Commonwealth Department of
Health and
Aged Care

Supplement to Medicare Benefits Schedule book of

1 November 1998

EFFECTIVE 1 MARCH 1999

Supplement to

MEDICARE BENEFITS SCHEDULE BOOK

OF 1 NOVEMBER 1998

EFFECTIVE 1 MARCH 1999

COMMONWEALTH DEPARTMENT OF HEALTH AND AGED CARE

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SUPPLEMENT TO 1 NOVEMBER 1998 MEDICARE BENEFITS SCHEDULE BOOK

AMENDMENTS EFFECTIVE 1 MARCH 1999

This supplement provides details of changes to the 1 November 1998 edition of the Medicare Benefits Schedule book. Any item not included in the summary of changes listed herein remains as it is shown in the 1 November 1998 Schedule book.

At the time of printing, the relevant legislation giving authority for the changes included herein may still be subject to the approval of Executive Council and the usual Parliamentary scrutiny.

SAFETY NET

The Medicare "safety net" increased to $280.30 with effect from 1 January 1999 (see para 1.1 of General Explanatory Notes to the 1 November 1998 Medicare Benefits Schedule book for details of the safety net).

MEDICAL RECORDS

There is widespread agreement within the medical profession that adequate and contemporaneous medical records are essential to the provision of quality care and to ensure continuity of care. Such medical records provide a level of accountability for the type of service rendered for which a Medicare benefit becomes payable.

Consequently, the government intends to legislate to make adequate and contemporaneous medical records for all services mandatory for Medicare benefit purposes from 1 November 1999.

Discussions with the profession will occur before a decision is taken on the exact form of this requirement.

IDENTIFICATION OF PRE-ADMISSION, POST-DISCHARGE AND OUTPATIENT SERVICES FOR BILLING PURPOSES

There is no longer a requirement for practitioners to identify hospital related services when billing for Medicare benefits purposes. Previously all pre-admission, post-discharge and outpatient type services were required to be identified by the inclusion of the letter "A" on patient accounts, receipts and requests for pathology and diagnostic imaging, and by the use of form DB1C when direct billing Medicare.

INCREASE IN FEES FOR GENERAL PRACTITIONER ATTENDANCES

Medicare Benefits Schedule fees for attendances by general practitioners increase by 0.75% from 1 March 1999. This is the second stage of the implementation of the 1998-99 Budget commitment to increase Medicare fees for GP attendances, and is additional to the full indexation of 1.5% applied from 1 November 1998.

The increase has been applied to Items 1 to 51, 193, 195, 601, 602, 16500 to 16509, 30003 and 41704.

CHANGES TO FEES FOR RADIATION ONCOLOGY

Increased fees for Megavoltage (Items 15203 to 15214) and Computerised Planning (Items 15500 to 15533) effective from 1 January 1999 are included in this Supplement.

REVIEW OF GENERAL MEDICAL SERVICES

The changes involve the following areas of the Schedule:-

- **Investigation of sleep apnoea** - items amended to specify the provision of the service by a "qualified sleep medicine practitioner" - (see explanatory note below).
- **Chemotherapeutic procedures** - items in Subgroup 11 of Group T1 amended to clarify that these items relate to services for the treatment of cancer.
- **Gastric banding for the treatment of obesity** - new items for (i) accessing and changing of fluids in implanted reservoirs associated with the adjustable gastric band (Item 14215), and (ii) repair, replacement or revision of the implanted reservoir (Item 31441).
- **Implanted devices for delivery of therapeutic agents** - new items to cover accessing and loading of implanted drug delivery devices other than for cytotoxic chemotherapy (Items 14218, 14221).
- **Electroconvulsive therapy** - service transferred from the Attendances area to Miscellaneous Therapeutic Procedures (Item 14224).
- **Vascular surgery** - amendment to items covering patch grafting (Items 33545, 33548) to allow the items to be claimed in association with other vascular procedures.
- **Tracheostomy** - new item (Item 41880) for percutaneous tracheostomy (transfer from Ministerial Determination effective from 23 November 1998) and amendment to the items covering open tracheostomy (Item 41881) and cricothyrostomy (Item 41884).
- **Plastic and Reconstructive surgery** - amendments to Items 45021 and 45024 covering abrasive therapy to limit their use to specific conditions, and a restructure of items covering microvascular anastomosis of blood vessels (Items 45501 to 45505) and skin flap surgery (Items 45562 and 45563).
- **Ultrasonic echography of orbital contents** - service transferred from Diagnostic Imaging Services area to General Medical Services (Item 11240)

Overnight investigation of sleep apnoea (Items 12203, 12207)

The payment of benefits for sleep studies (Items 12203 and 12207) has been limited to services provided by "qualified sleep medicine practitioners". This change has been made following consultation with the Australian Medical Association, the Thoracic Society of Australia and New Zealand and the Australasian Sleep Association. The change ensures appropriate standards in the delivery of sleep studies and will improve patient outcomes by ensuring practitioners providing sleep services have appropriate training and clinical experience in sleep medicine to be competent in independent clinical assessment and management of patients with respiratory sleep disorders and in reporting sleep studies.

Practitioners wishing to attract Medicare benefits for sleep studies will need to complete either Level I or Level II of the Advanced Training programs in Sleep Medicine supervised by the Specialist Advisory Committee in Thoracic and Sleep Medicine of the Royal Australasian College of Physicians. Upon completion of either of the Advanced Training Programs practitioners should provide the Health Insurance Commission with a copy of the certificate of completion issued jointly by the Thoracic Society of Australia and New Zealand and the Australasian Sleep Association. Further details of the Advanced Training Programs are available from the Royal Australasian College of Physicians.

Other practitioners, such as those who have undertaken sleep medicine training overseas, may be recognised as "qualified sleep medicine practitioners" where the Specialist Advisory Committee in Thoracic and Sleep Medicine of the Royal Australasian College of Physicians recognises, in writing, that the person has training equivalent to either Level I or Level II of the Advanced Training Programs in Sleep Medicine.

