Medicare Benefits Schedule book

1 November 2000

Health and Aged Care

COMMONWEALTH OF AUSTRALIA

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Commonwealth Department of Health and Aged Care

Medicare Benefits Schedule - November 2000

The November 2000 Medicare Benefits Schedule (MBS) book contains an error in relation to the 85% benefit level for items of service that have a fee of $350 or more.

By way of background, a maximum patient gap between the Schedule fee and the benefits payable for out-of-hospital services (ie the 85% benefit level listed in the MBS) applies to items of service over a specified amount. The amount of the gap is indexed each year based on a number of indices over the previous year. The maximum patient gap for the November 2000 edition of the MBS is $52.50, and applies to items of service where the Schedule fee is $350.00 or more. The maximum patient gap for the period 1 November 1999 – 31 October 2000 was $50.90.

The printed edition of the MBS does not reflect the increase in the maximum patient gap from $50.90 to $52.50. This means that the rebate printed in the MBS for any item where the Schedule fee is $350.00 or more, is $1.60 higher than it should be. The effect of this is that when the Health Insurance Commission processes claims for out-of-hospital services with Schedule fees of $350.00 or more, the benefit paid will be $1.60 less than the 85% benefit printed in the MBS.

When providing advice to patients in relation to gap payments associated with the affected services, doctors will need to be aware of this error so as not to provide incorrect information. Doctors will also need to be aware that if they bulk bill any of the affected services, they will receive a benefit $1.60 less than that printed in the MBS.

To assist in overcoming any confusion in relation to the correct benefit level for the affected services, a "ready reckoner" is attached that lists the affected item numbers and the correct benefit at the 85% level.

For your information, the Internet version of the MBS contains the correct benefit levels. The Internet version is available at:

http://www.health.gov.au/pubs/mbs/index.htm

Further information can be obtained by phoning the Commonwealth Department of Health and Aged Care on Freecall 1800 020 103

Cat. No. 0021369

CORRIGENDUM TO THE NOVEMBER 2000 EDITION OF THE MEDICARE BENEFITS SCHEDULE BOOK

LISTING OF CORRECT 85% BENEFIT LEVEL FOR ITEMS WITH FEES OF $350 OR MORE

Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit
162	$330.35	17738	$509.90	17791	$1,294.30	30382	$964.95
163	$439.80	17739	$524.70	17792	$1,309.10	30384	$803.40
164	$494.55	17740	$539.50	17793	$1,323.90	30385	$386.05
12203	$409.85	17741	$554.30	17794	$1,338.70	30387	$441.85
12207	$409.85	17742	$569.10	17795	$1,353.50	30388	$1,191.15
13200	$1,504.00	17743	$583.90	17796	$1,368.30	30392	$472.65
13203	$336.60	17744	$598.70	17797	$1,383.10	30393	$355.20
13206	$614.55	17745	$613.50	17798	$1,397.90	30394	$331.15
13218	$614.55	17746	$628.30	17799	$1,412.70	30396	$738.95
13603	$436.80	17747	$643.10	17986	$317.50	30400	$439.90
13760	$541.25	17748	$657.90	18027	$332.30	30402	$309.20
13845	$368.65	17749	$672.70	30020	$441.85	30403	$353.30
13851	$331.85	17750	$687.50	30165	$301.65	30405	$659.80
15307	$474.45	17751	$702.30	30168	$301.65	30414	$484.50
15308	$474.45	17752	$717.10	30171	$486.15	30415	$1,021.55
15315	$456.85	17753	$731.90	30174	$486.15	30416	$530.65
15316	$456.85	17754	$746.70	30177	$714.90	30417	$822.20
15323	$509.55	17755	$761.50	30246	$484.50	30418	$1,191.15
15324	$509.55	17756	$776.30	30247	$523.10	30419	$583.70
15327	$559.00	17757	$791.10	30250	$921.45	30421	$1,501.95
15328	$559.00	17758	$805.90	30251	$1,443.60	30422	$473.25
15331	$528.15	17759	$820.70	30253	$596.90	30425	$964.95
15332	$528.15	17760	$835.50	30255	$812.20	30427	$1,162.80
15335	$474.45	17761	$850.30	30275	$1,319.95	30428	$1,247.65
15336	$474.45	17762	$865.10	30289	$338.55	30430	$1,756.30
15345	$342.85	17763	$879.90	30294	$1,319.95	30431	$353.30
15506	$309.75	17764	$894.70	30296	$744.55	30433	$512.80
15524	$443.70	17765	$909.50	30297	$744.55	30434	$405.40
15533	$467.30	17766	$924.30	30306	$569.25	30436	$456.25
15600	$1,272.85	17767	$939.10	30308	$569.25	30437	$580.60
16003	$454.00	17768	$953.90	30309	$744.55	30438	$843.45
16006	$336.65	17769	$968.70	30310	$303.60	30440	$357.30
16015	$3,128.40	17770	$983.50	30314	$303.60	30443	$523.10
16018	$1,849.05	17771	$998.30	30315	$834.95	30445	$523.10
16519	$363.10	17772	$1,013.10	30317	$1,010.20	30446	$523.10
16520	$433.15	17773	$1,027.90	30318	$654.10	30448	$705.00
16522	$923.30	17774	$1,042.70	30320	$1,010.20	30449	$789.75
16609	$333.65	17775	$1,057.50	30321	$654.10	30450	$355.70
16627	$421.55	17776	$1,072.30	30323	$1,010.20	30454	$618.95
17724	$302.70	17777	$1,087.10	30324	$1,010.20	30455	$737.00
17725	$317.50	17778	$1,101.90	30330	$507.10	30457	$1,021.55
17726	$332.30	17779	$1,116.70	30335	$622.40	30458	$737.00
17727	$347.10	17780	$1,131.50	30336	$757.45	30460	$618.95
17728	$361.90	17781	$1,146.30	30347	$453.70	30461	$1,098.55
17729	$376.70	17782	$1,161.10	30351	$520.75	30463	$1,360.65
17730	$391.50	17783	$1,175.90	30354	$757.45	30464	$1,643.35
17731	$406.30	17784	$1,190.70	30355	$352.45	30466	$925.45
17732	$421.10	17785	$1,205.50	30358	$411.25	30467	$1,157.15
17733	$435.90	17786	$1,220.30	30373	$323.75	30469	$1,287.20
17734	$450.70	17787	$1,235.10	30375	$353.30	30472	$671.00
17735	$465.50	17788	$1,249.90	30376	$353.30	30479	$318.15
17736	$480.30	17789	$1,264.70	30378	$355.20	30485	$386.05
17737	$495.10	17790	$1,279.50	30379	$670.15	30490	$357.30

CORRIGENDUM TO THE NOVEMBER 2000 EDITION OF THE MEDICARE BENEFITS SCHEDULE BOOK

LISTING OF CORRECT 85% BENEFIT LEVEL FOR ITEMS WITH FEES OF $350 OR MORE

Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit
30491	$379.85	30577	$795.45	32015	$1,389.70	32718	$872.55
30496	$405.40	30578	$840.65	32018	$1,170.45	32721	$1,416.90
30497	$493.45	30580	$761.45	32021	$386.05	32724	$1,616.00
30499	$596.90	30581	$541.05	32024	$1,009.90	32730	$1,212.10
30500	$642.80	30583	$877.30	32025	$1,368.55	32733	$1,416.90
30502	$714.90	30584	$1,319.95	32026	$1,477.85	32739	$954.50
30503	$806.80	30586	$493.45	32028	$1,587.20	32742	$1,100.90
30505	$377.10	30587	$512.80	32030	$750.45	32745	$1,264.70
30506	$699.35	30589	$921.45	32033	$1,121.05	32748	$1,376.00
30508	$738.95	30590	$1,021.55	32036	$1,436.00	32751	$872.55
30509	$738.95	30593	$1,417.25	32039	$1,142.65	32754	$1,100.90
30511	$608.90	30594	$1,643.35	32042	$954.30	32763	$872.55
30512	$761.45	30596	$646.05	32045	$324.30	32766	$562.25
30514	$1,145.85	30597	$508.25	32046	$529.75	33050	$1,080.45
30515	$495.80	30599	$964.95	32047	$625.85	33055	$856.10
30517	$665.40	30600	$552.55	32051	$1,751.10	33070	$603.05
30518	$716.30	30601	$692.80	32054	$1,602.80	33075	$781.40
30520	$473.25	30602	$1,157.15	32057	$386.05	33080	$965.40
30521	$1,072.45	30603	$1,225.05	32060	$1,751.10	33100	$1,065.75
30523	$1,123.20	30605	$1,400.30	32063	$1,602.80	33103	$1,516.45
30524	$1,241.95	30606	$812.35	32066	$386.05	33109	$1,844.40
30526	$1,626.30	30609	$309.10	32069	$1,281.65	33112	$1,592.60
30527	$625.85	30614	$309.10	32093	$312.75	33115	$1,054.10
30529	$964.95	30615	$353.30	32094	$377.10	33118	$1,177.10
30530	$558.05	30644	$353.30	32102	$441.60	33121	$1,300.05
30532	$648.55	31000	$399.70	32105	$324.30	33124	$890.05
30533	$781.35	31001	$512.80	32108	$725.80	33127	$1,182.80
30535	$1,268.35	31002	$625.85	32111	$441.60	33130	$1,024.70
30536	$1,287.20	31355	$503.70	32112	$548.80	33133	$755.40
30538	$874.55	31406	$338.45	32117	$725.80	33136	$1,984.80
30539	$625.85	31409	$1,162.10	32126	$324.30	33139	$1,182.80
30541	$1,128.95	31412	$1,443.60	32129	$441.60	33142	$1,100.90
30542	$750.15	31426	$573.05	32131	$362.95	33145	$1,932.20
30544	$535.40	31429	$922.30	32162	$324.30	33148	$2,412.25
30545	$1,377.70	31432	$990.05	32165	$441.60	33151	$2,289.30
30547	$931.05	31435	$713.80	32183	$384.80	33154	$1,680.50
30548	$682.35	31438	$1,162.10	32186	$384.80	33157	$1,879.50
30550	$1,552.90	31452	$501.50	32203	$441.85	33160	$1,879.50
30551	$1,055.45	31454	$386.05	32206	$394.10	33163	$1,586.85
30553	$767.10	31462	$353.30	32209	$665.20	33166	$1,586.85
30554	$1,733.80	31464	$625.85	32507	$362.95	33169	$1,223.85
30556	$1,179.80	31466	$965.00	32508	$362.95	33172	$942.75
30557	$857.60	31468	$1,065.40	32511	$565.10	33175	$864.70
30559	$608.90	31470	$508.25	32514	$669.00	33178	$1,113.90
30560	$682.35	31472	$858.30	32517	$876.60	33181	$1,373.60
30562	$410.80	32000	$750.45	32700	$1,065.75	33500	$831.50
30563	$410.80	32003	$787.45	32703	$872.55	33506	$936.95
30564	$548.80	32004	$843.10	32708	$1,054.10	33509	$1,054.10
30565	$625.85	32005	$959.25	32710	$1,177.10	33512	$1,177.10
30566	$701.05	32006	$843.10	32711	$1,300.05	33515	$1,300.05
30568	$512.80	32009	$1,009.90	32712	$925.25	33518	$936.95
30575	$346.70	32012	$1,121.05	32715	$925.25	33521	$1,018.85

