AUSTRALIA

Supplement to

MEDICARE BENEFITS SCHEDULE BOOK

of 1 November 1993

Effective 1 May 1994

MARGE HARDING

COMMONWEALTH DEPARTMENT OF HUMAN SERVICES AND HEALTH

The Rules

A copy of the Rules is provided in full in pages 5 to 10. Most of the changes are of form rather than substance. The other amendments include:

- the replacement of former Rules 10 and 5 by an additional definition in sub-rule 1.(1) and an extra clause in sub-rule 2.(2);

- A definition of "cytology" has been provided in sub-rule 10.(1)(c) and new clarifications have been provided in Rule 10.(2) and 10.(3) to prevent items being claimed from both P5 and P6 for tissue aspiration when tissue particles are found in material submitted for cytology;

- the wording of the old Rule 11 (A) - now new Rule 12 - has been amended to clarify the fact that the restriction against claiming a P10 item only applies to the APA who claims a P11 item.

Groups

Group P5 has been renamed "Tissue Pathology"; and Group P6 has been renamed "Cytology".

Items

The following changes have been made to the Schedule:

- Item 66245 has been deleted and replaced by items 66249 and 66250 - this lifts the restriction on the number of electrophoresis tests attracting benefits where the tests are used to monitor patients with multiple myeloma while still restricting the payment of benefits for tests used to demonstrate lipoprotein sub-classes:

  66249 Electrophoresis, quantitative or qualitative, of serum, urine or other body fluid to demonstrate:
  (a) protein classes; or
  (b) presence and amount of paraprotein; or
  (c) the isoenzymes of lactate dehydrogenase, alkaline phosphatase and creatine kinase;
  including the preliminary quantitation of total protein, albumin and globulin or of total relevant enzyme activity Fee: $29.80

  66250 Electrophoresis, quantitation or qualitative, of serum, for demonstration of lipoprotein subclasses, if the cholesterol is >6.5 mmol/l and triglyceride >3.0 mmol/l or in the diagnosis of types III and IV hyperlipidaemia - each episode to a maximum of 2 episodes in a 12 month period Fee: $29.80.

- A provision in item 66343 which allowed the payment of benefits for tests ordered by a court or a parole board has been deleted as it was contrary to the provisions of Section 19 of the ***Health Insurance Act 1973.***

  66343 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:

  (a) participating in a drug abuse treatment program; or

  (b) being treated for drug effects;
  including all tests on blood, urine or other body fluid - each episode, to a maximum of 21 episodes in a 12-month period Fee: $20.25.

- 14 hormone items (66377 - 66403) have been deleted and replaced by 7 new items (66405 - 66417) which are modifications of the previous hormone items and bring the majority of hormones back under one set of item numbers:

66405 Quantitation of hormones and hormone binding proteins - ACTH, aldosterone, androstenedione, C-peptide, calcitonin, cortisol, cyclic AMP, DHEAS, 11-deoxycortisol, dihydrotestosterone, FSH, gastrin, glucagon, growth hormone, hydroxyprogesterone, insulin, LH, oestradiol, oestrone, progesterone, prolactin, PTH, renin, sex hormone binding globulin, somatomedin C(1gF1), free or total testosterone, TSH, (where not requested on its own or as part of a thyroid function test), urine steroid fraction or fractions, vasoactive intestinal peptide, vasopressin (antidiuretic hormone) - 1 test Fee: $31.15

66407 2 tests described in item 66405 Fee: $42.05

66409 3 tests described in item 66405 Fee: $52.95

66411 4 tests described in item 66405 Fee: $63.85

66413 5 tests described in item 66405 Fee: $74.75

66415 6 tests described in item 66405 Fee: $85.65

66417 Tests described in any of items 66405 to 66413 (inclusive), if the number of tests relating to the same patient episode does not exceed 6 - each test to a maximum of 5 tests (Item is subject to Rule 6) Fee: $10.90.

- An additional clause has been added to the descriptor for item 71061 to prevent claims for an additional fee being made for the same procedure under items 66213 or 66215:

71061 Immunoelectrophoresis or immunofixation, of serum, urine or other body fluid, and characterisation of, a paraprotein or cryoglobulin not previously characterised, including a service described in 1 or both of items 66213 and 66215 (if performed) - 1 or more tests Fee: $28.45.

- Item 71067 has been amended to add "total" to the description of the test.

- Items 71105 and 71107 have been deleted and replaced by a new combined item 71106.

71106 Rheumatoid factor - detection by any technique in serum or other body fluids, including quantitation if required Fee: $11.00.

- Item 71139 has been amended as follows:

71139 Characterisation of 3 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations, including a total lyphocyte count by any method, on 1 or more specimens of blood, CSF or serous fluid Fee: $101.35.

- Item 73057 has been amended to prevent its being used in the monitoring of hormone replacement therapy:

73057 Cytology of smears from vagina, not associated with item 73053 or 73055 nor to monitor hormone replacement therapy - each test Fee: $12.40.

- Item 73529 has also been amended to enable the service to be used in the management of ectopic pregnancies in symptomatic patients:

73529 Chorionic gonadotrophin (beta-HCG) - quantitation in serum by 1 or more methods for diagnosis of hydatidiform mole, HCG-secreting neoplasm, or threatened abortion, or follow-up of abortion or diagnosis of ectopic pregnancy, including any services performed in 73529 - 1 test Fee: $27.90.

