care recipient receiving care in a residential aged care service; and c) the professional attendance is not provided at a self-contained unit *(See para M12.6 of explanatory notes to this Category)* **Fee:** $53.70 **Benefit:** 85% = $45.65 **Extended Medicare Safety Net Cap:** $161.10

	A professional attendance lasting at least 40 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who: a) is participating in a video consultation with a specialist or consultant physician; and b) either: (i) is a care recipient receiving care in a residential care service; or (ii) is at consulting rooms situated within such a complex if the patient is a care recipient receiving care in a residential aged care service; and c) the professional attendance is not provided at a self-contained unit *(See para M12.6 of explanatory notes to this Category)* **Fee:** $78.95 **Benefit:** 85% = $67.15 **Extended Medicare Safety Net Cap:** $236.85
82225	

GROUP M15 - DIAGNOSTIC AUDIOLOGY SERVICES

82300	Audiology health service, consisting of **BRAIN STEM EVOKED RESPONSE AUDIOMETRY**, performed on a person by an eligible audiologist if: (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is a specialist in the specialty of otolaryngology head and neck surgery; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and (e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11300 applies has not been performed on the person on the same day. *(See para M15.1 and M15.5 of explanatory notes to this Category)* **Fee:** $153.95 **Benefit:** 85% = $130.90 **Extended Medicare Safety Net Cap:** $461.85
82306	Audiology health service, consisting of **NON-DETERMINATE AUDIOMETRY** performed on a person by an eligible audiologist if: (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is a specialist in the specialty of otolaryngology head and neck surgery; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and (e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11306 applies has not been performed on the person on the same day. *(See para M15.2 and M15.5 of explanatory notes to this Category)* **Fee:** $17.50 **Benefit:** 85% = $14.90 **Extended Medicare Safety Net Cap:** $52.50
82309	Audiology health service, consisting of an **AIR CONDUCTION AUDIOGRAM** performed on a person by an eligible audiologist if: (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is: (i) a specialist in the specialty of otolaryngology head and neck surgery; or (ii) a specialist or consultant physician in the specialty of neurology; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and (e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11309 applies has not been performed on the person on the same day. *(See para M15.3 and M15.5 of explanatory notes to this Category)* **Fee:** $21.05 **Benefit:** 85% = $17.90 **Extended Medicare Safety Net Cap:** $63.15
82312	Audiology health service, consisting of an **AIR AND BONE CONDUCTION AUDIOGRAM OR AIR CONDUCTION AND SPEECH DISCRIMINATION AUDIOGRAM** performed on a person by an eligible audiologist if: (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is: (i) a specialist in the specialty of otolaryngology head and neck surgery; or (ii) a specialist or consultant physician in the specialty of neurology; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and (e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11312 applies has not been performed on the person on the same day. *(See para M15.3 and M15.5 of explanatory notes to this Category)* **Fee:** $29.70 **Benefit:** 85% = $25.25 **Extended Medicare Safety Net Cap:** $89.10

82315	Audiology health service, consisting of an **AIR AND BONE CONDUCTION AND SPEECH DISCRIMINATION AUDIOGRAM** performed on a person by an eligible audiologist if: (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is: (i) a specialist in the specialty of otolaryngology head and neck surgery; or (ii) a specialist or consultant physician in the specialty of neurology; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and (e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11315 applies has not been performed on the person on the same day. *(See para M15.3 and M15.5 of explanatory notes to this Category)* **Fee:** $39.35 **Benefit:** 85% = $33.45 **Extended Medicare Safety Net Cap:** $118.05
82318	Audiology health service, consisting of an **AIR AND BONE CONDUCTION AND SPEECH DISCRIMINATION AUDIOGRAM WITH OTHER COCHLEAR TESTS** performed on a person by an eligible audiologist if: (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is: (i) a specialist in the specialty of otolaryngology head and neck surgery; or (ii) a specialist or consultant physician in the specialty of neurology; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and (e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11318 applies has not been performed on the person on the same day. *(See para M15.3 and M15.5 of explanatory notes to this Category)* **Fee:** $48.60 **Benefit:** 85% = $41.35 **Extended Medicare Safety Net Cap:** $145.80
82324	Audiology health service, consisting of an **IMPEDANCE AUDIOGRAM** involving tympanometry and measurement of static compliance and acoustic reflex performed on a person by an eligible audiologist (not being a service associated with a service to which item 82309, 82312, 82315 or 82318 applies) if: (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is: (i) a specialist in the specialty of otolaryngology head and neck surgery; or (ii) a specialist or consultant physician in the specialty of neurology; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and (e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11324 applies has not been performed on the person on the same day. *(See para M15.3 and M15.5 of explanatory notes to this Category)* **Fee:** $26.30 **Benefit:** 85% = $22.40 **Extended Medicare Safety Net Cap:** $78.90