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Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit
33524	$1,212.10	34518	$948.60	35622	$416.60	36576	$848.95
33527	$1,416.90	34521	$562.50	35623	$585.30	36579	$524.75
33530	$1,212.10	34527	$376.95	35634	$481.35	36585	$524.75
33533	$1,416.90	34533	$913.45	35638	$501.50	36588	$667.35
33536	$995.55	34800	$579.85	35641	$914.95	36591	$810.10
33539	$702.70	34803	$1,340.90	35649	$364.80	36594	$667.35
33542	$1,024.70	34806	$702.70	35653	$472.75	36597	$667.35
33548	$380.85	34809	$702.70	35657	$472.75	36600	$810.10
33800	$866.65	34812	$860.85	35661	$625.85	36603	$952.70
33803	$825.70	34815	$702.70	35664	$1,078.05	36606	$1,750.45
33806	$579.85	34818	$778.85	35667	$908.40	36609	$524.75
33810	$408.75	34821	$1,077.45	35670	$738.75	36612	$453.40
33811	$1,320.60	34824	$333.95	35673	$537.45	36615	$524.75
33812	$673.50	34827	$415.85	35677	$364.80	36618	$453.40
33815	$614.90	34830	$497.85	35678	$450.60	36621	$309.10
33818	$726.20	34833	$661.75	35680	$400.65	36624	$382.00
33821	$837.40	35000	$497.85	35684	$314.40	36627	$485.85
33824	$796.35	35003	$661.75	35694	$443.95	36633	$524.75
33827	$942.75	35006	$843.25	35697	$684.15	36639	$596.05
33830	$1,089.10	35009	$644.10	35700	$515.90	36645	$777.60
33833	$983.80	35012	$497.85	35710	$308.25	36648	$686.85
33836	$1,182.80	35202	$583.70	35713	$300.05	36803	$310.60
33839	$1,393.55	35300	$348.80	35717	$372.00	36806	$453.40
33842	$661.75	35303	$461.95	35720	$472.65	36809	$596.05
33845	$445.15	35304	$348.80	35723	$323.60	36825	$400.05
33848	$445.15	35305	$461.95	35726	$323.60	36845	$485.85
34100	$497.85	35306	$422.35	35750	$558.40	36854	$310.60
34112	$614.90	35309	$541.05	35753	$623.00	36863	$310.60
34115	$702.70	35310	$541.05	35756	$558.40	37000	$524.75
34118	$1,024.70	35312	$620.20	35759	$386.05	37004	$453.40
34121	$808.10	35315	$620.20	36500	$667.35	37014	$777.60
34124	$890.05	35319	$444.05	36502	$479.95	37020	$524.75
34127	$1,182.80	35320	$614.55	36503	$1,030.55	37029	$667.35
34130	$333.95	35321	$580.60	36506	$667.35	37038	$486.15
34133	$380.85	35330	$348.80	36509	$557.10	37044	$486.15
34136	$644.10	35548	$596.90	36516	$667.35	37045	$1,059.85
34139	$644.10	35551	$479.95	36519	$952.70	37047	$1,244.60
34142	$808.10	35560	$479.95	36522	$810.10	37050	$524.75
34145	$574.00	35561	$1,021.55	36525	$1,173.30	37053	$614.55
34148	$1,065.75	35562	$829.35	36528	$952.70	37200	$738.75
34151	$1,475.55	35564	$354.60	36531	$848.95	37203	$758.80
34154	$1,768.30	35565	$479.95	36537	$485.85	37206	$382.00
34157	$872.55	35567	$494.05	36540	$810.10	37207	$622.10
34160	$1,680.50	35580	$364.80	36543	$952.70	37209	$952.70
34163	$2,172.25	35584	$472.65	36546	$485.85	37210	$1,188.05
34166	$2,172.25	35590	$364.80	36549	$596.05	37211	$1,454.20
34169	$1,182.80	35593	$364.80	36552	$524.75	37221	$310.60
34172	$954.50	35596	$479.95	36558	$453.40	37306	$453.40
34175	$872.55	35599	$472.65	36564	$667.35	37309	$667.35
34509	$708.55	35600	$355.20	36567	$738.75	37330	$453.40
34512	$784.75	35602	$472.65	36570	$952.70	37333	$382.00
34515	$544.65	35612	$341.40	36573	$667.35	37336	$524.75

LISTING OF CORRECT 85% BENEFIT LEVEL FOR ITEMS WITH FEES OF $350 OR MORE

Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit
37342	$596.05	38427	$868.80	38572	$1,494.50	39130	$422.65
37345	$485.85	38430	$422.35	38577	$379.20	39139	$784.75
37348	$485.85	38438	$1,140.20	38600	$1,140.20	39303	$310.40
37372	$310.60	38440	$840.65	38603	$693.65	39306	$474.45
37375	$848.95	38441	$1,360.65	38609	$320.55	39309	$503.60
37381	$524.75	38446	$868.80	38612	$365.70	39315	$749.50
37384	$848.95	38447	$1,140.20	38613	$472.35	39318	$445.15
37390	$667.35	38449	$1,616.10	38615	$1,140.20	39321	$316.30
37396	$524.75	38450	$614.50	38618	$1,434.20	39327	$316.30
37402	$310.60	38452	$394.10	38621	$541.05	39500	$936.95
37405	$667.35	38453	$1,287.20	38624	$614.50	39503	$691.00
37408	$310.60	38455	$1,759.70	38627	$468.80	39600	$316.30
37411	$667.35	38456	$1,140.20	38637	$379.20	39603	$878.35
37417	$382.00	38457	$1,061.05	38640	$693.65	39606	$568.05
37423	$667.35	38458	$541.05	38643	$778.45	39609	$691.00
37426	$706.25	38466	$693.40	38647	$1,609.35	39612	$819.90
37432	$667.35	38468	$1,096.80	38650	$1,434.20	39615	$878.35
37444	$725.80	38469	$1,287.20	38653	$1,434.20	39640	$2,307.80
37607	$667.35	38470	$693.65	38656	$693.65	39642	$2,428.90
37610	$1,030.55	38473	$394.10	38670	$1,433.90	39646	$2,792.00
37616	$485.85	38475	$595.15	38673	$1,620.55	39650	$2,005.20
37800	$353.30	38477	$1,507.25	38677	$1,512.60	39653	$3,609.00
37803	$353.30	38478	$703.05	38680	$1,804.00	39654	$2,610.45
37806	$416.40	38480	$1,507.25	38700	$778.45	39656	$1,944.70
37809	$416.40	38481	$1,723.10	38703	$1,445.50	39658	$2,307.80
37812	$380.40	38483	$1,287.20	38706	$1,366.30	39660	$2,307.80
37818	$330.15	38485	$583.70	38709	$1,609.35	39662	$2,307.80
37821	$596.05	38487	$1,287.20	38712	$1,942.95	39700	$380.85
37824	$849.30	38488	$1,434.20	38715	$1,275.90	39703	$351.50
37827	$362.95	38489	$1,715.55	38718	$1,609.35	39706	$813.90
37830	$485.85	38490	$379.20	38721	$1,111.95	39709	$1,182.80
37836	$488.60	38493	$1,471.60	38724	$1,609.35	39712	$2,178.05
37839	$560.70	38496	$433.25	38727	$1,111.95	39715	$1,493.10
37842	$1,137.95	38497	$1,541.60	38730	$1,609.35	39718	$626.65
37845	$488.60	38500	$1,660.25	38733	$1,111.95	39721	$568.05
37848	$921.40	38503	$1,807.20	38736	$1,609.35	39800	$2,172.25
37851	$669.00	38506	$1,213.65	38739	$1,445.50	39803	$2,172.25
38203	$361.35	38507	$1,433.90	38742	$1,445.50	39806	$948.60
38206	$447.80	38508	$1,807.20	38745	$1,609.35	39812	$439.35
38209	$589.85	38509	$1,807.20	38748	$1,609.35	39815	$1,370.10
38212	$1,016.00	38512	$1,581.15	38751	$1,609.35	39818	$1,370.10
38215	$299.55	38515	$2,027.70	38754	$2,027.70	39821	$1,636.75
38218	$528.15	38518	$2,180.35	38757	$1,609.35	39900	$351.50
38270	$657.75	38521	$767.10	38760	$1,609.35	39903	$1,182.80
38278	$444.75	38550	$1,618.40	38763	$1,609.35	39906	$568.05
38284	$599.45	38553	$2,064.90	38766	$1,609.35	40000	$661.75
38287	$1,581.15	38556	$2,364.60	39106	$872.55	40003	$661.75
38290	$2,027.70	38559	$1,918.00	39112	$1,147.70	40006	$509.50
38293	$2,180.35	38562	$2,364.60	39121	$439.35	40009	$357.30
38418	$693.65	38565	$2,658.50	39124	$1,206.25	40012	$749.50
38421	$1,140.20	38568	$1,397.90	39127	$316.30	40015	$444.75
38424	$693.65	38571	$1,544.90	39128	$461.30	40100	$486.15