- Item 73917, which referred to temporary licensed collection centres has been deleted and consequential amendments made to items 73907 and 73913.

Fees

Following the Immunology Report, the Pathology Services Table Committee agreed to the following changes:

- The fees for item 71141 has been reduced to $192.35; and
- the fee for item no. 71147 has been reduced to $31.60.

RULES OF INTERPRETATION

Interpretation of Table

1. (1) In this Table:

"patient episode" means:

(a) a pathology service or pathology services (other than a pathology service to which paragraph 1 (1) (b) refers) provided for a single patient whose need for the service or services was determined under subsection 16A(1) of the Act on the same day, whether the services:
  (i) are requested by 1 or more practitioners; or
  (ii) are described in a single item or in more than 1 item; or
  (iii) are rendered by 1 approved pathology practitioner or more than 1 approved pathology practitioner; or
  (iv) are rendered on the same day or on different days; or

(b) a pathology service to which rule 4 refers that is provided in the circumstances set out in that rule that relates to the service;

"recognised pathologist" means a medical practitioner recognised as a specialist in pathology by a determination under section 3D or subsection 61 (3) of the Act;

"serial examinations" means a series of examinations requested on 1 occasion whether or not:

(a) the materials are received on different days by the approved pathology practitioner; or

(b) the examinations or cultures were requested on 1 or more request forms by the treating practitioner;

"the Act" means the *Health Insurance Act 1973*.

1. (2) In these Rules, a reference to a request to an approved pathology practitioner includes a reference to a request for a pathologist-determinable service to which subsection 16A (6) of the Act applies.

1. (3) A reference in this Table by number to an item that is not included in this Table is a reference to the item that has that number in the General Medical Services Table or the Diagnostic Imaging Services Table, as the case requires.

1. (4) A reference to a Group in the Table includes every item in that Group.

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.

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

(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) a pathology service specified in item 66201, other than an estimation of fructosamine or lithium; or

(b) quantitative estimation, described in item 66365, of 1 or more fractions of neonatal bilirubin;

if:

(c) the service is rendered in relation to a single specimen taken on each of not more than 4 occasions in a period of 24 hours; and

(d) the service is rendered to a patient in a hospital unit where:

(i) the presence of 1 nurse is required for each group of not more than 4 patients; and

(ii) the condition of the patients is continuously observed in relevant respects; and

(e) in order to render the service, an approved pathology practitioner who is a recognised pathologist has to arrange for a member of the laboratory staff of the approved pathology authority concerned to undertake duties in respect of the service that are in addition to the usual duties of the staff member; and

(f) 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 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 65007 in relation to a patient undergoing chemotherapy for neoplastic disease or immunosuppressant therapy;

(d) a service described in item 65007 in relation to methotrexate, gold or penicillamine therapy of a patient;

(e) a service described in item 66201 in relation to methotrexate therapy of a patient;

(f) quantitative estimation of urea, creatinine and electrolytes in relation to:

(i) cis-platinum therapy of a patient; or

(ii) chronic renal failure of a patient being treated in a dialysis program conducted by a recognised hospital;

if:

(g) under a request for a service, no more than 6 tests are requested; and

(h) the tests are performed within 6 months of the request; and

(i) the account for the service is endorsed "Rule 3 Exemption".

4. (3) Rule 3 does not apply to a pathology service:

(a) to which item 66217 applies; and

(b) for which a specimen is collected on each of 3 days for the purpose of making a valid estimation; and

(c) for which the account is endorsed "Rule 3 Exemption".

Item taken to refer only to the first service of a particular kind

5. For the purposes of an item in Group PI (Haematology):

(a) if pathology services of a kind referred to in item 65017 or 65019 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 that period; and

(b) if:

(i) tests (except tests mentioned in item 65023) 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 65023) are carried out on the stored material;

the later tests and the earlier tests are taken to be part of one patient episode.

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 described in item 66241, 66417 or 69241.

6. (2) Subject to subrule (3), if an approved pathology practitioner in an approved pathology authority:

(a) has been requested to render a pathology service that includes 2 or more tests included in a designated pathology service; and

(b) is able to perform 1 or more, but not all, of the tests because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority in relation to that test or those tests; and

(c) requests an approved pathology practitioner in another approved pathology authority to render 1 or more, but not all, of the tests;

the service rendered by the second-mentioned practitioner is taken to be the designated pathology service.

6. (3) Items in Group P10 (Patient episode initiation) do not apply to the second-mentioned approved pathology practitioner in subrule (2).

Certain tests on stored material to be treated as part of the same patient episode

7. For the purposes of items in Group P2 (Chemical):

(a) if a pathology service that involves the measurement of a substance in urine requires calculation of a substance/creatinine ratio, the service is taken to include the measurement of creatinine necessary for the calculation; 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.

Meaning of "serial examinations or cultures"

8. For the purposes of 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.

Tests in Group P4 (Immunology) relating to antibodies

9. For the purposes of 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)

10. (1) For the purposes of items in Group P5 (Tissue Pathology):

(a) **"biopsy material"** means all tissue (other than a bone marrow biopsy) received by an approved pathology practitioner from an operation, or a group of operations, performed on a patient at the same time; and

(b) if:

(i) a pathology service that comprises the examination of biopsy material is rendered under any of those items; and

(ii) a further pathology service mentioned in any of those items is also rendered using that biopsy material;

those pathology services are taken to be 1 pathology service; and

(c) "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. In accordance with customary laboratory practice examination of a blood film and a bone marrow aspirate is excluded from this definition.