The need for transitional arrangements was recognised so that practitioners already providing sleep studies were not automatically excluded from attracting Medicare benefits for their services, nor that they be required to undertake one of the Advanced Training Programs if their training and clinical experience is sufficient. An assessment scheme was developed in consultation with the Australian Medical Association, the Thoracic Society of Australia and New Zealand and the Australasian Sleep Association to ensure that the training and clinical experience of those practitioners was sufficient to be recognised as a "qualified sleep medicine practitioner". Information on the application and assessment process is available from the Honorary Secretary, the Thoracic Society of Australia and New Zealand on (02) 9256 5457.

Amend Note for Guidance D1.14

D1.14.1 A "qualified sleep medicine practitioner" as described in Items 12203 and 12207 means:

For practitioners providing sleep studies before 1 March 1999:

(a) a person who, before 1 March 1999, has been assessed by the Credentialling Subcommittee (the Credentialling Subcommittee) of the Specialist Advisory Committee in Thoracic and Sleep Medicine of the Royal Australasian College of Physicians as having sufficient training and experience in sleep medicine to be competent in independent clinical assessment and management of patients with respiratory sleep disorders and in reporting sleep studies; or

(b) a person who, before 1 March 1999, has been assessed by the Credentialling Subcommittee as having substantial training or experience in sleep medicine but as requiring further specified training or experience in sleep medicine to be competent in independent clinical assessment and management of patients with respiratory sleep disorders and in reporting sleep studies. This will apply for two years after the assessment; or

(c) a person mentioned in paragraph (b) who has finished the training or gained the experience specified for that person that has been verified by the Credentialling Subcommittee; OR

For practitioners who commence providing sleep studies after 1 March 1999:

(d) a person who, after completing at least 12 months' core training, including clinical practice in sleep medicine and in reporting sleep studies, has attained Level I or Level II of the Advanced Training program in Sleep Medicine of the Thoracic Society of Australia and New Zealand and the Australasian Sleep Association; or

(e) a person whom the Specialist Advisory Committee in Thoracic and Sleep Medicine of the Royal Australasian College of Physicians has recognised, in writing, as having training equivalent to the training mentioned in (d) above.

DIAGNOSTIC IMAGING SERVICES (EFFECTIVE 1 MARCH 1999)

NOTES FOR GUIDANCE

Capital Sensitive Computed Tomography (CT) Items

From 1 March 1999, a reduced Schedule fee will apply 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 CT equipment, must have been first manufactured ten or more years ago.

A range of additional items has been introduced to cover services provided on older equipment.

New items are: 56041, 56047, 56050, 56053, 56056, 56059, 56062, 56068, 56141, 56147, 56250, 56256, 56259, 56341, 56347, 56441, 56447, 56449, 56452, 56541, 56547, 56659, 56665, 56841, 56847, 57041, 57047, 57247, 57345 and 57355.

These items are identified by the addition of the letter '(NK)' at the end of the item. These items should be used where services are performed on equipment ten years old or older, except where equipment is located in a remote area when items with the letter "K", as described below, will apply.

Remote areas include all areas in Australia which are more than 30 kilometres by road from a hospital or a free standing radiology facility which provides a radiology or CT service under the direction of a specialist in the specialty of diagnostic radiology.

Existing items have been amended to add the letter '(K)' at the end of the item. These items 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) gantry;
(b) couch;
(c) computer; and
(d) operator station.

Professional supervision for computed tomography (CT) and mammography services

From 1 March 1999, a professional supervision requirement has been introduced for CT and mammography services.

CT or mammography services are not eligible for a Medicare rebate unless the service is performed under the professional supervision of a specialist in the specialty of diagnostic radiology who is available to monitor and influence the conduct and diagnostic quality of the examination, and including, if necessary, personal attendance on the patient.

Services that are performed in an emergency, or because of medical necessity in a remote location, are exempt from this requirement. For the purposes of professional supervision for CT and mammography, remote areas include all areas in Australia which are more than 30 kilometres by road from either a hospital or a free-standing radiology facility which provides a CT or mammography service under the direction of a specialist in the specialty of diagnostic radiology.

Computed tomography (CT) Scans of Chest and Abdomen (Items 56301, 56307, 56801, 56807, 57001, 57007, 56341. 56347. 56841, 56847, 57041, and 57047)

Items for CT of the chest and abdomen have been amended to exclude scanning for coronary artery calcification until the effectiveness of this new clinical indication has been established.

Ultrasonic Echography of Orbital Contents (Transfer of Item 55055 to Item 11240)

This service has been transferred to the General Medical Services Table into Group D1 - Miscellaneous Diagnostic Procedures and Investigations, Subgroup 2 - Ophthalmology (Item 11240), as it is not an imaging service.

PATHOLOGY SERVICES (EFFECTIVE 1 MARCH 1999)

HIV viral RNA load items

A new HIV viral RNA load item (69382) has been introduced for the quantitation of HIV viral RNA load in cerebrospinal fluid for HIV positive patients with nervous system involvement. This is in recognition that these patients have specific needs and require more testing than currently provided by the existing HIV viral RNA load items. As a consequence of this new item, reference to 'cerebrospinal fluid' has been removed from existing HIV items 69378 and 69381. Rule 20 does not apply to new item 69382.

The two existing HIV viral RNA load items (69378 and 69381) have been amended by increasing the number of episodes allowed under each item in a 12 month period from six to seven. This is in line with the current standard of care guidelines for HIV patients on antiretroviral therapy. As a consequence of this change, Rule 20, which restricts the maximum number of episodes claimable for items 69378 and 69381 to six in a 12 month period, has been changed to seven.

Red cell folate, B12 and serum folate items

The two existing folate items (66599 and 66602) have been changed to reflect current practice in patient management. The changes emphasise the clinical relevance of the test for red cell folate over the test for serum folate but provides an option for the test for serum folate if the requesting practitioner or pathology laboratory considers this necessary in the interpretation of a patient's folate status. A Medicare rebate is no longer payable for serum folate requested on its own. The changes also remove any ambiguity that existed in a request for folate under the previous item structure.