CORRIGENDUM TO THE NOVEMBER 2000 EDITION OF THE MEDICARE BENEFITS SCHEDULE BOOK

LISTING OF CORRECT 85% BENEFIT LEVEL FOR ITEMS WITH FEES OF $350 OR MORE

Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit
40103	$737.85	41557	$796.05	41837	$909.80	42704	$310.40
40106	$749.50	41560	$877.30	41840	$1,130.75	42707	$568.05
40109	$813.90	41563	$1,098.55	41843	$987.95	42710	$650.00
40112	$1,059.85	41564	$1,436.00	41858	$332.30	42716	$878.35
40115	$509.50	41566	$796.05	41861	$417.90	42719	$351.50
40118	$691.00	41569	$877.30	41867	$425.00	42722	$389.45
40300	$691.00	41572	$751.80	41870	$301.65	42725	$989.60
40301	$693.40	41575	$1,843.85	41873	$405.05	42731	$1,130.05
40303	$796.35	41576	$2,792.00	41876	$405.05	42743	$439.35
40306	$1,065.75	41578	$1,843.85	41879	$688.75	42746	$691.00
40309	$796.35	41579	$1,369.70	41901	$417.90	42749	$878.35
40312	$1,089.10	41581	$2,128.60	41905	$300.50	42752	$989.60
40315	$1,182.80	41584	$1,444.35	42506	$322.20	42758	$492.05
40316	$1,566.60	41587	$1,986.10	42509	$421.65	42761	$351.50
40318	$1,493.10	41590	$877.30	42510	$494.05	42764	$351.50
40321	$796.35	41593	$1,159.30	42512	$322.20	42767	$796.35
40324	$445.15	41596	$1,301.85	42515	$421.65	42773	$650.00
40327	$445.15	41599	$1,301.85	42521	$884.25	42776	$989.60
40330	$691.00	41602	$877.30	42530	$439.35	42779	$1,247.20
40331	$691.00	41605	$405.05	42536	$597.35	42782	$298.80
40332	$1,160.75	41608	$796.05	42539	$872.55	42783	$298.80
40333	$568.05	41611	$493.45	42542	$339.80	42809	$298.80
40334	$767.90	41614	$796.05	42543	$635.60	42810	$389.50
40335	$1,454.35	41615	$796.05	42545	$942.75	42815	$439.35
40339	$1,182.80	41617	$1,423.00	42548	$538.80	42818	$404.05
40342	$1,089.10	41620	$589.45	42551	$439.35	42833	$404.05
40345	$1,010.30	41623	$877.30	42554	$521.25	42836	$515.35
40348	$1,296.75	41629	$353.30	42557	$749.50	42839	$492.05
40351	$1,296.75	41635	$838.45	42563	$351.50	42842	$626.65
40600	$691.00	41638	$1,059.50	42566	$521.25	42848	$492.05
40700	$1,305.80	41671	$323.75	42569	$749.50	42851	$626.65
40703	$1,089.10	41672	$416.95	42574	$323.75	42860	$650.00
40706	$1,616.00	41710	$353.30	42578	$310.40	42863	$550.50
40709	$351.50	41713	$419.70	42596	$339.80	42866	$532.95
40712	$761.25	41722	$405.05	42599	$439.35	42869	$374.90
40800	$444.75	41728	$646.05	42602	$439.35	43518	$405.05
40801	$1,306.65	41729	$390.20	42605	$310.40	43521	$309.10
40803	$878.35	41731	$552.55	42623	$492.05	43524	$405.05
40903	$379.20	41734	$737.00	42626	$825.70	43801	$692.80
41512	$403.65	41737	$323.75	42629	$609.05	43804	$741.05
41518	$670.60	41746	$552.55	42641	$328.00	43807	$813.25
41521	$717.40	41749	$419.70	42653	$989.60	43810	$957.60
41527	$405.05	41767	$521.25	42656	$1,247.20	43813	$957.60
41530	$692.80	41770	$493.45	42659	$650.00	43816	$885.40
41533	$838.45	41773	$405.05	42662	$650.00	43819	$705.05
41536	$945.40	41776	$403.65	42665	$415.85	43822	$705.05
41539	$796.05	41779	$493.45	42671	$650.00	43825	$813.25
41542	$877.30	41782	$688.75	42674	$298.80	43828	$903.95
41545	$353.30	41785	$867.10	42695	$298.80	43831	$692.80
41548	$486.15	41786	$521.25	42698	$495.50	43834	$813.25
41551	$1,187.75	41787	$390.20	42702	$648.30	43837	$1,029.65
41554	$1,408.75	41834	$951.05	42703	$392.85	43840	$885.40

CORRIGENDUM TO THE NOVEMBER 2000 EDITION OF THE MEDICARE BENEFITS SCHEDULE BOOK

LISTING OF CORRECT 85% BENEFIT LEVEL FOR ITEMS WITH FEES OF $350 OR MORE

Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit
43843	$1,390.35	45018	$316.30	45527	$524.90	45675	$323.75
43846	$1,498.55	45035	$494.05	45528	$813.55	45676	$395.40
43849	$344.25	45036	$825.70	45530	$803.40	45677	$369.00
43852	$1,210.00	45048	$550.50	45533	$916.85	45680	$474.45
43855	$1,282.20	45051	$316.40	45536	$303.95	45683	$532.95
43858	$416.40	45209	$316.40	45539	$781.50	45686	$638.40
43861	$1,246.10	45215	$737.00	45542	$425.00	45695	$328.00
43864	$921.40	45218	$301.65	45543	$543.85	45698	$304.65
43867	$488.60	45233	$316.40	45544	$543.85	45701	$591.55
43870	$705.05	45406	$298.80	45545	$432.20	45707	$556.30
43873	$957.60	45409	$415.85	45552	$444.75	45710	$328.00
43876	$813.25	45412	$591.55	45554	$492.05	45713	$380.85
43879	$957.60	45415	$650.00	45555	$444.75	45714	$556.30
43882	$1,246.10	45418	$708.55	45560	$316.30	45716	$556.30
43900	$813.25	45442	$404.05	45562	$803.40	45720	$700.20
43903	$1,390.35	45445	$380.85	45563	$803.40	45723	$796.35
43906	$1,210.00	45451	$316.40	45564	$1,929.90	45726	$906.75
43909	$1,210.00	45460	$923.30	45565	$1,434.35	45729	$1,024.70
43912	$1,140.20	45461	$642.90	45566	$781.50	45731	$1,039.55
43915	$849.30	45462	$472.35	45575	$508.25	45732	$1,177.00
43933	$353.40	45464	$1,436.90	45578	$596.90	45735	$1,201.80
43936	$705.05	45465	$1,008.60	45584	$439.35	45738	$1,358.45
43939	$524.65	45466	$747.70	45585	$439.35	45741	$1,327.30
43945	$705.05	45468	$1,374.25	45587	$641.10	45744	$1,498.90
43951	$625.85	45469	$1,023.95	45588	$987.90	45747	$1,452.80
43954	$777.20	45471	$1,740.95	45590	$323.75	45752	$1,633.60
43957	$849.30	45472	$1,300.30	45593	$389.45	45753	$1,643.70
43963	$1,210.00	45474	$2,106.65	45596	$648.55	45754	$1,980.70
43966	$1,390.35	45475	$1,576.60	45597	$885.90	45758	$459.85
43969	$1,931.50	45477	$2,472.30	45599	$676.70	45761	$530.35
43972	$1,390.35	45478	$1,851.90	45602	$492.05	45767	$1,902.90
43975	$1,642.90	45480	$2,837.95	45605	$405.05	45770	$1,445.35
43978	$1,390.35	45481	$2,128.20	45608	$591.55	45773	$1,312.60
43981	$344.25	45483	$3,240.65	45611	$316.40	45776	$1,312.60
43984	$957.60	45484	$2,432.25	45614	$405.05	45779	$951.05
43987	$1,065.80	45485	$358.35	45623	$510.50	45782	$714.90
43990	$1,318.25	45486	$298.80	45624	$677.30	45785	$1,246.15
43993	$1,426.50	45488	$298.80	45629	$316.40	45788	$1,231.35
43996	$1,606.85	45489	$474.45	45632	$346.00	45791	$641.10
44108	$330.15	45490	$650.10	45635	$405.05	45794	$339.80
44111	$395.65	45491	$825.70	45638	$737.00	46306	$357.40
44114	$395.65	45492	$1,001.40	45639	$737.00	46307	$357.40
44130	$308.25	45494	$1,223.30	45641	$790.55	46309	$357.40
44331	$405.05	45500	$796.35	45644	$943.60	46312	$474.55
44334	$877.30	45501	$1,329.25	45646	$648.55	46315	$650.15
44367	$353.80	45502	$1,329.25	45647	$943.60	46318	$825.90
44370	$508.25	45503	$1,528.25	45656	$338.55	46321	$1,001.60
44373	$1,098.55	45504	$1,329.25	45659	$353.30	46324	$576.10
45000	$369.00	45505	$1,329.25	45660	$2,188.75	46325	$603.40
45003	$415.85	45520	$648.55	45661	$943.60	46333	$386.65
45006	$755.40	45522	$439.35	45662	$493.45	46339	$310.50
45012	$441.85	45524	$524.90	45671	$596.90	46342	$310.50

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Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit
46345	$386.65	47565	$502.10	48621	$1,193.65	49215	$453.30
46354	$328.10	47566	$654.50	48624	$1,486.80	49221	$423.95
46357	$421.80	47567	$317.60	48627	$1,926.50	49224	$497.20
46360	$518.40	47570	$372.60	48630	$2,146.35	49227	$497.20
46375	$342.80	47573	$478.85	48632	$1,163.00	49300	$353.30
46378	$474.55	47588	$973.60	48636	$577.75	49303	$372.60
46387	$430.60	47591	$1,193.65	48639	$1,010.30	49306	$790.40
46390	$591.70	47603	$387.25	48640	$2,658.25	49309	$533.90
46393	$694.10	47615	$313.95	48642	$570.55	49312	$680.45
46399	$350.65	47618	$405.65	48645	$790.40	49315	$607.20
46402	$350.65	47624	$387.25	48648	$790.40	49318	$973.60
46405	$439.45	47657	$313.95	48651	$1,120.25	49319	$1,750.00
46408	$486.25	47684	$533.90	48654	$790.40	49321	$1,193.65
46414	$357.30	47687	$973.60	48657	$1,120.25	49324	$1,413.50
46417	$328.10	47690	$753.75	48660	$790.40	49327	$1,633.35
46432	$298.90	47693	$973.60	48663	$577.75	49330	$1,633.35
46435	$357.40	47699	$1,120.25	48666	$328.65	49333	$1,853.25
46444	$328.10	47702	$1,413.50	48669	$1,083.60	49339	$2,109.70
46447	$421.80	47741	$321.40	48672	$797.85	49342	$2,109.70
46471	$386.65	47768	$321.40	48675	$460.65	49345	$2,512.90
46474	$518.40	47771	$377.10	48678	$387.70	49346	$607.20
46477	$650.15	47780	$388.40	48681	$680.45	49354	$607.20
46504	$808.30	47783	$388.40	48684	$680.45	49366	$423.95
46507	$948.80	47786	$507.10	48687	$973.60	49503	$328.65
47386	$313.95	47789	$507.10	48690	$1,120.25	49506	$519.25
47393	$372.60	48200	$533.90	48903	$387.25	49509	$533.90
47420	$350.65	48203	$658.50	48906	$387.25	49512	$790.40
47432	$368.95	48206	$387.70	48909	$533.90	49515	$607.20
47438	$460.65	48209	$511.85	48915	$533.90	49517	$886.70
47441	$588.85	48212	$387.70	48918	$1,120.25	49518	$973.60
47450	$299.30	48215	$511.85	48921	$1,156.90	49519	$1,750.00
47451	$371.65	48218	$387.70	48924	$1,340.20	49521	$1,193.65
47459	$357.95	48221	$533.90	48930	$533.90	49524	$1,413.50
47480	$313.95	48227	$328.65	48933	$717.15	49527	$1,193.65
47483	$387.25	48233	$423.95	48936	$533.90	49530	$1,486.80
47486	$680.45	48236	$570.55	48939	$790.40	49533	$1,706.65
47489	$1,046.95	48242	$423.95	48942	$1,046.95	49536	$680.45
47495	$313.95	48403	$350.65	48948	$423.95	49539	$680.45
47498	$497.20	48409	$350.65	48951	$643.75	49542	$973.60
47501	$680.45	48412	$438.50	48954	$680.45	49545	$533.90
47504	$1,046.95	48415	$570.55	48957	$790.40	49548	$680.45
47507	$1,046.95	48418	$438.50	48960	$680.45	49551	$973.60
47510	$1,046.95	48421	$570.55	49103	$497.20	49554	$1,413.50
47519	$621.85	48424	$533.90	49106	$680.45	49560	$376.95
47522	$533.90	48427	$658.50	49109	$497.20	49561	$472.30
47525	$621.85	48506	$328.65	49112	$497.20	49562	$520.10
47528	$533.90	48512	$643.75	49115	$827.05	49563	$567.75
47531	$695.10	48606	$973.60	49121	$423.95	49564	$662.95
47534	$790.40	48609	$1,230.20	49200	$585.10	49566	$533.90
47549	$299.30	48612	$1,853.25	49203	$423.95	49569	$533.90
47555	$387.25	48613	$2,658.25	49206	$387.25	49703	$423.95
47558	$533.90	48618	$1,853.25	49209	$533.90	49709	$497.20