10. (2) For the purposes of 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.

10. (3) For the purposes of subrule 10. (2) - any sample submitted for cytology from which a cell block is prepared does not qualify for a Group P5 item.

Items in Groups P10 (Patient episode initiation) and P11 (Specimen referred) not to apply in certain circumstances

11. (1) For the purposes of this rule and items in Groups P10 (Patient episode initiation) and P11 (Specimen referred):

"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 nursing home; or
(l) accommodation for aged persons that is attached to a nursing home or situated within a nursing home complex;

"licensed collection centre" has the same meaning as in Part IIA of the Act;

"prescribed laboratory" means a laboratory operated by:

(a) the Commonwealth; or
(b) a State or internal Territory; or
(c) an authority of a State or internal Territory; or
(d) 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.

11. (2) If a service described in an item in Group P10 or P11 is rendered by, or on behalf of, an approved pathology practitioner who is a recognised pathologist, the relevant one of those items does not apply to the service if:

(a) the service is rendered upon a request made in the course of an out-patient service at a recognised hospital; or

(b) the service is rendered upon a request made for a patient who is a private patient in a recognised hospital when the request is made; or

(c) the pathology equipment of a recognised hospital, or a prescribed laboratory, is used rendering the service; or

(d) a member of the staff of a recognised hospital, or a prescribed laboratory, participates in the service in the course of the member' s employment with the hospital or laboratory.

11. (3) An item in Group P10 or P11 does not apply to a pathology service to which subsection 16A (7) of the Act applies.

11. (4) An item in Group P10 or P11 does not apply to a pathology service unless at least one item in Groups PI to P9 also applies to that service.

11. (5) Subject to subrule (7), if one item in Group P10 applies to a patient episode, no other item in that Group applies to that patient episode.

11. (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.

11. (7) If, in respect of the same patient episode:

(a) services referred to in 1 or more items in Group P5 and one or more of Groups PI, P2, P3, P4, P6, P7 and P8 are rendered by an approved pathology practitioner in the laboratory of another approved pathology authority; and

(b) services referred to in 1 or more items in Group P6 and one or more of Groups PI, P2, P3, P4, P5, P7 and P8 are rendered by another approved pathology practitioner in another approved pathology authority;

the fee specified in the applicable item in Group P10 is payable to both approved pathology practitioners.

11. (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 one request; and

(b) in or by a single approved pathology authority;

only a single amount specified in the applicable item in Group P10 is payable for the services.

Application of an item in Group P11 (Specimen referred) to a service excludes certain other items

12. If item 73921 applies to a patient episode, none of the items in Group P10 applies to any pathology service rendered by the approved pathology authority or approved pathology provider who claimed item 73921 in respect of that patient episode.

Circumstances in which an item in Group P11 (Specimen referred) does not apply

13. (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.

13. (2) An approved pathology authority is related to another approved pathology authority for the purposes of subclause (1) if:

(a) both approved pathology authorities are employed (including employed under contract) by the same person, whether or not that 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) if both of the approved pathology authorities are corporations - the approved pathology authorities are related corporations within the meaning of the Corporations Law; 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).

Abbreviations

14. (1) The abbreviations in Part 3 of this Table may be used to identify particular pathology services or groups of pathology services.

14. (2) The names of services not listed in Part 3 of this Table must be written in full.

Commonwealth Department of
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SUPPLEMENT TO 1 NOVEMBER 1993 MEDICARE BENEFITS SCHEDULE BOOK

AMENDMENTS EFFECTIVE 1 MAY 1994

DISCLAIMER

This supplement provides details of changes to the 1 November 1993 edition of the Medicare Benefits Schedule book.

Review of General Medical Services

These changes result, in the main, from reviews of services undertaken in consultation with the medical profession under the auspices of the Medicare Benefits Consultative Committee. The Schedule amendments involve the introduction of new items, the deletion of obsolete items and amendments to existing items to ensure that the Schedule reflects and supports current proper medical practice in Australia.

The changes relate to:

(1) Intensive Care - intensive care management and procedures have been amended as a result of a revision of the changes to these services which were introduced into the Schedule from 1 July last year. A new Subgroup now covers procedures undertaken in an intensive care unit (ICU) with a separate Subgroup containing services which may also be provided outside of an ICU. (Note: items 13815 and 13830 remain as shown in the 1/11/93 Schedule book). Attention is drawn to revised Notes for Guidance relating to intensive care (see page 3 of these notes).

(2) Obstetrics - the fees for antenatal care have been increased to a level B general practitioner consultation i.e., from $21.90 to $24.15 for item 16500 and from $217.20 to $241.50 for item 16503. Also, the G and S fee differential has been removed from the two confinement items by the deletion of items 16506 and 16516.

(3) The remaining amendments to general medical services are miscellaneous changes to correct anomalies and omissions.

agreed to with the profession

Bone Densitometry

A Ministerial Determination has been made to provide Medicare benefits for bone densitometry effective from 1 March 1994 (Items 12300 and 12303). Attention is drawn to explanatory notes covering these services at page 2 of these notes.