A new rule (Rule 23) has been introduced to apply to the two amended folate items. The rule specifies that no more than a maximum of 3 episodes can be claimed in a 12 month period for both items and that Medicare benefits are not payable to item 66599 when claimed in conjunction with item 66602.

Change to microbiology item 69375 (Herpes simplex etc)

Item 69375 has been changed to remove ambiguity in the wording of the item descriptor in relation to the number of cultures that have to be performed for a Medicare benefit to be payable. Furthermore, a reference to item 69315 has been removed from the item descriptor to remove an anomaly from the 1 November 1998 changes.

Amended Rule 20 and New Rule 23

HIV viral RNA load testing

20. For items 69378 and 69381, no more than a maximum of 7 episodes for either item 69378 or item 69381, or any combination for both items, can be claimed in a 12 month period.

Serum B12 and red cell folate testing

23. For items 66599 and 66602

(1) A Medicare benefit is not payable for more than 3 episodes of services described in item 66599 or 66602, or any combination of those items, in a 12 month period.

(2) This rule does not authorise payment of a Medicare benefit for a service described in item 66599 if that service was provided as part of the same patient episode as a service described in item 66602.

Other Pathology changes

A test for the quantitation of total free fatty acids is available under item 66752 (effective 1 November 1998).

The new and amended items and rules were developed in co-operation with the Australian Association of Pathology Practices and the Royal College of Pathologists of Australasia.

SUMMARY OF CHANGES

The 1 March 1999 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following symbols appearing above the item number:-

(a)	new item	†
(b)	description amended	‡
(c)	fee amended	+
(d)	anaesthetics amended	@
(e)	item number change	*
(f)	addition/deletion (Assist.)	A
(g)	new item (previous Ministerial Determination)	▲

New Items

11240	14215	14218	14221	14224	31441	41880	45501	45504	45505	45562	56041
56047	56050	56053	56056	56059	56062	56068	56141	56147	56250	56256	56259
56341	56347	56441	56447	56449	56452	56541	56547	56659	56665	56841	56847
57041	57047	57247	57345	57355	69382						

Ceased Items

340	41880	41883	55055

Amended Descriptions

11240	12203	12207	13915	13918	13921	13924	13927	13930	13933	13936	13939
13942	13945	14224	33545	33548	41881	41884	45021	45024	45502	45563	56001
56007	56010	56013	56016	56019	56022	56028	56101	56107	56210	56216	56219
56301	56307	56401	56407	56409	56412	56501	56507	56619	56625	56801	56807
57001	57007	57201	57341	57350	59503	66599	66602	69375	69378	69381	

Amended Fees

1	2	3	4	13	19	20	23	24	25	33	35
36	37	38	40	43	44	47	48	50	51	193	195
601	602	15203	15204	15207	15208	15211	15214	15500	15503	15506	15509
15512	15515	15518	15521	15524	15527	15530	15533	16500	16502	16504	16505
16508	16509	30003	41704								

Item Number Change

Old	New	Old	New
55055	11240	340	14224

(Assist.) added to Item

38270

SPECIAL ARRANGEMENTS - TRANSITIONAL PERIOD

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

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 March 1999 and continues beyond that date, the old (1 November 1998) item, fee and benefit levels will apply. In any other case the date the service is rendered will determine which item and fee is applicable.

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

	LEVEL A			LEVEL B		
	FEE	BENEFITS		FEE	BENEFITS	
PATIENTS		85%	75%		85%	75%
ONE	29.90	25.45	22.45	43.15	36.70	32.40
TWO	20.95	17.85	15.75	34.20	29.10	25.65
THREE	18.00	15.30	13.50	31.25	26.60	23.45
FOUR	16.50	14.05	12.40	29.75	25.30	22.35
FIVE	15.60	13.30	11.70	28.85	24.55	21.65
SIX	15.00	12.75	11.25	28.25	24.05	21.20
SEVEN+	13.15	11.20	9.90	26.40	22.45	19.80

	LEVEL C			LEVEL D		
	FEE	BENEFITS		FEE	BENEFITS	
PATIENTS		85%	75%		85%	75%
ONE	63.55	54.05	47.70	85.15	72.40	63.90
TWO	54.60	46.45	40.95	76.20	64.80	57.15
THREE	51.65	43.95	38.75	73.25	62.30	54.95
FOUR	50.15	42.65	37.65	71.75	61.00	53.85
FIVE	49.25	41.90	36.95	70.85	60.25	53.15
SIX	48.65	41.40	36.50	70.25	59.75	52.70
SEVEN+	46.80	39.80	35.10	68.40	58.15	51.30

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

	BRIEF			STANDARD		
	FEE	BENEFITS		FEE	BENEFITS	
PATIENTS		85%	75%		85%	75%
ONE	24.00	20.40	18.00	33.50	28.50	25.15
TWO	16.25	13.85	12.20	24.75	21.05	18.60
THREE	13.70	11.65	10.30	21.85	18.60	16.40
FOUR	12.40	10.55	9.30	20.40	17.35	15.30
FIVE	11.60	9.90	8.70	19.50	16.60	14.65
SIX	11.10	9.45	8.35	18.95	16.15	14.25
SEVEN+	9.20	7.85	6.90	16.70	14.20	12.55

	LONG			PROLONGED		
	FEE	BENEFITS		FEE	BENEFITS	
PATIENTS		85%	75%		85%	75%
ONE	51.00	43.35	38.25	73.00	62.05	54.75
TWO	43.25	36.80	32.45	65.25	55.50	48.95
THREE	40.70	34.60	30.55	62.70	53.30	47.05
FOUR	39.40	33.50	29.55	61.40	52.20	46.05
FIVE	38.60	32.85	28.95	60.60	51.55	45.45
SIX	38.10	32.40	28.60	60.10	51.10	45.10
SEVEN+	36.20	30.80	27.15	58.20	49.50	43.65