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Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit
49712	$533.90	50375	$336.15	52333	$556.30	53015	$405.05
49715	$827.05	50378	$627.55	52336	$328.00	53016	$323.75
49724	$460.65	50381	$454.80	52337	$779.85	53017	$416.95
49815	$533.90	50384	$838.00	52339	$380.85	53019	$399.70
49824	$537.55	50387	$454.80	52342	$700.20	53050	$646.05
49827	$313.95	50393	$605.90	52345	$796.35	53209	$1,231.35
49830	$588.85	50394	$2,109.70	52348	$906.75	53212	$641.10
49833	$350.65	50396	$309.15	52351	$1,024.70	53218	$456.45
49836	$643.75	50399	$665.30	52354	$1,039.55	53221	$626.65
49837	$451.45	50405	$395.45	52357	$1,177.00	53224	$700.35
49838	$817.80	50408	$724.65	52360	$1,201.80	53227	$872.55
49839	$350.65	50411	$967.55	52363	$1,358.45	53230	$989.60
49842	$643.75	50414	$1,323.70	52366	$1,327.30	53233	$1,118.40
49845	$313.95	50417	$967.55	52369	$1,498.90	53236	$313.95
50102	$423.95	50420	$789.45	52372	$1,452.80	53239	$313.95
50106	$313.95	50423	$724.65	52375	$1,633.60	53413	$320.55
50109	$313.95	50426	$309.15	52378	$530.35	53414	$377.10
50121	$607.20	51904	$301.65	52379	$942.75	53418	$388.40
50127	$494.45	51906	$486.15	52380	$1,643.70	53419	$388.40
50206	$423.95	52035	$318.15	52382	$1,980.70	53422	$507.10
50209	$533.90	52051	$338.55	52424	$316.30	53423	$507.10
50212	$1,230.20	52054	$405.05	52430	$796.35	53424	$427.60
50215	$1,560.05	52092	$309.10	52432	$1,329.25	53425	$427.60
50218	$2,073.15	52094	$405.00	52434	$1,528.25	53427	$603.25
50221	$1,926.50	52114	$405.05	52440	$369.00	53429	$603.25
50224	$2,146.35	52117	$492.05	52442	$474.45	53453	$323.75
50227	$2,512.90	52120	$589.45	52444	$532.95	53455	$389.45
50230	$1,266.85	52122	$591.55	52446	$638.40	53460	$321.40
50233	$1,633.35	52123	$676.70	52452	$328.00	55130	$319.70
50236	$1,266.85	52126	$648.55	52454	$304.65	56036	$322.50
50239	$827.05	52129	$885.90	52456	$591.55	56216	$298.85
50300	$848.80	52131	$423.95	52460	$556.30	56307	$347.50
50303	$1,178.00	52136	$562.25	52476	$374.90	56407	$307.50
50306	$1,868.85	52148	$484.50	52478	$405.05	56412	$307.50
50312	$492.60	52150	$523.05	52480	$338.55	56501	$332.50
50315	$487.20	52152	$921.45	52482	$323.75	56507	$427.50
50318	$487.20	52154	$1,443.60	52484	$395.40	56801	$414.05
50321	$670.70	52156	$596.90	52615	$339.80	56807	$507.50
50324	$978.35	52158	$812.20	52618	$404.05	57001	$414.15
50327	$1,204.95	52160	$1,319.95	52621	$404.05	57007	$515.25
50333	$427.80	52168	$573.05	52624	$316.30	57341	$417.50
50336	$665.30	52170	$922.30	52627	$339.80	57350	$457.50
50339	$384.70	52172	$990.05	52633	$339.80	60000	$479.10
50342	$454.80	52174	$713.80	52809	$316.40	60003	$727.10
50351	$724.65	52176	$1,162.10	52812	$474.45	60006	$1,056.10
50354	$967.55	52184	$423.95	52815	$503.60	60009	$1,244.80
50357	$384.70	52186	$533.90	52818	$316.40	60012	$479.10
50360	$454.80	52306	$416.60	52821	$749.50	60015	$727.10
50363	$336.15	52315	$316.40	52830	$310.40	60018	$1,056.10
50366	$627.55	52321	$316.40	52832	$445.15	60021	$1,244.80
50369	$454.80	52324	$316.40	53006	$353.30	60024	$479.10
50372	$838.00	52330	$556.30	53007	$419.70	60027	$727.10

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Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit
60030	$1,056.10	63006	$422.50	63350	$422.50	63606	$422.50
60033	$1,244.80	63009	$422.50	63353	$422.50	63609	$422.50
60036	$479.10	63012	$422.50	63356	$422.50	63612	$422.50
60039	$727.10	63015	$422.50	63359	$422.50	63615	$422.50
60042	$1,056.10	63018	$422.50	63362	$422.50	63618	$422.50
60045	$1,244.80	63021	$422.50	63365	$422.50	63621	$422.50
60048	$479.10	63024	$422.50	63400	$422.50	63624	$422.50
60051	$727.10	63050	$422.50	63403	$422.50	63627	$422.50
60054	$1,056.10	63053	$422.50	63406	$422.50	63650	$422.50
60057	$1,244.80	63056	$422.50	63409	$422.50	63653	$422.50
60060	$479.10	63059	$422.50	63412	$422.50	63656	$422.50
60063	$727.10	63062	$422.50	63415	$422.50	63659	$422.50
60066	$1,056.10	63100	$422.50	63418	$422.50	63662	$422.50
60069	$1,244.80	63103	$422.50	63421	$422.50	63665	$422.50
61302	$338.75	63106	$422.50	63424	$422.50	63668	$422.50
61303	$440.25	63109	$422.50	63427	$422.50	63671	$422.50
61306	$566.10	63112	$422.50	63430	$422.50	63674	$422.50
61307	$675.25	63115	$422.50	63450	$422.50	63677	$422.50
61314	$313.60	63118	$422.50	63453	$422.50	63680	$422.50
61317	$376.65	63121	$422.50	63456	$422.50	63700	$422.50
61348	$333.95	63124	$422.50	63459	$422.50	63703	$422.50
61360	$299.10	63127	$422.50	63462	$422.50	63706	$422.50
61361	$349.70	63130	$422.50	63465	$422.50	63709	$422.50
61364	$380.65	63133	$422.50	63468	$422.50	63712	$422.50
61373	$374.35	63150	$422.50	63471	$422.50	63715	$422.50
61381	$448.15	63153	$422.50	63474	$422.50	63718	$422.50
61383	$492.30	63156	$422.50	63477	$422.50	63721	$422.50
61384	$546.95	63159	$422.50	63480	$422.50	63736	$422.50
61387	$322.95	63162	$422.50	63500	$422.50	63739	$422.50
61390	$304.90	63200	$422.50	63503	$422.50	63742	$422.50
61393	$475.30	63203	$422.50	63506	$422.50	63745	$422.50
61402	$474.90	63206	$422.50	63509	$422.50	63750	$422.50
61409	$708.90	63209	$422.50	63512	$422.50	63753	$422.50
61421	$365.70	63212	$422.50	63515	$422.50	63756	$422.50
61425	$471.10	63215	$422.50	63518	$422.50	63800	$422.50
61426	$431.10	63218	$422.50	63521	$422.50	63803	$422.50
61429	$420.80	63221	$422.50	63524	$422.50	63806	$422.50
61430	$522.30	63250	$422.50	63550	$422.50	63850	$422.50
61433	$380.65	63253	$422.50	63553	$422.50	63853	$422.50
61434	$483.90	63256	$422.50	63556	$422.50	63856	$422.50
61437	$420.60	63270	$422.50	63559	$422.50	63859	$422.50
61438	$534.10	63273	$422.50	63562	$422.50	63862	$422.50
61441	$374.35	63276	$422.50	63565	$422.50	63865	$422.50
61442	$603.25	63279	$422.50	63568	$422.50	63868	$422.50
61449	$345.20	63290	$422.50	63571	$422.50	63870	$422.50
61453	$396.10	63293	$422.50	63574	$422.50	63880	$422.50
61457	$357.60	63300	$422.50	63580	$422.50	63883	$422.50
61461	$407.60	63303	$422.50	63583	$422.50	63900	$422.50
61484	$715.30	63306	$422.50	63590	$422.50	63903	$422.50
61485	$818.50	63309	$422.50	63593	$422.50	63906	$422.50
63000	$422.50	63312	$422.50	63600	$422.50	63909	$422.50
63003	$422.50	63315	$422.50	63603	$422.50	63920	$422.50

CORRIGENDUM TO THE NOVEMBER 2000 EDITION OF THE MEDICARE BENEFITS SCHEDULE BOOK

LISTING OF CORRECT 85% BENEFIT LEVEL FOR ITEMS WITH FEES OF $350 OR MORE

Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit	Item No.	85% Benefit
63930	$422.50						
63940	$422.50						
63943	$422.50						
63946	$422.50						
71145	$366.45						
73287	$301.50						
75024	$414.75						
75027	$588.15						
75030	$517.95						
75033	$882.45						
75034	$423.40						
75036	$1,238.95						
75037	$1,574.05						
75039	$379.75						
75045	$812.85						
75050	$448.90						
75051	$717.25						
75612	$339.80						
75809	$304.05						
75812	$343.65						
75815	$430.80						
75818	$517.95						
75821	$407.00						
75824	$478.35						
75827	$557.60						
75830	$621.00						
75833	$771.45						
75836	$890.30						

REPLACEMENT PAGE - LEVEL C

* FEES + BENEFITS INCORRECT IN MBS BOOK.