82327	Audiology health service, consisting of an **IMPEDANCE AUDIOGRAM** involving tympanometry and measurement of static compliance and acoustic reflex performed on a person by an eligible audiologist (being a service associated with a service to which item 82309, 82312, 82315 or 82318 applies) if: (a) the service is performed pursuant to a written request made by an eligible practitioner to assist the eligible practitioner in the diagnosis and/or treatment and/or management of ear disease or a related disorder in the person; and (b) the eligible practitioner is: (i) a specialist in the specialty of otolaryngology head and neck surgery; or (ii) a specialist or consultant physician in the specialty of neurology; and (c) the service is not performed for the purpose of a hearing screening; and (d) the person is not an admitted patient of a hospital; and (e) the service is performed on the person individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11327 applies has not been performed on the person on the same day. *(See para M15.3 and M15.5 of explanatory notes to this Category)* **Fee:** $15.80 **Benefit:** 85% = $13.45 **Extended Medicare Safety Net Cap:** $47.40
82332	Audiology health service, consisting of an **OTO-ACOUSTIC EMISSION AUDIOMETRY** for the detection of permanent congenital hearing impairment, performed by an eligible audiologist on an infant or child in circumstances in which: (a) the service is performed pursuant to a written request made by an eligible practitioner who is: (i) a specialist in the specialty of otolaryngology head and neck surgery; or (ii) a specialist or consultant physician in the specialty of neurology; and (b) the infant or child is at risk due to 1 or more of the following factors: (i) admission to a neonatal intensive care unit; (ii) family history of hearing impairment; (iii) intra-uterine or perinatal infection (either suspected or confirmed); (iv) birthweight less than 1.5kg; (v) craniofacial deformity; (vi) birth asphyxia; (vii) chromosomal abnormality, including Down Syndrome; (viii) exchange transfusion; and (c) middle ear pathology has been excluded by specialist opinion; and (d) the infant or child is not an admitted patient of a hospital; and (e) the service is performed on the infant or child individually and in person; and (f) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the eligible practitioner who requested the service; and (g) a service to which item 11332 applies has not been performed on the infant or child on the same day. *(See para M15.4 and M15.5 of explanatory notes to this Category)* **Fee:** $46.85 **Benefit:** 85% = $39.85 **Extended Medicare Safety Net Cap:** $140.55

INDEX

A

Allied health services for indigenous Australians 81300,81305,81310 81315,81320,81325,81330,81335,81340,81345,81350 81355,81360
Autism, pervasive developmental disorder, consultant physicians
  allied health services 82005,82010,82015 82020,82025

B

Bulk-billing 10990-10992

P

Pervasive developmental disorder, autism, consultant physicians
  allied health services 82000
Pregnancy, attendance for complication by
  Pregnancy support counselling 81000,81005,81010
Psychological therapy services 80000,80005,80010 80015,80020
  Focussed psychological strategies 80100,80105,80110 80115,80120,80125,80130,80135,80140,80145,80150 80155,80160,80165,80170