	GROUP A1 - GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
+ 1	**EMERGENCY ATTENDANCE - AFTER HOURS** **(on not more than 1 patient on 1 occasion)** Professional attendance **AT A PLACE OTHER THAN CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance ***other than an attendance between 11pm and 7am***, on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday *(See para A.10 and A.5 of explanatory notes to this* Category) **Fee:** $55.65 **Benefit:** 75% = $41.75 85% = $47.35
+ 2	Professional attendance **AT CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance ***other than an attendance between 11pm and 7am***, on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday *(See para A.10 of explanatory notes to this Category)* **Fee:** $55.65 **Benefit:** 75% = $41.75 85% = $47.35
+ 601	Professional attendance, at a place **OTHER THAN CONSULTING ROOMS**, where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance on any day of the week ***between 11pm and 7am*** *(See para A.10 and A.5 of explanatory notes to this* Category) **Fee:** $66.55 **Benefit:** 75% = $49.95 85% = $56.60
+ 602	Professional attendance, **AT CONSULTING ROOMS**, where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance on any day of the week between ***11pm and 7am*** *(See para A.10 and A.5 of explanatory notes to this* Category) **Fee:** $66.55 **Benefit:** 75% = $49.95 85% = $56.60
+ 3	**GENERAL PRACTITIONER ATTENDANCES** **LEVEL 'A'** Professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.5 of explanatory notes to this Category)* **Fee:** $12.00 **Benefit:** 75% = $9.00 85% = $10.20
+ 4	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, nursing home or institution) **Derived Fee:** The fee for item 3, plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 3 plus $1.15 per patient
+ 13	**CONSULTATION AT AN INSTITUTION - OTHER THAN A HOSPITAL OR NURSING HOME** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) - each patient *(See para A.5 and A.6 of explanatory notes to this* Category) **Derived Fee:** The fee for item 3, plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 3 plus $1.15 per patient

Item	Description
+ 19	**CONSULTATION AT A HOSPITAL** (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) - each patient *(See para A.5 and A.7 of explanatory notes to this* Category) **Derived Fee:** The fee for item 3, plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 3 plus $1.15 per patient
+ 20	**CONSULTATION AT A NURSING HOME** (Professional attendance on 1 or more patients in 1 nursing home including aged persons' accommodation attached to a nursing home or aged persons' accommodation situated within a complex that includes a nursing home (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 nursing home or aged persons' accommodation (excluding accommodation in a self-contained unit) on 1 occasion) - each patient *(See para A.5 and A.8 of explanatory notes to this* Category) **Derived Fee:** The fee for item 3, plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 3 plus $1.15 per patient
+ 23	**LEVEL 'B'** Professional attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.5 of explanatory notes to this Category)* **Fee:** $25.25 **Benefit:** 75% = $18.95 85% = $21.50
+ 24	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, nursing home or institution) **Derived Fee:** The fee for item 23, plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 23 plus $1.15 per patient
+ 25	**CONSULTATION AT AN INSTITUTION - OTHER THAN A HOSPITAL OR NURSING HOME** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) - each patient *(See para A.5 and A.6 of explanatory notes to this* Category) **Derived Fee:** The fee for item 23, plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 23 plus $1.15 per patient
+ 33	**CONSULTATION AT A HOSPITAL** (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) - each patient *(See para A.5 and A.7 of explanatory notes to this* Category) **Derived Fee:** The fee for item 23, plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 23 plus $1.15 per patient
+ 35	**CONSULTATION AT A NURSING HOME** (Professional attendance on 1 or more patients in 1 nursing home including aged persons' accommodation attached to a nursing home or aged persons' accommodation situated within a complex that includes a nursing home (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 nursing home or aged persons' accommodation (excluding accommodation in a self-contained unit) on 1 occasion) - each patient *(See para A.5 and A.8 of explanatory notes to this* Category) **Derived Fee:** The fee for item 23, plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 23 plus $1.15 per patient

Item	Description
+	**LEVEL 'C'** Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.5 of explanatory notes to this Category)*
36	**Fee:** $45.65 **Benefit:** 75% = $34.25 85% = $38.85
+	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, nursing home or institution)
37	**Derived Fee:** The fee for item 36, plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 36 plus $1.15 per patient
+	**CONSULTATION AT AN INSTITUTION - OTHER THAN A HOSPITAL OR NURSING HOME** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) - each patient *(See para A.5 and A.6 of explanatory notes to this* Category)
38	**Derived Fee:** The fee for item 36, plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 36 plus $1.15 per patient
+	**CONSULTATION AT A HOSPITAL** (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) - each patient *(See para A.5 and A.7 of explanatory notes to this* Category)
40	**Derived Fee:** The fee for item 36, plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 36 plus $1.15 per patient
+	**CONSULTATION AT A NURSING HOME** (Professional attendance on 1 or more patients in 1 nursing home including aged persons' accommodation attached to a nursing home or aged persons' accommodation situated within a complex that includes a nursing home (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 nursing home or aged persons' accommodation (excluding accommodation in a self-contained unit) on 1 occasion) - each patient *(See para A.5 and A.8 of explanatory notes to this* Category)
43	**Derived Fee:** The fee for item 36, plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 36 plus $1.15 per patient
+	**LEVEL 'D'** Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.5 of explanatory notes to this Category)*
44	**Fee:** $67.25 **Benefit:** 75% = $50.45 85% = $57.20
+	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, nursing home or institution)
47	**Derived Fee:** The fee for item 44, plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 44 plus $1.15 per patient
+	**CONSULTATION AT AN INSTITUTION - OTHER THAN A HOSPITAL OR NURSING HOME** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) - each patient *(See para A.5 and A.6 of explanatory notes to this* Category)
48	**Derived Fee:** The fee for item 44, plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 44 plus $1.15 per patient