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

	LEVEL A			LEVEL B		
	FEE	BENEFITS		FEE	BENEFITS	
PATIENTS		85%	75%		85%	75%
ONE	32.00	27.20	24.00	46.15	39.25	34.65
TWO	22.45	19.10	16.85	36.60	31.15	27.45
THREE	19.25	16.40	14.45	33.40	28.40	25.05
FOUR	17.65	15.05	13.25	31.80	27.05	23.85
FIVE	16.70	14.20	12.55	30.85	26.25	23.15
SIX	16.05	13.65	12.05	30.20	25.70	22.65
SEVEN+	14.15	12.05	10.65	28.30	24.10	21.25

*	LEVEL C			LEVEL D		
	FEE	BENEFITS		FEE	BENEFITS	
PATIENTS		85%	75%		85%	75%
ONE	67.90	57.75	50.95	91.00	77.35	68.25
TWO	58.35	49.60	43.80	81.45	69.25	61.10
THREE	55.15	46.90	41.40	78.25	66.55	58.70
FOUR	53.55	45.55	40.20	76.65	65.20	57.50
FIVE	52.60	44.75	39.45	75.70	64.35	56.80
SIX	51.95	44.20	39.00	75.05	63.80	56.30
SEVEN+	50.05	42.55	37.55	73.15	62.20	54.90

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

Commonwealth Department of Health and Aged Care

Medicare Benefits Schedule Book

Operating from 1 November 2000

This book provides information on the arrangements for the payment of Medicare benefits for professional services rendered by registered medical practitioners and approved dental practitioners (oral surgeons). These arrangements operate under the Health Insurance Act 1973 (as amended). However, at the time of printing, the relevant legislation giving authority for the changes included in this edition of the book may still be subject to the approval of Executive Council and the usual Parliamentary scrutiny. This book is not a legal document, and, in cases of discrepancy, the legislation will be the source document for payment of Medicare benefits.

BOOK LAYOUT

This book contains the following Sections, colour coded as indicated:-

- **Contents (black edging)**
- **Introduction**
- **Summary of Changes included in this Edition**
- **General Explanatory Notes**
  (Includes an outline of the Medicare benefit arrangements and general notes for guidance for all services)
- **General Medical Services comprising**
  - Professional Attendances (Category 1) - (buff edging)
  - Diagnostic Services (Category 2) - (blue edging)
  - Therapeutic Procedures (Category 3) - (red edging)
  (Includes specific explanatory notes preceding each category)
- **Index to General Medical Services (green edging)**
- **Approved Dental Practitioner Services (Category 4) - (grey edging)**
  (Includes an outline of these arrangements, specific explanatory notes and an index)
- **Diagnostic Imaging Services (Category 5) - (purple edging)**
  (Includes an outline of these arrangements, specific explanatory notes and an index)
- **Pathology Services (Category 6) - (yellow edging)**
  (Includes an outline of these arrangements, specific explanatory notes and an index)

CONTENTS

INTRODUCTION

The book is divided into the following sections :-

- **General Explanatory Notes**
  (includes an outline of the Medicare benefit arrangements and general notes for guidance for all services)

- **General Medical Services** comprising
  - **Professional Attendances** (Category 1) - **(buff edging)**
  - **Diagnostic Services** (Category 2) - **(blue edging)**
  - **Therapeutic Procedures** (Category 3) - **(red edging)**
  (includes specific explanatory notes preceding each Category)

- **Index to General Medical Services (green edging)**

- **Approved Dental Practitioner Services** (Category 4) - **(grey edging)**
  (includes an outline of these arrangements, specific explanatory notes and an index)

- **Diagnostic Imaging Services** (Category 5) - **(purple edging)**
  (includes an outline of these arrangements, specific explanatory notes and an index)

- **Pathology Services** (Category 6) - **(yellow edging)**
  (includes an outline of these arrangements, specific explanatory notes and an index)

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

Located with the item number and description for each service is the Schedule fee and Medicare benefit, together with a reference to an explanatory note relating to the item if applicable. In the case of services which have an associated anaesthetic, the appropriate anaesthetic item number and the number of "basic" and "time" units (indicated by "B" and "T"), are also shown, e.g. (Anaes. 17709 = 3B + 6T).

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

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

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

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

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

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

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

NSW – 132 150
VIC - 03 9605 7964
QLD - 07 3004 5280
SA - 08 8274 9788
WA - 132 150
TAS - 03 6215 5740
ACT - 02 6124 7611
NT - use South Australia number

Changes to Provider Details
It is important that the Health Insurance Commission be notified promptly of changes to practice addresses to ensure correct provider details for each practice location. Addresses of the Commission are listed at paragraph 2.9 of the General Explanatory Notes of this book. (See also paragraph 2.2 of the General Explanatory Notes).

Distribution of the Medicare Benefits Schedule Book
It is also important to notify the Department of Health and Aged Care of changes to mailing details to ensure receipt of the Medicare Benefits Schedule book and up-dates. Enquiries regarding distribution of the book and notification of changes of details should be directed to the Central Office of the Department, Fax (02) 6289 4996 or Freecall 1800 020103. Addresses of the State Offices of the Department are listed below. Please note that matters of interpretation of the Schedule should be directed to the Health Insurance Commission (see above).

NEW SOUTH WALES

Level 7
1 Oxford Street
SYDNEY NSW 2000
Tel (02)9263 3555

VICTORIA

2 Lonsdale Street
MELBOURNE VIC 3000
Tel (03)9665 8888

QUEENSLAND

5th Floor Samuel Griffith Building
340 Adelaide Street
BRISBANE QLD 4000
Tel (07)3360 2555

SOUTH AUSTRALIA

Commonwealth Centre
55 Currie Street
ADELAIDE SA 5000
Tel (08)8237 8111

WESTERN AUSTRALIA

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

TASMANIA

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

AUSTRALIAN CAPITAL TERRITORY

Alexander Building
Furzer Street
PHILLIP ACT 2606
Tel (02) 6289 1555

NORTHERN TERRITORY

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

Future Editions of the Medicare Benefits Schedule Book
The Department welcomes any suggestions for improvements on the layout of the Medicare Benefits Schedule book from individual practitioners. Any suggestions should be forwarded to:- The Director, Financial and Schedule Review Section, Medicare Benefits Branch, MDP 106, GPO Box 9848, Canberra ACT 2601.

Internet
The Medicare Benefits Schedule is also available on the Department of Health and Aged Care's Internet site at www.health.gov.au. The site contains a viewing file and an ASCII text downloadable file of the current version of the Schedule.

SUMMARY OF CHANGES INCLUDED IN THIS EDITION

General Fee Increase
A 2.1% increase in Schedule fees will apply to all items in Group A1 plus equivalent attendance items. There has been no increase in the Schedule fees for items in Group A2 (other unreferred attendances), Group A6 (group therapy), item 173 in Group A7 (acupuncture) and Bone Densitometry (Items 12306 to 12321). A 1.2% increase will apply to all other items except for Pathology and Diagnostic Imaging.

Increase in Maximum Gap Payment
The maximum patient gap between the Schedule fee and the benefits payable for out-of-hospital services increases to $52.50 as at 1 November 2000. The 85% benefit level will apply for all fees up to $350.00, after which, benefits are calculated at the Schedule fee less $52.50.

Review of General Medical Services
The main changes involve the following services/areas of the Schedule:-

- Enhanced Primary Care (see note below)
- Case Conferences for Consultant Physicians (new items) (see note below)
- Nursing Home Attendances (see note below)
- Assisted Reproductive Services (lifting of 6-cycle limit on stimulated cycles)
- Breast biopsy using vacuum-assisted breast biopsy device (new item – Item 30358)
- Upper GI/HPB services (new and amended items) (see note below)
- Obstetrics and Gynaecology (new/amended items) (see note below)
- Lens extraction and insertion (clarification that benefits are not payable for correction of refractive error only)
- Total Ear Reconstruction (new items 45660 and 45661)
- Oral and maxillo-facial services (new/amended items) (see note below)
- Vaccines and bulk-billing (see General Explanatory Note 7.5.4)

ENHANCED PRIMARY CARE
New items have been introduced for provision of services to care recipients in residential aged care facilities. Item 730 enables a medical practitioner to contribute to a care plan in a residential aged care facility. Items 734, 736, 738, 775, 778 and 779 enable a medical practitioner to organise and participate in a case conference for a care recipient in a residential aged care facility.

The notes for guidance have also been amended to clarify the intention that:-
- EPC services should generally only be provided by the patient's usual medical practitioner or practice
- Third party service providers, such as a nurse or other assistant, may only be used to collect information for health assessments where specific requirements are met
- Diagnostic imaging or pathology services should only be ordered as part of a health assessment where they are clinically relevant.

CASE CONFERENCES FOR CONSULTANT PHYSICIANS
A range of new items has been introduced for case conferences for consultant physicians in community settings and for discharge planning for hospital in-patients. These items provide for case conferencing in residential aged care facilities.

Four new items (801, 803, 805 and 807) cover the organisation of, or participation in, a community case conference with a multidisciplinary team of at least three other formal care providers. A further four items (809, 811, 813 and 815) cover the organisation of, or participation in, a discharge case conference.

Similar to the Enhanced Primary Care items, these items have been developed in recognition that improved coordination in community settings leads to improved patient outcomes through a more flexible, efficient and responsive match between patients' needs and services.

NURSING HOME ATTENDANCES
With the introduction of the Aged Care Act 1997, the use of the term "nursing home" throughout the Schedule was no longer appropriate. The Schedule has been reviewed and references to "nursing home" replaced with "residential aged care facility" (see definition in General Explanatory Note 14.5).

This has required changes to the descriptions of some items to ensure that there are no unintended consequences of this change.