Safety Net

The Medicare "safety net" increased with effect from 1 January 1994 to $253.30 (see para 1.1 of General Explanatory Notes to the 1 November 1993 Medicare Benefits Schedule book).

SUMMARY OF CHANGES

Details of new items, ceased items and amendments to existing item numbers and descriptions of services are summarised below.

New Items

11601	12300	12303	13609	30564	32026	32029	32112	32131	35012	35623	37219	41615	42510
42610	42615	47565	47566	49346	49360	49363	49366	49569					

Ceased Items

11630	16506	16516	30381	41882

Renumbered Items

Old	New	Old	New	Old	New
13827	13506	13809	13870	32027	32025
12100	13839	13812	13873	32048	32028
12103	13842	13819	13876	35621	35619
12106	13845	13821	13879	35624	35620
12109	13848	13824	13882	35625	35622
12112	13851	13833	13885		
12115	13854	13836	13888		

Amended Descriptions (Includes Current and Renumbered Items)

11600 13818 13876 16500 16503 16507 16517 16552 16558 16561 32025 32028 32117 32168
32500 35567 35636 35638 36624 40803 42587 42611 42614 47531

Amended Anaesthetics

32025 32028 32183 32186 35567 35622 35638 42611

Deleted Anaesthetics

42614

Amended Fees (Includes Current and Renumbered Items)

11830 13818 13876 16500 16503 30609 32025 32028 32183 32186 35567 41883

NOTES FOR GUIDANCE

Bone Densitometry

Add new note:-

D1.13 Bone Densitometry (Items 12300,12303)

D1.13.1 Benefits are available for one referred bone densitometry service only in a period of 24 months (except in circumstances set out in paragraphs D1.13.7 to D1.13.8). Only tests performed for certain indications, conditions or treatments (see below) and carried out using either dual energy X-ray absorptiometry (DEXA) or quantitative computerised tomography (QCT) attract benefits.

D1.13.2 An examination under either of these items covers measurement of one or more sites, interpretation and provision of a report.

Referrals

D1.13.3 Bone densitometry services are available on the basis of referral by a medical practitioner to a specialist or consultant physician. However, providers of bone densitometry to whom a patient is referred for management may determine that a bone densitometry service is required in line with the provisions of the new items.

D1.13.4 For item 12300 the referral should specify the item requested by number and the indication for the test, namely;

(a) one or more fractures occurring after minimal trauma; or
(b) monitoring of osteoporosis proven by previous bone densitometry.

Osteoporosis is present when the bone (organ) density falls more than two standard deviations below the young normal mean at the same site and in the same sex.

D1.13.5 For item 12303 the referral should specify the item requested by number and the indication for the test, namely;

(a) prolonged glucocorticoid therapy;
(b) conditions associated with excess glucocorticoid secretion;
(c) male hypogonadism;
(d) amenorrhea lasting more than 6 months before the age of 40;
(e) primary hyperparathyroidism;
(f) chronic liver disease;
(g) chronic renal disease;
(h) proven malabsorptive disorders;
(i) rheumatoid arthritis; or
(j) conditions associated with thyroxine excess.

Definitions

D1.13.6 For item 12303

(a) Pregnancy is excluded from 'amenorrhea lasting more than 6 months before the age of 40'.
(b) 'Malabsorptive disorders' - malabsorption of fat is defined as faecal fat estimated at greater than 18gm per 72 hours on a normal fat diet.

Requests for other services

D1.13.7 Applications may be made to the Medicare Benefits Advisory Committee under section 11 of the Health Insurance

Act for a benefit for bone densitometry testing to monitor bone loss associated with clinical conditions or treatments not specified above where bone loss may result from that condition or treatment.

D1.13.8 In the case of the conditions specified above, where the clinical situation of the patient requires a further test in under 24 months, an application with appropriate clinical details may be made to the Medicare Benefits Advisory Committee under Section 11 of the Health Insurance Act.

D1.13.9 Any applications under Section 11 of the Health Insurance Act should be referred to the local office of the Health Insurance Commission for transmission to the Medicare Benefits Advisory Committee for consideration. For an explanation of the provisions of Section 11 see paragraph 9.2 of the General Explanatory Notes.

Review

D1.13.10 Medicare benefit arrangements for bone densitometry will be reviewed 12 months after their introduction.

Intensive Care

Replace Note **T.1.5** with the following:-

T1.5 Intensive Care Units

T1.5.1 'Intensive Care Unit' means a separate hospital area that:

(a) is equipped and staffed so as to be capable of providing to a patient:
  (i) mechanical ventilation for a period of several days; and
  (ii) invasive cardiovascular monitoring; and
(b) is supported by:
  (i) at least one specialist or consultant physician in the specialty of intensive care who is immediately available during normal working hours; and
  (ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and
  (iii) a registered nurse for at least 18 hours in each day; and
(c) has defined admission and discharge policies.

T1.5.2 For Neonatal Intensive Care Units an 'Intensive Care Unit' means a separate hospital area that:

(a) is equipped and staffed so as to be capable of providing to a patient, being a newly-born child:
  (i) mechanical ventilation for a period of several days; and
  (ii) invasive cardiovascular monitoring; and
(b) is supported by:
  (i) at least one consultant physician in the specialty of paediatric medicine, appointed to manage the unit, and who is immediately available during normal working hours; and
  (ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and
  (iii) a registered nurse for at least 18 hours in each day; and
(c) has defined admission and discharge policies.