+ 50	**CONSULTATION AT A HOSPITAL** (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) - each patient *(See para A.5 and A.7 of explanatory notes to this* Category) **Derived Fee:** The fee for item 44, plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 44 plus $1.15 per patient
+ 51	**CONSULTATION AT A NURSING HOME** (Professional attendance on 1 or more patients in 1 nursing home including aged persons' accommodation attached to a nursing home or aged persons' accommodation situated within a complex that includes a nursing home (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 nursing home or aged persons' accommodation (excluding accommodation in a self-contained unit) on 1 occasion) - each patient *(See para A.5 and A.8 of explanatory notes to this* Category) **Derived Fee:** The fee for item 44, plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 44 plus $1.15 per patient
	GROUP A7 - ACUPUNCTURE
+ 193	Professional attendance by a general practitioner **at a place other than a hospital**, involving either: (i) taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems; **OR** (ii) a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies AND at which ACUPUNCTURE is performed by the medical practitioner by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed *(See para A.14 of explanatory notes to this Category)* **Fee:** $25.25 **Benefit:** 75% = $18.95 85% = $21.50
+ 195	Professional attendance by a general practitioner **on 1 or more patients at a hospital**, on one occasion, involving either: (i) taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems; **OR** (ii) a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies AND at which ACUPUNCTURE is performed by the medical practitioner by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed *(See para A.14 of explanatory notes to this Category)* **Derived Fee:** The fee for item193 plus $17.90 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 193 plus $1.15 per patient
	GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
	SUBGROUP 2 - OPHTHALMOLOGY
* ‡ 11240	ORBITAL CONTENTS, ultrasonic echography of, unidimensional, not being a service associated with a service to which items in Group I1 apply **Fee:** $61.70 **Benefit:** 75% = $46.30 85% = $52.45

SUBGROUP 10 - OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

‡

OVERNIGHT INVESTIGATION FOR SLEEP APNOEA FOR A PERIOD OF AT LEAST 8 HOURS DURATION 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 the supervising medical 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 the supervising medical 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 D1.14 of explanatory notes to this Category)

12203 **Fee:** $450.10 **Benefit:** 75% = $337.60 85% = $399.70

‡

OVERNIGHT INVESTIGATION FOR SLEEP APNOEA FOR A PERIOD OF AT LEAST 8 HOURS DURATION, 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 the supervising medical 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 the supervising medical 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 D1.14 of explanatory notes to this Category)

12207 **Fee:** $450.10 **Benefit:** 75% = $337.60 85% = $399.70

GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES

SUBGROUP 11 - CHEMOTHERAPEUTIC PROCEDURES

‡

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

13915 **Fee:** $49.30 **Benefit:** 75% = $37.00 85% = $41.95

‡

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

13918 **Fee:** $74.20 **Benefit:** 75% = $55.65 85% = $63.10

‡

CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - for the first day of treatment

13921 **Fee:** $83.95 **Benefit:** 75% = $63.00 85% = $71.40

‡

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

13924 **Fee:** $49.50 **Benefit:** 75% = $37.15 85% = $42.10

‡ 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:** $64.00 **Benefit:** 75% = $48.00 85% = $54.40
‡ 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:** $89.25 **Benefit:** 75% = $66.95 85% = $75.90
‡ 13933	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
‡ 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:** $64.50 **Benefit:** 75% = $48.40 85% = $54.85
‡ 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 or 13936 applies *(See para T1.10 of explanatory notes to this Category)* **Fee:** $74.20 **Benefit:** 75% = $55.65 85% = $63.10
‡ 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 or 13936 applies **Fee:** $49.50 **Benefit:** 75% = $37.15 85% = $42.10
‡ 13945	LONG-TERM IMPLANTED DRUG DELIVERY DEVICE FOR CYTOTOXIC CHEMOTHERAPY, accessing of **Fee:** $39.80 **Benefit:** 75% = $29.85 85% = $33.85
	SUBGROUP 13 - OTHER THERAPEUTIC PROCEDURES
† 14215	LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, accessing of to add or remove fluid **Fee:** $74.20 **Benefit:** 75% = $55.65 85% = $63.10
† 14218	IMPLANTED PUMP OR RESERVOIR, loading of, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space **Fee:** $74.20 **Benefit:** 75% = $55.65 85% = $63.10
† 14221	LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of, not being a service associated with a service to which item 13945 applies **Fee:** $39.80 **Benefit:** 75% = $29.85 85% = $33.85
	ELECTROCONVULSIVE THERAPY
* ‡ 14224	ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes. 17705 = 4B + 1T) **Fee:** $53.25 **Benefit:** 75% = $39.95 85% = $45.30
	GROUP T2 - RADIATION ONCOLOGY
	SUBGROUP 3 - MEGAVOLTAGE
+ 15203	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator - with or without electron facilities - each attendance at which treatment is given - 1 field **Fee:** $45.20 **Benefit:** 75% = $33.90 85% = $38.45
+ 15204	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15203 plus for each field in excess of 1, an amount of $28.75

+ 15207	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of 10 MV photons or greater, with electron facilities - each attendance at which treatment is given - 1 field **Fee:** $45.20 **Benefit:** 75% = $33.90 85% = $38.45
+ 15208	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15207 plus for each field in excess of 1, an amount of $28.75
+ 15211	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit - each attendance at which treatment is given - 1 field **Fee:** $41.45 **Benefit:** 75% = $31.10 85% = $35.25
+ 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 $24.15
	GROUP T2 - RADIATION ONCOLOGY
	SUBGROUP 5 - COMPUTERISED PLANNING
+ 15500	**RADIOTHERAPY PLANNING** RADIATION FIELD SETTING using a simulator or isocentric x-ray or megavoltage machine 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) **Fee:** $184.00 **Benefit:** 75% = $138.00 85% = $156.40
+ 15503	RADIATION FIELD SETTING using a simulator or isocentric x-ray or megavoltage machine 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) **Fee:** $236.15 **Benefit:** 75% = $177.15 85% = $200.75
+ 15506	RADIATION FIELD SETTING using a simulator or isocentric x-ray or megavoltage machine 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 off-axis fields or several joined fields (not being a service associated with a service to which item 15515 applies) **Fee:** $352.65 **Benefit:** 75% = $264.50 85% = $302.25
+ 15509	RADIATION FIELD SETTING using a diagnostic x-ray 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) **Fee:** $159.50 **Benefit:** 75% = $119.65 85% = $135.60
+ 15512	RADIATION FIELD SETTING using a diagnostic x-ray 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) **Fee:** $205.45 **Benefit:** 75% = $154.10 85% = $174.65
+ 15515	RADIATION FIELD SETTING using a diagnostic x-ray 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 off-axis fields or several joined fields (not being a service associated with a service to which item 15506 applies) **Fee:** $297.50 **Benefit:** 75% = $223.15 85% = $252.90
+ 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 **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
+ 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 **Fee:** $257.60 **Benefit:** 75% = $193.20 85% = $219.00
+ 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 off-axis fields, or several joined fields **Fee:** $483.05 **Benefit:** 75% = $362.30 85% = $432.65
+ 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 **Fee:** $59.75 **Benefit:** 75% = $44.85 85% = $50.80