UPPER GI/HPB SURGERY
A number of changes to the General Surgery area of the Schedule have been made following a review of upper GI/HPB services, to reflect changes in clinical practice in this area (particularly laparoscopic procedures) and to encourage best practice:-

- New items and amendments to existing items covering procedures associated with enteral feeding (31456 to 31462), management of gastro-oesophageal reflux and para-oesophageal hernias (30532, 30533, 31464 to 31468), biliary surgery (30472, 31472), and dilatation of upper GI stricture (41819, 41820).
- New items for laparoscopic splenectomy (31470), and drainage of pus, blood or bile (31454).
- Amendment to items 30536 to 30539 (oesophagectomy), items 30461 to 30464 (resection of bile duct carcinoma), and item 30596 (splenorrhaphy or partial splenectomy).

OBSTETRICS AND GYNAECOLOGY
A number of changes have been made to the Obstetrics and Gynaecology sections of the Schedule to reflect current practice:-

- New items covering external cephalic version (16501), laparoscopic resection of complicated (level 4/5) endometriosis (35641), resection of uterine septum (35634, 35635), and control of post-operative haemorrhage following gynaecological surgery (35759).
- Amendments to items 35638 (complex operative laparoscopy), and 35623 and 35636 (resection of myoma/uterine septum).

ORAL AND MAXILLOFACIAL SERVICES
Various changes have been introduced following a major review of oral and maxillofacial services by approved dental practitioners to better reflect modern practice and advances in the craft.

Eighty-nine new items have been introduced in recognition of modern practice and/or to complement existing services (51900-52006, 52010, 52025, 52031, 52035, 52056, 52058-52059, 52061-52062, 52064, 52073, 52094-52095, 52097-52098, 52130-52131, 52133, 52136-52137, 52150-52186, 52320, 52424-52484, 52826-52832, 53004, 53007, 53017, 53050-53066, 53070, 53200, 53220, 53226, 53236-53242, and 53600-53706).

Sixteen existing items have been amended to address fee anomalies, introduce an explicit OMS regional restrictor, and/or as a consequence of the introduction of the new items (52027, 52034, 52055, 52057, 52060, 52063, 52090, 52345, 52351, 52357, 52363, 52369, 52375, 52382, 53003, 53068 and 53223).

CHANGES TO PATHOLOGY SERVICES
Nine new items have been included in the Pathology Services Table covering full blood examination (65070), metals (66667 – 66673) and Hepatitis C (69442 – 69445)

A number of items have been amended in the following Groups P1 (Haematology), P2 (Chemical), P3 (Microbiology) and P4 (Immunology) as follows:

Items 65078, 65081, 65087, 65084, 65096, 65099, 65102, 65105, 65108, 65165, 71127 and 71135
– reference to items 65063 and/or 65069 have been removed and new item 65070 has been included
Item 65132 – removal of arterial thrombosis
Item 65137 – removal of 'connected with a service' and addition of 'associated with any service', and inclusion of reference to items 65133 - 65136
Item 65142 – removal of 'characterisation' and addition of 'clarification'
Item 66536 – inclusion of requirement for 'serum cholesterol level >4.0 mmol/L and has a history of ischaemic heart disease'
Item 66560 – removal of 'in proven diabetes mellitus – 1 or more tests'
Items 69315 and 69372 – addition of reference to item 69370
Items 69327 and 69330 – addition of 'isolated as a result of this procedure'
Item 69462 – removal of 'immune status to' and inclusion of 'and if this is positive' at (b). Fee increase to $39.55

A number of Rules have been amended as follows:

Rules 4 and 17 - reference to items 65063 and 65069 have been removed and new item 65070 has been included
Rule 5 – removal of 'were transfused into the patient within 24 hours' and replaced with 'issued for the patient's care in any 1 day'

Rule 14(1) – revised definition of 'Biopsy material'
Rule 23 – nutritional and toxicity testing

A number of abbreviations have been amended and new ones included
A new complexity level for specimen type: Jaw, upper or lower, including bone, radical resection for neoplasm with a complexity level of 6 has been included

CHANGES TO DIAGNOSTIC IMAGING SERVICES
Musculoskeletal ultrasound—the existing items have been deleted and a new ultrasound subgroup created (subgroup 6). Please refer to Section DIH of the explanatory notes for the Diagnostic Imaging Services Table.

Nuclear medicine—from 1 November 2000, Medicare rebates will be only available to patients of practitioners who are recognised as credentialled specialists in nuclear medicine. Please refer to Section DIK of the explanatory notes for the Diagnostic Imaging Services Table.

Professional supervision requirements—these have been clarified, as detailed in Section DIH of the explanatory notes for the Diagnostic Imaging Services Table. A 'personal attendance' requirement has also been introduced for musculoskeletal ultrasound services.

Obstetric ultrasound—new items for multiple pregnancies have been introduced. Item 55058, ultrasound of umbilical blood flow has been moved to the obstetric and gynaecological subgroup as item 55729. The requirements for items 55712 and 55715 have also been clarified. Please refer to Section DIH of the explanatory notes for the Diagnostic Imaging Services Table.

Cardiac ultrasound—a new item (55116) has been introduced for stress echocardiography examinations. Items 55102 and 55105 have been deleted. Minor amendments have been implemented to items 55112 and 55118 in order to reflect current clinical practice. Please refer to Section DIH of the explanatory notes for the Diagnostic Imaging Services Table.

Specialist requests—dental specialists (periodontistry, endodontistry, pedeodontistry, orthodontistry and prosthodontistry) and oral medicine and oral pathology surgeons are now able to request certain diagnostic imaging items, as noted in Section DIA4.8 of the explanatory notes for the Diagnostic Imaging Services Table.

Rural or pre-existing practices exemptions—from 1 January 2001, general practitioners providing specialist-type (R-type) diagnostic imaging services will be required to participate in a continuing medical education and quality assurance program in order to continue to be eligible for Medicare benefits for these services. Please refer to Section DIA and DIC of the explanatory notes for the Diagnostic Imaging Services Table.

SUMMARY OF CHANGES

The changes outlined above are summarised in the following paragraphs and are identified in the Schedule by one or more of the following symbols appearing above the item number where appropriate:-

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

New Items

730	734	736	738	775	778	779	801	803	805	807	809	811	813	815
16501	30358	31454	31456	31458	31460	31462	31464	31466	31468	31470	31472	35634	35635	35641
35759	41820	45660	45661	51900	51902	51904	51906	52010	52025	52031	52035	52056	52058	52059
52061	52062	52064	52073	52094	52095	52097	52098	52130	52131	52133	52136	52137	52150	52152
52154	52156	52158	52160	52166	52168	52170	52172	52174	52176	52180	52182	52184	52186	52320
52424	52430	52432	52434	52440	52442	52444	52446	52448	52450	52452	52454	52456	52458	52460
52470	52476	52478	52480	52482	52484	52826	52828	52830	52832	53004	53007	53017	53050	53052
53054	53056	53058	53060	53062	53064	53066	53070	53220	53226	53236	53239	53242	53600	53700
53702	53704	53706	55116	55117	55759	55762	55764	55766	55768	55770	55772	55774	55800	55802
55804	55806	55808	55810	55812	55814	55816	55818	55820	55822	55824	55826	55828	55830	55832
55834	55836	55838	55840	55842	55844	55846	55848	55850	65070	66667	66669	66670	66672	66673
69442	69443	69445												

Deleted Items

30470	55050	55051	55052	55053	55102	55105	65063	65069	66668

Amended Description

4	13	20	24	25	35	37	38	43	47	48	51	58	81	92
104	107	110	122	320	322	324	326	328	330	332	334	336	338	348
700	702	704	706	720	722	724	726	740	742	744	746	749	757	759
762	765	768	771	773	13200	30363	30461	30463	30464	30472	30532	30533	30536	30538
30539	30596	35623	35636	35638	41819	42698	42701	42702	45723	45729	45732	45738	45744	45752
45754	51300	51303	51700	51800	51803	52027	52034	52055	52057	52060	52063	52090	52345	52351
52357	52363	52369	52375	52382	53003	53233	55036	55037	55038	55039	55044	55045	55112	55118
55130	55700	55703	55704	55705	55718	55723	57350	57355	65132	65137	65142	66536	66560	69315
69324	69327	69330	69336	69345	69372	69462	71059	73912						

Fee Amended

726	728	53003	53200	69462

Item Number Change

Old	New	Old	New	Old	New	Old	New
53018	53068	55058	55729				

Anaesthetic Unit Values Amended

35623	35636

Assist – deletion of

35636	37206	37207	37208

SPECIAL ARRANGEMENTS - TRANSITIONAL PERIOD

Where an item refers to a service in which treatment continues over a period of time in excess of one day and the treatment commenced before 1 November 2000 and continues beyond that date, the general rule is that the 1 November 1999 level of fees and benefits would apply.

GENERAL EXPLANATORY NOTES

MEDICARE BENEFIT ARRANGEMENTS

1. OUTLINE OF SCHEME

1.1 Medicare

1.1.1 The Australian Medicare Program provides access to medical and hospital services for all Australian residents and certain categories of visitors to Australia. Legislation covering the major elements of the Program is contained in the Health Insurance Act 1973 (as amended).

1.1.2 With regard to medical expenses, the basic aim of the Medicare program is to provide:-

- automatic entitlement to benefits in respect of professional services (other than professional services to which the following dot point applies) equal to 85% of the Medicare Benefits Schedule fee, with a maximum payment of $52.50 (indexed annually) by the patient for any one service where the Schedule fee is charged;
- for professional services rendered while hospital treatment (i.e., accommodation and nursing care) is provided to a patient who has been admitted to a hospital or day hospital facility (other than public patients), a flat rate of benefit of 75% of the Schedule fee, that is, there is no limit to the maximum amount of gap between the benefit and the Schedule fee; and
- access to public hospital services for eligible persons who choose to be treated free of charge as public patients in accordance with the provisions of the 1998-2003 Australian Health Care Agreements.

Patients may insure with private health insurance organisations for the gap between the 75% Medicare benefit and the Schedule fee, or for amounts in excess of the Schedule fee where the patient has an arrangement with their health fund. For out-of-hospital services the maximum amount of 'gap' (i.e. the difference between the Medicare rebate and the Schedule fee) payable by a family group or an individual in any one calendar year is $285.00 (indexed annually from 1 January). A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25.

1.1.3 The Health Insurance Commission is responsible for the operation of Medicare and Medicare benefits based on the services and fees contained in this book. For details of locations of Medicare offices, see paragraph 2.9 below.

1.1.4 Where an eligible person incurs medical expenses in respect of a professional service Medicare will pay benefits for that service as outlined in these notes. The definition of professional service as contained in the Health Insurance Act provides that such a service must be "clinically relevant". A clinically relevant service means a service rendered by a medical or dental practitioner or an optometrist that is generally accepted in the medical, dental or optometrical profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered.