T1.5.3 Medicare benefits are payable under the 'management' items only once per day irrespective of the number of intensivists involved with the patient on that day. However, benefits are also payable for an attendance by another specialist/consultant physician who is not managing the patient but who has been asked to attend the patient. Where appropriate, accounts should be endorsed to the effect that the consultation was not part of the patient's intensive care management in order to identify which consultations should attract benefits in addition to the intensive care items.

T1.5.4 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 and pressure monitoring; or
(vi) all babies having frequent seizures.

T1.5.5 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, 13879, 13882, 13885 and 13888.

T1.5.6 Likewise, benefits are not payable under items 13870, 13873, 13876, 13879, 13882, 13885 and 13888 in respect of babies not meeting the above criteria, but who, for whatever other reasons, are physically located in a Neonatal Intensive Care Unit.

T1.5.7 Benefits are payable for admissions to an Intensive Care Unit following surgery only where clear clinical justification for post-operative intensive care exists.

T1.6 Procedures Associated with Intensive Care (Item 13818)

T1.6.1 Item 13818 covers the insertion of a right heart balloon catheter (Swan-Ganz catheter). Benefits are payable under this item only once per day except where a second discrete operation is performed on that day.

T1.6.2 Benefits for monitoring of pressures, up to a maximum of 4 on one day are payable under items 11600 and 11601 outside of an ICU and item 13876 within an ICU.

T1.7 Management and Procedures in Intensive Care Unit (Items 13870 - 13882)

Items 13870 and 13873

T1.7.1 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 ECGs, arterial sampling, bladder catheterisation and blood sampling performed on the patient on the one day. If a patient is transferred from one ICU to another it would be necessary for an arrangement to be made between the two ICUs regarding the billing of the patient.
T1.7.2 Items 13870 and 13873 should be itemised on accounts according to each calendar day and not per 24 hour period. For periods when patients are in an ICU for very short periods (say less than 2 hours) with minimal ICU management during that time, a fee should not be raised.

Item 13876

T1.7.3 Item 13876 covers the monitoring of pressures in an ICU.
T1.7.4 Benefits are attracted under item 13876 only once on the one day irrespective of the number of medical practitioners involved in the monitoring of pressures in an ICU.
T1.7.5 Benefits are payable under items 11600 and 11601 where monitoring occurs outside the ICU by practitioners not associated with the ICU, eg, an anaesthetist in an operating theatre.

Items 13879 and 13882

T1.7.6 Benefits are not payable under item 13879 where ventilation is initiated in the context of an anaesthetic for surgery.
T1.7.7 Benefits are payable for initiation of mechanical ventilation under item 13879 irrespective of where the initiation took place (eg ICU or elsewhere) provided management of subsequent ventilatory support of the patient takes place in the ICU. For example, an anaesthetist may initiate the ventilator support outside the ICU (and bill item 13879) and the patient, after admission to the ICU, is charged item 13882 by the intensivist.

Miscellaneous Changes

Amend Note **T1.3.1** (Assisted Reproductive Services) by adding "66377-66403" after "55057" (third line).

Renumber Note **T1.6** (PUVA or UVB Therapy) to **T1.8.**

Amend Note **T6.1.14** (Anaesthetics) to read:-
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

Add new note:-
T7.5 Destruction of Nerve Branch by Neurolytic Agent (Item 18292)
T7.5.1 This item includes the use of botulinus toxin as a neurolytic agent.

Amend note under Group T7 heading (page 87) to read:
(Note: Where anaesthesia for an operative procedure comprises both a regional nerve block and a general anaesthetic benefits will be paid only under the anaesthetic item relevant to the operation. The only instances where additional benefits are payable under an item in this Group is in relation to item 18206 or 18209).

MEDICARE BENEFITS SCHEDULE (MBS) ON DISK

As foreshadowed in the accompanying instructions forwarded with the 1 November 1993 MBS disks, a review of the costing of the disks has been undertaken. As a result of this review the fee for the supply of the disk will be increased to $50.00 effective from the 1 November 1994 reprint of the MBS.

SPECIAL ARRANGEMENTS - TRANSITIONAL PERIOD

Where the description, item number or Schedule fee for an item has been amended the following rules will apply:-

(a) If the item refers to a service in which treatment continues over a period of time in excess of one day and the treatment commenced before 1 May 1994 and continues beyond that date, the old item, fee and benefit levels will apply. In any other case, other than that set out in (b), the date the service is rendered will determine which item and fee is applicable.

(b) However, in the case of the relevant obstetric items the fee and benefit will depend on the date of the actual confinement. If the confinement takes place before 1 May 1994, fees and benefits at the 1 November 1993 level will apply. If the confinement takes place on or after 1 May 1994, fees and benefits at the new (1 May 1994) level will apply.

	GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
	SUBGROUP 5 - VASCULAR
‡ 11600	BLOOD PRESSURE MONITORING (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - each day of monitoring for each pressure up to a maximum of 4 pressures (not being a service to which item 13876 applies) (AU 4 - 17904) **Fee:** $49.30 **Benefit:** 75% = $37.00 85% = $41.95
† 11601	BLOOD PRESSURE MONITORING (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - for each pressure up to a maximum of 4 pressures (not being a service to which item 13876 applies) performed in association with the administration of an anaesthetic relating to another discrete operation on the same day (AU 4 - 17904) **Fee:** $49.30 **Benefit:** 75% = $37.00 85% = $41.95
	SUBGROUP 7 - GASTROENTEROLOGY & COLORECTAL
+ 11830	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex **Fee:** $133.00 **Benefit:** 75% = $99.75 85% = $113.05
	SUBGROUP 11 - OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
† 12300	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 confirmation of a presumptive diagnosis of osteoporosis made on the basis of 1 or more fractures occurring after minimal trauma or for the monitoring of osteoporosis proven by previous bone densitometry - measurement of 1 or more sites - 1 service only in a period of 24 consecutive months - interpretation and report *(See para D1.13 of explanatory notes to this Category)* **Fee:** $75.00 **Benefit:** 75% = $56.25 85% = $63.75
† 12303	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 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, amenorrhea lasting more than 6 months before the age of 40, 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 1 or more sites - 1 service only in a period of 24 consecutive months - interpretation and report *(See para D1.13 of explanatory notes to this Category)* **Fee:** $75.00 **Benefit:** 75% = $56.25 85% = $63.75
	GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES
	SUBGROUP 6 - GASTROENTEROLOGY
* 13506	GASTRO-OESOPHAGEAL balloon intubation, Minnesota, Sengstaken-Blakemore or similar, for control of bleeding from gastric oesophageal varices **Fee:** $131.40 **Benefit:** 75% = $98.55 85% = $111.70

	SUBGROUP 7 - PERFUSION
† 13609	CARDIOPLEGIA, retrograde administration of, involving crystalloid or blood, via a roller pump or pump-oxygenator **Fee:** $180.00 **Benefit:** 75% = $135.00 85% = $153.00
	SUBGROUP 9 - PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT
	(Note: items 13815 and 13830 remain as shown in the 1/11/93 Schedule book)
‡ + 13818	RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement *(See para T1.6 of explanatory notes to this Category)* **Fee:** $81.00 **Benefit:** 75% = $60.75 85% = $68.85
* 13839	ARTERIAL PUNCTURE and collection of blood for diagnostic purposes **Fee:** $16.40 **Benefit:** 75% = $12.30 85% = $13.95
* 13842	INTRA-ARTERIAL CANNULISATION for the purpose of taking multiple arterial blood samples for blood gas analysis **Fee:** $49.30 **Benefit:** 75% = $37.00 85% = $41.95
* 13845	COUNTERPULSATION BY INTRA-AORTIC BALLOON - management on the first day, including percutaneous insertion, initial and subsequent consultations and monitoring of parameters **Fee:** $385.30 **Benefit:** 75% = $289.00 85% = $357.60
* 13848	COUNTERPULSATION BY INTRA-AORTIC BALLOON - management on each day subsequent to the first, including associated consultations and monitoring of parameters **Fee:** $93.30 **Benefit:** 75% = $70.00 85% = $79.35
* 13851	CIRCULATORY SUPPORT DEVICE, management of, on first day **Fee:** $351.65 **Benefit:** 75% = $263.75 85% = $323.95
* 13854	CIRCULATORY SUPPORT DEVICE, management of, on each day subsequent to the first **Fee:** $81.70 **Benefit:** 75% = $61.30 85% = $69.45
	SUBGROUP 9A - MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT
* 13870	*(Note: See para T1.5 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 - including initial and subsequent attendances, electrocardiograms, arterial sampling, bladder catheterisation and blood sampling - management on the first day *(See para T1.7 of explanatory notes to this Category)* **Fee:** $217.35 **Benefit:** 75% = $163.05 85% = $189.65
* 13873	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician - including all attendances, electrocardiograms, arterial sampling, bladder catheterisation and blood sampling - management on each day subsequent to the first day *(See para T1.7 of explanatory notes to this Category)* **Fee:** $161.75 **Benefit:** 75% = $121.35 85% = $137.50
* ‡ + 13876	CENTRAL VENOUS PRESSURE, pulmonary arterial pressure, systemic arterial pressure or cardiac intracavity pressure, continuous monitoring by indwelling catheter by a specialist or consultant physician in an Intensive Care Unit - each day of monitoring for each pressure up to a maximum of 4 pressures *(See para T1.7 of explanatory notes to this Category)* **Fee:** $49.30 **Benefit:** 75% = $37.00 85% = $41.95