+ 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 **Fee:** $266.85 **Benefit:** 75% = $200.15 85% = $226.85
+ 15533	RADIATION DOSIMETRY by a non-CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields, or tangential fields or irregularly shaped fields using multiple blocks, or off-axis fields, or several joined fields **Fee:** $506.05 **Benefit:** 75% = $379.55 85% = $455.65
	GROUP T4 - OBSTETRICS
+ 16500	**ANTENATAL CARE** ANTENATAL ATTENDANCE *(See para T4.1 of explanatory notes to this Category)* **Fee:** $25.25 **Benefit:** 75% = $18.95 85% = $21.50
+ 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:** $25.25 **Benefit:** 75% = $18.95 85% = $21.50
+ 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:** $25.25 **Benefit:** 75% = $18.95 85% = $21.50
+ 16505	THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of - each attendance that is not a routine antenatal attendance **Fee:** $25.25 **Benefit:** 75% = $18.95 85% = $21.50
+ 16508	PREGNANCY COMPLICATED BY acute intercurrent infection, intra-uterine 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:** $25.25 **Benefit:** 75% = $18.95 85% = $21.50
+ 16509	PRE-ECLAMPSIA, ECLAMPSIA OR ANTEPARTUM HAEMORRHAGE, treatment of - each attendance that is not a routine antenatal attendance **Fee:** $25.25 **Benefit:** 75% = $18.95 85% = $21.50
	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 1 - GENERAL
+ 30003	LOCALISED BURNS, dressing of, (not involving grafting) - each attendance at which the procedure is performed, including any associated consultation **Fee:** $25.25 **Benefit:** 75% = $18.95 85% = $21.50
† 31441	LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, repair, revision or replacement of (Anaes. 17710 = 6B + 4T) **Fee:** $190.75 **Benefit:** 75% = $143.10 85% = $162.15
	SUBGROUP 3 - VASCULAR
‡ 33545	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is less than 3cm long (Anaes. 17714 = 8B + 6T) (Assist.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $207.45 **Benefit:** 75% = $155.60 85% = $176.35
‡ 33548	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Anaes. 17715 = 8B + 7T) (Assist.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $421.85 **Benefit:** 75% = $316.40 85% = $371.45

	SUBGROUP 6 - CARDIO-THORACIC
A 38270	BALLOON VALVULOPLASTY OR SEPTOSTOMY, including cardiac catheterisations before and after balloon dilatation (Anaes. 17728 = 20B + 8T) (Assist.) **Fee:** $691.50 **Benefit:** 75% = $518.65 85% = $641.10
	SUBGROUP 8 - EAR, NOSE AND THROAT
+ 41704	MAXILLARY ANTRUM, LAVAGE OF - each attendance at which the procedure is performed, including any associated consultation (Anaes. 17707 = 5B + 2T) **Fee:** $25.25 **Benefit:** 75% = $18.95 85% = $21.50
▲ 41880	TRACHEOSTOMY by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (Anaes. 17708 = 6B + 2T) **Fee:** $192.60 **Benefit:** 75% = $144.45 85% = $163.75
‡ 41881	TRACHEOSTOMY by open exposure of the trachea, including separation of the strap muscles or division of the thyroid isthmus, where performed (Anaes. 17710 = 6B + 4T) (Assist.) **Fee:** $304.50 **Benefit:** 75% = $228.40 85% = $258.85
‡ 41884	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes. 17708 = 6B + 2T) **Fee:** $68.95 **Benefit:** 75% = $51.75 85% = $58.65
	SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY
‡ 45021	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or cystic acne - limited to 1 aesthetic area (Anaes. 17705 = 3B + 2T) *(See para T8.48 of explanatory notes to this Category)* **Fee:** $134.50 **Benefit:** 75% = $100.90 85% = $114.35
‡ 45024	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or cystic acne - more than 1 aesthetic area (Anaes. 17706 = 3B + 3T) *(See para T8.48 of explanatory notes to this Category)* **Fee:** $302.00 **Benefit:** 75% = $226.50 85% = $256.70
† 45501	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit (Anaes. 17743 = 10B + 33T) (Assist.) **Fee:** $1,345.15 **Benefit:** 75% =$1,008.90 85% =$1,294.75
‡ 45502	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of limb or digit (Anaes. 17743 = 10B + 33T) (Assist.) **Fee:** $1,345.15 **Benefit:** 75% =$1,008.90 85% =$1,294.75
† 45504	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes. 17743 = 10B + 33T) (Assist.) **Fee:** $1,345.15 **Benefit:** 75% =$1,008.90 85% =$1,294.75
† 45505	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes. 17743 = 10B + 33T) (Assist.) **Fee:** $1,345.15 **Benefit:** 75% =$1,008.90 85% =$1,294.75
† 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. 17714 = 4B + 10T) (Assist.) **Fee:** $833.25 **Benefit:** 75% = $624.95 85% = $782.85
‡ 45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes. 17714 = 4B + 10T) (Assist.) **Fee:** $833.25 **Benefit:** 75% = $624.95 85% = $782.85