1.1.5 It is recognised that medical practitioners will sometimes be called upon to provide services which cannot be considered as being medically necessary. Accounts for these services should not be itemised as attracting Medicare benefits. The fee charged for such services is a private matter between the practitioner and the patient.

1.1.6 For any service listed in the Schedule to be eligible for a Medicare rebate, the service must be rendered in accordance with the provisions of the relevant Commonwealth and State and Territory laws. Practitioners have the responsibility to ensure that the supply of medicines or medical devices used in the provision of medical services is strictly in accordance with the provisions of the Therapeutic Goods Act 1989.

2. PROVIDER ELIGIBILITY

2.1 Access to Medicare Benefits

2.1.1 Amendments to the Health Insurance Act 1973 which came into force in December 1996 provide that from that date, medical practitioners have to meet minimum proficiency requirements before any services they provide (except assistance at operations) can attract a Medicare benefit. To be eligible to provide a medical service which can attract a Medicare benefit, or to provide services for or on behalf of another practitioner, one of the following conditions must apply:-

- the person was a medical practitioner prior to 1 November 1996 (this does not include an intern or Australian Medical Council candidate who has not completed a required period of supervised training, a person without the legal right to be in Australia on 1 November 1996, or a person acting as a medical practitioner on a temporary visa); or
- the person is a recognised specialist, consultant physician or general practitioner; or
- the person is in an approved placement under section 3GA of the Health Insurance Act 1973; or
- the person is a temporary resident doctor with a determination under Section 3J of the Health Insurance Act 1973, while working in accord with that determination (Note: New Zealand citizens entering Australia do so under a special temporary entry visa and are regarded as temporary resident doctors).

2.1.2 Any practitioner who does not satisfy these requirements is not a Medical Practitioner for Medicare purposes and Medicare benefits cannot be paid for their services. This does not affect the practitioners ability to prescribe, refer, order diagnostic tests etc.

2.1.3 It is an offence under Section 19CC of the Health Insurance Act 1973 to provide a service without first informing a patient where a Medicare benefit is not payable for that service.

2.2 Provider Numbers

2.2.1 When an eligible medical practitioner wishes to have Medicare benefits payable for his/her services and/or, for Medicare purposes, wishes to raise valid

- referrals for specialist services; or
- requests for pathology or diagnostic imaging services,

the practitioner can apply in writing to the Health Insurance Commission for a Medicare provider number for the sites from which medical services/referrals/requests will be provided. A blank downloadable form is available on the Commission's website at www.hic.gov.au/medicare/providers/forms.htm.

2.2.2 Medicare Provider Numbers are allocated to practitioners to provide an easy method of identifying the place from which a service is provided. Health Insurance Regulations provide that, for Medicare purposes, a valid account/receipt must contain the practitioners' name and either:-

- the address of the place from which the service was provided; OR
- the provider number for the place from which the service was provided.

2.2.3 The provider number comprises a stem number which is up to 6 characters followed by a number/alpha denoting the practice location followed by an alpha character which is a check character.

2.2.4 Medical registration information is validated by medical registration authorities to ensure appropriate processing of Medicare claims.

2.2.5 Pay group arrangements are available which allow Medicare benefit cheques, which would normally be payable to a medical practitioner, to be made payable to a third party. Information about pay group links is contained in the provider number application form and is available from the Health Insurance Commission and on the Commission's website at www.hic.gov.au. Existing pay group arrangements can be terminated by a written request from the practitioner, however, the Health Insurance Commission will routinely inform the payee of such a termination.

2.2.6 Medicare provider number information is released in accord with the secrecy provisions of the Health Insurance Act 1973 (Section 130) to authorised external organisations including Private Health Insurance Funds, the Department of Veterans' Affairs and the Department of Health and Aged Care.

2.3 Locum Tenens

2.3.1 Where a locum tenens is to provide services at a practice location for more than two weeks or will be providing services at the location for less than two weeks but on a regular basis, the locum should apply for a provider number for that location. If the locum is to provide services at a practice for less than two weeks and will not be returning to that location in the future, the locum should contact the Health Insurance Commission's provider liaison area (phone 132 150) to discuss options. In some cases the locum may be able to use one of his/her other provider numbers. The use of a provider number other than the provider number allocated to the location MUST NOT apply where:

- the practitioner is an RACGP or specialist trainee with a provider number issued for an approved training placement; or
- the practitioner is associated with an approved rural placement under Section 3GA of the Health Insurance Act 1973; or
- the practitioner has access to Medicare benefits as a result of the issue of a determination under Section 3J of the Health Insurance Act 1973 which only gives the practitioner access to Medicare benefits at specific practice locations; or
- the locum is to provide services at a practice which is participating in the Practice Incentives Program as the use of a provider number not specifically allocated for the practice will affect payments to the practice under the Practice Incentives Program.

2.3.2 Locums can direct Medicare payments to the principal of the practice by either arranging a pay group link and/or by nominating the principal as the payee on direct bill stationery.

2.4 Approved Placement for Rural Locations (Section 3GA Approvals)

2.4.1 There are two categories of medical practitioner for whose services Medicare benefits are not payable. They are medical practitioners:-

- subject to the 10 year moritorium; and
- first registered on or after 1 November 1996 who are not eligible for recognition as either a general practitioner or specialist.

2.4.2 Arrangements exist to enable medical practitioners (otherwise ineligible to access Medicare) to do after hours work or rural locum work through a structure that provides adequate supervision, quality assurance and backup arrangements while allowing Medicare billing from an approved practice placement site.

2.4.3 Further information on approved placements for rural locums is available from the Department of Health and Aged Care on (02) 6289 4203.

2.5 Overseas Trained Doctors and the Ten Year Moratorium

2.5.1 Section 19AB of the Health Insurance Act 1973 provides that services provided by overseas trained doctors (including New Zealand doctors) and overseas doctors trained in Australia will not attract Medicare benefits for a period of 10 years from the time they become registered as a medical practitioner for the purposes of the Health Insurance Act (the date from which the 10 year moratorium will commence varies from case to case). These measures do not apply to doctors who:-

- before 1 January 1997, registered with a State or Territory medical board (not including a person on a temporary resident visa) provided that they retained the continuous legal right to remain in Australia; or
- made an application to the Australian Medical Council (AMC) which was received before 1 January 1997, to undertake examinations, successful completion of which would ordinarily enable the person to become a medical practitioner (and was eligible to lodge an application with the AMC); or
- is a temporary resident doctor (including New Zealand doctors) with a determination under Section 3J of the Health Insurance Act 1973 while working in accord with that determination.

2.5.2 The Minister can grant an exemption to these requirements and can impose conditions on any exemption provided. Requests for exemption from the moritorium should be directed to the Department of Health and Aged Care on (02) 6289 5903.

2.6 Temporary Resident Doctors (TRD) and Occupational Trainees (OT)

2.6.1 To be allocated a Medicare provider number a TRD/OT must be supported by their employer and be able to demonstrate that there is a need to have Medicare benefits payable for their services, refer or request specialist services for Medicare purposes and/or provide prescriptions under the Pharmaceutical Benefits Scheme. The following documentation is required with an application for a Medicare provider number:-

- Australian medical registration papers; and
- a copy of personal details in a passport and all Australian visas and entry stamps; and
- a letter from the employer stating the reason why a Medicare provider number and/or presciber number is required; and
- a copy of the employment contract.

2.6.2 Those TRD/OT deemed eligible for a Medicare provider number by the issue of a Section 3J determination by the Minister's delegate will need to provide their name and address, as well as their Medicare provider number on all bills for services they
have rendered where a Medicare benefit is to be claimed.

2.6.3 The issue of a 3J determination is not automatic and is not backdated. Medicare benefits cannot be paid for services rendered by a TRD/OT until a 3J determination has been issued. Delegations for the issue of 3J determinations are held by the Department of Health and Aged Care and as a result, applications received by the Health Insurance Commission will be forwarded to the Department for approval. Applicants for 3J determinations should apply to the Health Insurance Commission.

2.6.4 TRD/OT are usually granted conditional medical registration. Use of a Medicare provider number outside of the conditions imposed through their visa and medical registration will make the TRD/OT liable to action by the Department of Immigration and Multicultural Affairs and the State or Territory medical board.

2.6.5 Information about applying for a Medicare provider number can be obtained by telephone on 132 150 (a local call cost) or by contacting the Provider Liaison Section of the Health Insurance Commission in your State.

2.7 Use of Provider Numbers and Closure of Practice Locations

2.7.1 Use of an incorrect Medicare provider number may be a breach of Health Insurance Regulations which require that an account/receipt lodged with a claim for Medicare benefits must contain the practitioner's name and either:-

- the address of the place from which the service was provided; OR
- the provider number for the place from which the service was provided.

2.7.2 It is important that the Health Insurance Commission be notified promptly where a practitioner ceases to practice from a location. Failure to notify closure can lead to misdirection of Medicare cheques and other information from the Health Insurance Commission.

2.8 Practice Incentives Program

2.8.1 Practitioners who work at practices participating in the Practice Incentives Program are reminded about the importance of having a provider number linked to that practice. Under the Practice Incentives Program, only services rendered by a practitioner with a provider number linked to the practice location will be taken into account when determining the practice's payment. Medicare and the Department of Veterans' Affairs data is used to identify consultations linked to provider numbers. Even practitioners working for limited periods at the practice should have a provider number allocated for that period.

2.9 Addresses of the Health Insurance Commission

Postal: Medicare, GPO Box 9822, in the Capital City in each State
Telephone: 132150, All States (a local call cost)

NEW SOUTH WALES	VICTORIA	QUEENSLAND
The Colonial State Bank Tower 150 George Street PARRAMATTA NSW 2165	State Headquarters 460 Bourke Street MELBOURNE VIC 3000	State Headquarters 444 Queen Street BRISBANE QLD 4000

SOUTH AUSTRALIA	WESTERN AUSTRALIA	TASMANIA
State Headquarters 209 Greenhill Road EASTWOOD SA 5063	State Headquarters Bank West Tower 108 St. George's Terrace PERTH WA 6000	242 Liverpool Street HOBART TAS 7000

AUSTRALIAN CAPITAL TERRITORY	NORTHERN TERRITORY
134 Reed Street TUGGERANONG ACT 2901	As per South Australia

3. PATIENT ELIGIBILITY FOR MEDICARE

3.1 Eligible Persons

3.1.1 An "eligible person" means a person who resides legally in Australia and whose stay in Australia is not subject to any limitation as to time, but does not include a foreign diplomat or family (except where eligibility is expressly granted to such persons by the terms of a reciprocal health care agreement). A person covered by a reciprocal health care agreement is eligible for Medicare for services of immediate medical necessity.

3.1.2 The Health Insurance Act gives the Minister discretionary powers to either include or exclude certain persons or categories of persons for eligibility purposes under the Medicare arrangements.