* 13879	MECHANICAL VENTILATION, initiation of, by a specialist or consultant physician in conjunction with subsequent management of ventilatory support on the first day, in an Intensive Care Unit *(See para T1.7 of explanatory notes to this Category)* **Fee:** $157.70 **Benefit:** 75% = $118.30 85% = $134.05
* 13882	VENTILATORY SUPPORT in an Intensive Care Unit, management of, by a specialist or consultant physician - not being a service to which item 13879 applies - each day *(See para T1.7 of explanatory notes to this Category)* **Fee:** $53.60 **Benefit:** 75% = $40.20 85% = $45.60
* 13885	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, management by a specialist or consultant physician - on the first day in an Intensive Care Unit **Fee:** $97.05 **Benefit:** 75% = $72.80 85% = $82.50
* 13888	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, management by a specialist or consultant physician - on each day subsequent to the first day in an Intensive Care Unit **Fee:** $50.55 **Benefit:** 75% = $37.95 85% = $43.00
	GROUP T4 - OBSTETRICS
‡ + 16500	ANTENATAL CARE (not including any service or services to which item 16517 applies) where the attendances do not exceed 10 - each attendance **Fee:** $24.15 **Benefit:** 75% = $18.15 85% = $20.55
‡ + 16503	ANTENATAL CARE (not including any service or services to which item 16517 applies) where attendances exceed 10 **Fee:** $241.50 **Benefit:** 75% = $181.15 85% = $213.80
‡ 16507	CONFINEMENT AND POSTNATAL CARE for 9 days where the medical practitioner has not given the antenatal care **Fee:** $290.00 **Benefit:** 75% = $217.50 85% = $262.30
‡ 16517	ANTENATAL CARE, CONFINEMENT with delivery by any means (including Caesarean section) AND POSTNATAL CARE for 9 days **Fee:** $621.55 **Benefit:** 75% = $466.20 85% = $593.85
‡ 16552	CHORIONIC VILLUS SAMPLING using interventional imaging techniques **Fee:** $182.65 **Benefit:** 75% = $137.00 85% = $155.30
‡ 16558	VERSION, EXTERNAL, under general anaesthesia, not being a service to which items 16507 to 16517 apply (AU 6 - 17906) **Fee:** $45.25 **Benefit:** 75% = $33.95 85% = $38.50
‡ 16561	VERSION, INTERNAL, under general anaesthesia, not being a service to which items 16507 to 16517 apply (AU 6 - 17906) **Fee:** $81.00 **Benefit:** 75% = $60.75 85% = $68.85
	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 1 - GENERAL
† 30564	SMALL BOWEL STRICTUREPLASTY for chronic inflammatory bowel disease (AU 14 - 17914) **Fee:** $550.00 **Benefit:** 75% = $412.50 85% = $522.30
+ 30609	FEMORAL OR INGUINAL HERNIA, laparoscopic repair of, not being a service associated with a service to which item 30612 or 30614 applies (AU 8 - 17908) **Fee:** $330.75 **Benefit:** 75% = $248.10 85% = $303.05
	SUBGROUP 2 - COLORECTAL
* ‡ @ + 32025	RECTUM, LOW RESTORATIVE ANTERIOR RESECTION WITH EXTRAPERITONEAL ANASTOMOSIS (of the rectum) less than 10 centimetres from the anal verge, with or without covering stoma (AU 27 - 17927) **Fee:** $1,300.00 **Benefit:** 75% = $975.00 85% =$1,272.30

† 32026	RECTUM, ULTRA LOW RESTORATIVE RESECTION, with or without covering stoma, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge (AU 30 - 17930) **Fee:** $1,400.00 **Benefit:** 75% =$1,050.00 85% =$1,372.30
* ‡ @ + 32028	RECTUM, LOW OR ULTRA LOW RESTORATIVE RESECTION, with peranal sutured coloanal anastomosis, with or without covering stoma (AU 34 - 17934) **Fee:** $1,500.00 **Benefit:** 75% =$1,125.00 85% =$1,472.30
† 32029	COLONIC RESERVOIR, construction of, being a service associated with a service to which any other item in this Subgroup applies (AU 20 - 17920) **Fee:** $300.00 **Benefit:** 75% = $225.00 85% = $272.30
† 32112	RECTAL PROLAPSE, perineal recto-sigmoidectomy for (AU 17 - 17917) **Fee:** $550.00 **Benefit:** 75% = $412.50 85% = $522.30
‡ 32117	RECTAL PROLAPSE, abdominal rectopexy of (AU 13 - 17913) **Fee:** $711.95 **Benefit:** 75% = $534.00 85% = $684.25
† 32131	RECTOCELE, perineal repair of (AU 13-17913) **Fee:** $380.00 **Benefit:** 75% = $285.00 85% = $352.30
‡ 32168	FISTULA WOUND, review of, under general or regional anaesthetic, as an independent procedure (AU 7 - 17907) **Fee:** $93.80 **Benefit:** 75% = $70.35 85% = $79.75
@ + 32183	INTESTINAL SLING PROCEDURE prior to radiotherapy (AU 19 - 17919) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $372.30
@ + 32186	COLONIC LAVAGE, total, intra operative (AU 19 - 17919) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $372.30
	SUBGROUP 3 - VASCULAR
‡ 32500	**VARICOSE VEINS** VARICOSE VEINS, (excluding telangiectases, starburst vessels, spider nevi or similar), multiple injections using continuous compression techniques including associated consultation - 1 or both legs - not being a service associated with any other varicose veins operation on the same leg (excluding after-care) **Fee:** $99.60 **Benefit:** 75% = $74.70 85% = $84.70
† 35012	SACRAL or PRE-SACRAL SYMPATHECTOMY (AU 11 - 17911) **Fee:** $503.45 **Benefit:** 75% = $377.60 85% = $475.75
	SUBGROUP 4 - GYNAECOLOGICAL
‡ @ + 35567	VAGINAL REPAIR including 1 or more of anterior, posterior or entrocele repair, with sacrospinous colpopexy (AU 14 - 17914) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $472.30
* 35619	CERVIX, dilatation of, under general anaesthesia, not being a service to which item 35639, 35640 or 35643 applies (AU 7 - 17907) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $57.90 **Benefit:** 75% = $43.45 85% = $49.25
* 35620	ENDOMETRIAL BIOPSY where malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (AU 5 - 17905) **Fee:** $37.95 **Benefit:** 75% = $28.50 85% = $32.30