	GROUP I2 - COMPUTED TOMOGRAPHY - EXAMINATION AND REPORT
‡	**HEAD**
56001	COMPUTED TOMOGRAPHY - scan of brain without intravenous contrast medium, not being a service to which item 57001 applies (R) (K) **Fee:** $201.45 **Benefit:** 75% = $151.10 85% = $171.25
‡ 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) **Fee:** $257.25 **Benefit:** 75% = $192.95 85% = $218.70
‡ 56010	COMPUTED TOMOGRAPHY - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) **Fee:** $291.45 **Benefit:** 75% = $218.60 85% = $247.75
‡ 56013	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) **Fee:** $291.45 **Benefit:** 75% = $218.60 85% = $247.75
‡ 56016	COMPUTED TOMOGRAPHY - scan of middle ear and temporal bone, unilateral or bilateral, with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) **Fee:** $347.10 **Benefit:** 75% = $260.35 85% = $296.70
‡ 56019	COMPUTED TOMOGRAPHY - scan of temporal bones with air study (including reconstructions), with intrathecal injection but not including an associated brain scan (R) (K) *(See para DII. of explanatory notes to this Category)* **Fee:** $426.40 **Benefit:** 75% = $319.80 85% = $376.00
‡ 56022	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (K) **Fee:** $230.90 **Benefit:** 75% = $173.20 85% = $196.30
‡ 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) **Fee:** $343.70 **Benefit:** 75% = $257.80 85% = $293.30
† 56041	COMPUTED TOMOGRAPHY - scan of brain without intravenous contrast medium, not being a service to which item 57041 applies (R) (NK) **Fee:** $100.75 **Benefit:** 75% = $75.60 85% = $85.65
† 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) **Fee:** $128.65 **Benefit:** 75% = $96.50 85% = $109.40
† 56050	COMPUTED TOMOGRAPHY - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) **Fee:** $145.75 **Benefit:** 75% = $109.35 85% = $123.90
† 56053	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) **Fee:** $145.75 **Benefit:** 75% = $109.35 85% = $123.90
† 56056	COMPUTED TOMOGRAPHY - scan or middle ear and temporal bone, unilateral or bilateral, with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) **Fee:** $173.55 **Benefit:** 75% = $130.20 85% = $147.55
† 56059	COMPUTED TOMOGRAPHY - scan of temporal bone, with air study (including reconstructions) with intrathecal injection but not including an associated brain scan (R) (NK) *(See para DII. of explanatory notes to this Category)* **Fee:** $213.20 **Benefit:** 75% = $159.90 85% = $181.25
† 56062	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (NK) **Fee:** $115.45 **Benefit:** 75% = $86.60 85% = $98.15

† 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) **Fee:** $171.85 **Benefit:** 75% = $128.90 85% = $146.10
‡ 56101	**NECK** 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) **Fee:** $237.45 **Benefit:** 75% = $178.10 85% = $201.85
‡ 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) **Fee:** $350.15 **Benefit:** 75% = $262.65 85% = $299.75
† 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) **Fee:** $118.75 **Benefit:** 75% = $89.10 85% = $100.95
† 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) **Fee:** $175.10 **Benefit:** 75% = $131.35 85% = $148.85
‡ 56210	**SPINE** COMPUTED TOMOGRAPHY - scan of spine, 1 or more regions, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) *(See para DII. of explanatory notes to this Category)* **Fee:** $249.95 **Benefit:** 75% = $187.50 85% = $212.50
‡ 56216	COMPUTED TOMOGRAPHY - scan of spine, 1 or more regions, with intravenous contrast medium and with any scans of the spine 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) *(See para DII. of explanatory notes to this Category)* **Fee:** $362.20 **Benefit:** 75% = $271.65 85% = $311.80
‡ 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) *(See para DII. of explanatory notes to this Category)* **Fee:** $336.30 **Benefit:** 75% = $252.25 85% = $285.90
† 56250	COMPUTED TOMOGRAPHY - scan of spine, 1 or more regions, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) *(See para DII. of explanatory notes to this Category)* **Fee:** $125.00 **Benefit:** 75% = $93.75 85% = $106.25
† 56256	COMPUTED TOMOGRAPHY - scan of spine, 1 or more regions, with intravenous contrast medium and with any scans of the spine 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) **Fee:** $181.10 **Benefit:** 75% = $135.85 85% = $153.95
† 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) *(See para DII. of explanatory notes to this Category)* **Fee:** $168.15 **Benefit:** 75% = $126.15 85% = $142.95

CHEST AND UPPER ABDOMEN

Item	Description	Fee
‡ 56301	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56801 or 57001 applies and not including a study performed to exclude coronary artery calcification (R) (K)	**Fee:** $305.05 **Benefit:** 75% = $228.80 85% = $259.30
‡ 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 (R) (K)	**Fee:** $412.70 **Benefit:** 75% = $309.55 85% = $362.30
† 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 (R) (NK)	**Fee:** $152.55 **Benefit:** 75% = $114.45 85% = $129.70
† 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 (R) (NK)	**Fee:** $206.35 **Benefit:** 75% = $154.80 85% = $175.40

UPPER ABDOMEN

Item	Description	Fee
‡ 56401	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) without intravenous contrast medium, not being a service to which item 56301, 56501, 56801 or 57001 applies (R) (K)	**Fee:** $258.80 **Benefit:** 75% = $194.10 85% = $220.00
‡ 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)	**Fee:** $370.30 **Benefit:** 75% = $277.75 85% = $319.90
‡ 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)	**Fee:** $258.80 **Benefit:** 75% = $194.10 85% = $220.00
‡ 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)	**Fee:** $370.30 **Benefit:** 75% = $277.75 85% = $319.90
† 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)	**Fee:** $129.40 **Benefit:** 75% = $97.05 85% = $110.00
† 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)	**Fee:** $185.15 **Benefit:** 75% = $138.90 85% = $157.40
† 56449	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium, not being a service to which item 56401 applies (R) (NK)	**Fee:** $129.40 **Benefit:** 75% = $97.05 85% = $110.00

† 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) **Fee:** $185.15 **Benefit:** 75% = $138.90 85% = $157.40
‡ 56501	**UPPER ABDOMEN AND PELVIS** COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis without intravenous contrast medium, not being a service to which item 56801 or 57001 applies (R) (K) **Fee:** $394.10 **Benefit:** 75% = $295.60 85% = $343.70
‡ 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 being a service to which item 56807 or 57007 applies (R) (K) **Fee:** $497.35 **Benefit:** 75% = $373.05 85% = $446.95
† 56541	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis without intravenous contrast medium, not being a service to which item 56841 or 57041 applies (R) (NK) **Fee:** $197.05 **Benefit:** 75% = $147.80 85% = $167.50
† 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 being a service to which item 56847 or 57047 applies (R) (NK) **Fee:** $248.70 **Benefit:** 75% = $186.55 85% = $211.40
‡ 56619	**EXTREMITIES** 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) *(See para DII. of explanatory notes to this Category)* **Fee:** $228.75 **Benefit:** 75% = $171.60 85% = $194.45
‡ 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) *(See para DII. of explanatory notes to this Category)* **Fee:** $341.50 **Benefit:** 75% = $256.15 85% = $291.10
† 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) *(See para DII. of explanatory notes to this Category)* **Fee:** $114.40 **Benefit:** 75% = $85.80 85% = $97.25
† 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) *(See para DII. of explanatory notes to this Category)* **Fee:** $170.75 **Benefit:** 75% = $128.10 85% = $145.15
‡ 56801	**CHEST, ABDOMEN, PELVIS AND NECK** 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 (R) (K) **Fee:** $476.05 **Benefit:** 75% = $357.05 85% = $425.65
‡ 56807	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification(R) (K) **Fee:** $579.25 **Benefit:** 75% = $434.45 85% = $528.85

Item	Description
† 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 (R) (NK) **Fee:** $238.05 **Benefit:** 75% = $178.55 85% = $202.35
† 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 (R) (NK) **Fee:** $289.65 **Benefit:** 75% = $217.25 85% = $246.25
‡ 57001	**BRAIN, CHEST AND UPPER ABDOMEN** 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 (R) (K) **Fee:** $476.15 **Benefit:** 75% = $357.15 85% = $425.75
‡ 57007	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification(R) (K) **Fee:** $579.35 **Benefit:** 75% = $434.55 85% = $528.95
† 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(R) (NK) **Fee:** $238.10 **Benefit:** 75% = $178.60 85% = $202.40
† 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(R) (NK) **Fee:** $289.70 **Benefit:** 75% = $217.30 85% = $246.25
‡ 57201	**PELVIMETRY** COMPUTED TOMOGRAPHY - PELVIMETRY (R) (K) **Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65
† 57247	COMPUTED TOMOGRAPHY - PELVIMETRY (R) (NK) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
‡ 57341	**INTERVENTIONAL TECHNIQUES** 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) **Fee:** $493.90 **Benefit:** 75% = $370.45 85% = $443.50
† 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) **Fee:** $246.95 **Benefit:** 75% = $185.25 85% = $209.95
‡ 57350	**SPIRAL ANGIOGRAPHY** COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium and with any scans prior to intravenous contrast injection when undertaken - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, including multiple projections, not being a service to which another item in this group applies (R) (K) **Fee:** $539.05 **Benefit:** 75% = $404.30 85% = $488.65

† 57355	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium and with any scans prior to intravenous contrast injection when undertaken - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, including multiple projections, not being a service to which another item in this group applies (R) (NK) **Fee:** $269.55 **Benefit:** 75% = $202.20 85% = $229.15
	GROUP I3 - DIAGNOSTIC RADIOLOGY
	SUBGROUP 11 - RADIOGRAPHIC EXAMINATION IN CONNECTION WITH PREGNANCY AND REPORT
‡ 59503	PELVIMETRY, not being a service associated with a service to which item 57201 applies (R) **Fee:** $95.50 **Benefit:** 75% = $71.65 85% = $81.20
	PATHOLOGY SERVICES GROUP P2 - CHEMICAL
‡ 66599	Serum B12 or red cell folate and, if required, serum folate (Item is subject to rule 23) **Fee:** $24.35 **Benefit:** 75% = $18.30 85% = $20.70
‡ 66602	Serum B12 and red cell folate and, if required, serum folate (Item is subject to rule 23) **Fee:** $44.45 **Benefit:** 75% = $33.35 85% = $37.80
	GROUP P3 - MICROBIOLOGY
69372	Detection of microbial antigens (except if the service described in item 69369 has been performed) - 1 or more tests **Fee:** $25.00 **Benefit:** 75% = $18.75 85% = $21.25
‡ 69375	Examination for Herpes simplex virus or varicella zoster virus or cytomegalovirus by culture, including a service described in item 69369 or 69372 (if performed) - 1 or more tests **Fee:** $28.20 **Benefit:** 75% = $21.15 85% = $24.00
‡ 69378	Quantitation of HIV viral RNA load in plasma or serum in the monitoring of a HIV sero-positive patient, who is not on antiretroviral therapy - 1 or more assays on 1 or more specimens in any 1 episode to a maximum of 7 episodes in a 12 month period (Item is subject to rule 20) **Fee:** $176.00 **Benefit:** 75% = $132.00 85% = $149.60
‡ 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 assays on 1 or more specimens in any 1 episode to a maximum of 7 episodes in a 12 month period (Item is subject to rule 20) **Fee:** $176.00 **Benefit:** 75% = $132.00 85% = $149.60
† 69382	Quantitation of HIV viral RNA load in cerebrospinal fluid in a HIV sero-positive patient - 1 or more assays on 1 or more specimens in any 1 episode (Item is not subject to rule 20) **Fee:** $176.00 **Benefit:** 75% = $132.00 85% = $149.60

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