* @ 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 (AU 12 - 17912) **Fee:** $429.20 **Benefit:** 75% = $321.90 85% = $401.50
† 35623	HYSTEROSCOPIC RESECTION of myoma or uterine septum followed by endometrial ablation by laser or diathermy (AU 15 - 17915) **Fee:** $583.45 **Benefit:** 75% = $437.60 85% = $555.75
‡ 35636	HYSTEROSCOPY AND LAPAROSCOPY where performed, under general anaesthesia involving either myomectomy or resection of uterine septum or both (AU 10 - 17910) **Fee:** $308.50 **Benefit:** 75% = $231.40 85% = $280.80
‡ @ 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, division of adhesions 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 procedure (AU 14 - 17914) **Fee:** $506.80 **Benefit:** 75% = $380.10 85% = $479.10
	SUBGROUP 5 - UROLOGICAL
‡ 36624	NEPHROSTOMY, percutaneous, using interventional imaging techniques (AU 9 - 17909) **Fee:** $397.50 **Benefit:** 75% = $298.15 85% = $369.80
† 37219	PROSTATE, transrectal needle biopsy of, using transrectal prostatic ultrasound techniques and obtaining 1 or more prostatic specimens, being a service associated with a service to which item 55300 or 55303 applies (AU 6 - 17906) **Fee:** $200.00 **Benefit:** 75% = $150.00 85% = $172.30
	SUBGROUP 7 - NEUROSURGICAL
‡ 40803	INTRACRANIAL STEREOTACTIC PROCEDURE BY ANY METHOD, not being a service to which item 40800 or 40801 applies (AU 17 - 17917) **Fee:** $851.60 **Benefit:** 75% = $638.70 85% = $823.90
	SUBGROUP 8 - EAR, NOSE AND THROAT
† 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 (AU 12 - 17912) **Fee:** $776.30 **Benefit:** 75% = $582.25 85% = $748.60
+ 41883	TRACHEOSTOMY (AU 10 - 17910) **Fee:** $181.00 **Benefit:** 75% = $135.75 85% = $153.85
	SUBGROUP 9 - OPHTHALMOLOGY
† 42510	EYE, enucleation of, with insertion of hydroxy atatite implant (coral implant), by 1 or more stages (AU 13 - 17913) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $472.30
‡ 42587	TRICHIASIS, treatment of by cryotherapy, laser or electrolysis - each eyelid (AU 6 - 17906) **Fee:** $36.95 **Benefit:** 75% = $27.75 85% = $31.45
† 42610	NASOLACRIMAL TUBE (unilateral) replacement of, or lacrimal passages, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (AU 4 - 17904) **Fee:** $68.50 **Benefit:** 75% = $51.40 85% = $58.25

‡ @ 42611	NASOLACRIMAL TUBE (bilateral) replacement of, or lacrimal passages, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (AU 5 - 17905) **Fee:** $102.85 **Benefit:** 75% = $77.15 85% = $87.45
‡ 42614	NASOLACRIMAL TUBE (unilateral) replacement of, or lacrimal passages, probing for obstruction, unilateral, with or without lavage, not being a service associated with a service to which item 42610 applies (excluding after-care) **Fee:** $34.30 **Benefit:** 75% = $25.75 85% = $29.20
† 42615	NASOLACRIMAL TUBE (bilateral) replacement of, or lacrimal passages, probing for obstruction, bilateral, with or without lavage, not being a service associated with a service to which item 42611 applies (excluding after-care) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
	SUBGROUP 15 - ORTHOPAEDIC
‡ 47531	FEMUR, treatment of fracture of shaft, by intramedullary fixation and cross fixation (AU 15 - 17915) **Fee:** $683.95 **Benefit:** 75% = $513.00 85% = $656.25
† 47565	TIBIA, shaft of, treatment of fracture of, by internal fixation or external fixation (AU 14 - 17914) **Fee:** $507.30 **Benefit:** 75% = $380.50 85% = $479.60
† 47566	TIBIA, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (AU 15 - 17915) **Fee:** $646.80 **Benefit:** 75% = $485.10 85% = $619.10
† 49346	HIP, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (AU 15 - 17915) **Fee:** $603.50 **Benefit:** 75% = $452.65 85% = $575.80
† 49360	HIP, diagnostic arthroscopy of (AU 9 - 17909) **Fee:** $245.00 **Benefit:** 75% = $183.75 85% = $217.30
† 49363	HIP, diagnostic arthroscopy of, with synovial biopsy (AU 10 - 17910) **Fee:** $295.00 **Benefit:** 75% = $221.25 85% = $267.30
† 49366	HIP, arthroscopic surgery of (AU 12 - 17912) **Fee:** $435.85 **Benefit:** 75% = $326.90 85% = $408.15
† 49569	KNEE, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (AU 14 - 17914) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75

Supplement to Medicare Benefits Schedule Book of 1 November 1993
Effective 1 May 1994