3.1.3 Eligible persons must enrol with Medicare before benefits can be paid.

3.2 Medicare Cards

3.2.1 An eligible person who applies to enrol for Medicare benefits (using a Medicare Enrolment/Amendment Application) will be issued with a uniquely numbered Medicare Card which shows the Medicare Card number, the patient identifier number (reference number), the applicant's first given name, initial of second given name, surname, and an effective "valid to" date. These cards may be issued on an individual or family basis. Up to five persons may be listed on the one Medicare card, and up to nine persons may be listed under the one Medicare card number.

3.2.2 Medicare cards issued with the word "VISITOR" and a date means that at the time the card was issued, Medicare eligibility was restricted. These cards are issued to persons including visitors who have been determined to be eligible and eligible persons awaiting permanent resident status.

3.2.3 Special Medicare cards are issued where appropriate to persons accessing out-of-hospital medical care under a Reciprocal Health Care Agreement (RHCA). These cards are similar to a resident Medicare card and include a "Valid to" date but are endorsed "Visitor RHCA". Persons covered by the New Zealand (for arrivals after 1 September 1999) and Ireland Agreements do not hold Medicare "Visitor RHCA" cards as they are not entitled to access out-of-hospital benefits.

3.3 Health Care Expenses Incurred Overseas

3.3.1 Medicare does NOT cover medical or hospital expenses or the cost of medical evacuation incurred outside Australia. It is recommended that Australian residents travelling overseas take out private traveller's or health insurance which offers adequate coverage for the countries to be visited. (See also Reciprocal Health Care Agreements.)

3.4 Visitors to Australia and Temporary Residents

3.4.1 Medicare benefits are generally not payable to visitors to Australia or temporary residents and such persons should take out private health insurance. People visiting Australia specifically for medical or hospital treatment are not eligible for Medicare benefits. (See also Reciprocal Health Care Agreements.)

3.4.2 All eligible visitors must enrol with Medicare to receive benefits. A practitioner can determine the eligibility period for visitors by checking the "valid to" date at the bottom right hand corner of the card.

3.5 Reciprocal Health Care Agreements

3.5.1 Visitors from countries with which Australia has Reciprocal Health Care Agreements are eligible for benefits to the extent specified in the Agreement for immediately necessary medical care under the Medicare Program. Likewise, Australians visiting these countries are entitled to health care under their public health schemes. Agreements are currently in place with New Zealand, the United Kingdom, the Netherlands, Sweden, Finland, Italy, Malta and Ireland. It is anticipated that an Agreement with Norway, and possibly Denmark, will be operational by 2001 (Medicare will be able to advise the status of these Agreements). Visitors are eligible for benefits for the duration of their stay, except in the case of Italy and Malta, where benefits are for six months only. With the exception of New Zealand, the Agreements provide diplomats and their families with full Medicare cover for the term of their stay, which is not restricted to immediately necessary treatment.

3.5.2 The Agreements provide for immediately necessary medical treatment only, that is, treatment for any episode of ill-health which requires prompt medical attention. However, the Agreements with New Zealand (for those visitors arriving after 1 September 1999) and Ireland are restricted to public hospital care only. Persons covered by these two Agreements do not hold Medicare "Visitor RHCA" cards as they are not entitled to access out-of-hospital benefits.

3.5.3 The Agreements do not include pre-arranged or elective treatment, or treatment as a private patient in a public or private hospital.

3.6 Workers' Compensation, Third Party Insurance, Damages, etc.

3.6.1 From 1 February 1996, Medicare benefits are payable for medical expenses for professional services that are wholly covered by workers compensation or damages under a Commonwealth or State or Territory law.

3.6.2 The only exception to this is where a person has entered into a *reimbursement arrangement* with a compensation insurer. In such cases, a Medicare benefit is not payable. (A *reimbursement arrangement* is an agreement between a compensation claimant and the insurer stating that the medical expenses of the person will be paid by the insurer as and when they arise.)

3.6.3 The practitioner has the option to either bulk-bill Medicare or give the patient a private account as would normally occur with any other consultation.

3.6.4 There are arrangements in place to recover any Medicare benefits paid as a result of the injury once a settlement or judgement is made on the compensation claim. The recovery is done between the insurer or compensation payer, the compensable person and the Health Insurance Commission. These recovery arrangements do not impact on practitioners.

4. GENERAL PRACTICE

4.1 General Practice Items

4.1.1 Some of the items in the Medicare Benefits Schedule are only available to General Practitioners. For the purposes of the Medicare Benefits Schedule a General Practitioner is a medical practitioner who is:-

- Vocationally Registered under section 3F of the Health Insurance Act (see 4.3 below); or
- a holder of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) who participates in, and meets the requirements for, quality assurance and continuing medical education as defined in the RACGP Quality Assurance and Continuing Education Programme; or
- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP, or undertaking an approved placement in general practice as part of some other training program recognised by the RACGP as being of an equivalent standard.

4.2 Fellows of the RACGP and Trainees in General Practice

4.2.1 A medical practitioner who is seeking recognition as a general practitioner, as a Fellow of the RACGP or as a general practice trainee should apply to the Manager, Health Programs Branch, Health Insurance Commission, at any of the Commission addresses listed in paragraph 2.9.

4.3 Vocational Registration of General Practitioners

Recognition Method

4.3.1 The criteria for registration as a vocationally registered general practitioner are certification from either:-

- the Royal Australian College of General Practitioners (RACGP); or
- a General Practice Recognition Eligibility Committee (GPREC); or
- the General Practice Recognition Appeal Committee (GPRAC),

that the practitioner's medical practice is or will be within 28 days predominantly general practice, and

- that the RACGP or the Eligibility Committee certifies that the practitioner is a Fellow of the RACGP; and
- the RACGP certifies that the practitioner meets its minimum requirements for taking part in continuing medical education and quality assurance programs.

4.3.2 The GPRAC will hear appeals from medical practitioners who are refused certification by either the RACGP or a GPREC.

4.3.3 The only training and experience which the RACGP regards as appropriate for eligibility will be the attainment of Fellowship of the RACGP.

4.3.4 In assessing whether a practitioner's medical practice is predominately general practice, the RACGP and GPRECs/GPRAC will consider only services eligible for Medicare benefits. To qualify, 50% of this clinical time and services claimed against Medicare must be in general practice as defined. The RACGP and GPRECs/GPRAC will have regard to whether the practitioner provides a comprehensive primary medical service, including treating a wide range of patients and conditions using a variety of accepted medical skills and techniques, providing services away from the practitioner's surgery on request, for example, home visits and making appropriate provision for the practitioner's patients to have access to after hours medical care.

4.3.5 All enquiries concerning eligibility for registration should be directed to the RACGP at 52 Parramatta Road, Forest Lodge, NSW, 2037, or to the GPREC, Health Insurance Commission, PO Box 1001, Tuggeranong, ACT 2901.

How to Apply for Registration

4.3.6 To be listed on the register, application on the approved form must be made to the RACGP or a GPREC for certification of eligibility. The RACGP or the GPREC will notify the Health Insurance Commission of the eligibility status of the practitioner for inclusion on the VR register.

4.3.7 The RACGP and GPREC address for the purpose of submission of applications for registration as a vocationally registered general practitioner are:

The Secretary-General
The Royal Australian College
of General Practitioners
52 Parramatta Road
FOREST LODGE NSW 2037

Secretary
General Practice Recognition Eligibility Committee
Health Insurance Commission
PO Box 1001
TUGGERANONG ACT 2901

4.3.8 Continued vocational registration is dependent upon involvement in appropriate Continuing Medical Education (CME) and Quality Assurance (QA) programs approved by the RACGP, and the practitioner continuing to be predominantly in general practice.
4.3.9 All enquiries regarding the QA and CME requirements should be directed to the RACGP at 52 Parramatta Road, Forest Lodge, NSW, 2037.

Removal from Vocational Register
4.3.10 A medical practitioner may at any time request the Managing Director of the Health Insurance Commission to remove his/her name from the Vocational Register of General Practitioners.
4.3.11 Provision also exists for removal of a medical practitioner from the Vocational Register where the RACGP or a GPREC is no longer satisfied that the practitioner should remain on the Register. Examples of reasons for which a practitioner might be removed are:-

- the practitioner's medical practice is no longer predominantly general practice;
- the RACGP's minimum requirements for involvement in continuing Medical Education and Quality Assurance programs have not been met by the practitioner.

4.3.12 Appeals against removal may be made to the GPRAC, at the Health Insurance Commission, PO Box 1001, Tuggeranong, ACT, 2901.
4.3.13 Practitioners removed from the register for any reason must make a formal application to re-enter the register.

5. RECOGNITION AS A SPECIALIST OR CONSULTANT PHYSICIAN

5.1 Recognition Method

5.1.1 A medical practitioner who, having made formal application and paid the prescribed fee, and who:-

- is registered as a specialist under State or Territory law; or
- holds a fellowship of a specified specialist College; or
- is recommended for recognition as a specialist or consultant physician by a Specialist Recognition Advisory Committee;

may be recognised by the Minister as a specialist or consultant physician for the purposes of the Health Insurance Act.
5.1.2 A medical practitioner who:-

- is training towards a fellowship of a specified specialist College;

should apply to the Manager, Health Programs Branch, Health Insurance Commission, at any of the Commission addresses listed in paragraph 2.9, to be recognised as a specialist or consultant physician trainee.
5.1.3 There is provision for appeal to a Specialist Recognition Appeal Committee by medical practitioners who have not been recommended for recognition as specialists or consultant physicians by a Specialist Recognition Advisory Committee.
5.1.4 Where a medical practitioner has been recognised as a specialist or consultant physician for the purposes of the Health Insurance Act, Medicare benefits are payable at the appropriate higher rate in respect of certain services rendered by the practitioner in the practice of the recognised specialty, provided (other than in the case of examination by specialist anaesthetists in preparation for anaesthesia - see paragraph 6.3.1)the patient has been referred in accordance with paragraph 6.
5.1.5 All enquiries concerning the recognition of specialists and consultant physicians or specialist and consultant physician trainees should be directed to the Provider Liaison Section, Health Insurance Commission, PO Box 9822 in your State capital city. ACT and NT enquiries should be directed to NSW. Telephone enquiries can be directed to 132150 for the cost of a local call.

5.2 Emergency Medicine

5.2.1 For these purposes the following will determine when a practitioner is acting within the speciality of emergency medicine:-

Where the patient is treated by the medical practitioner within 30 minutes of presentation, and that patient is:

(a) at risk of serious morbidity or mortality requiring urgent assessment and resuscitation; or
(b) suffering from suspected acute organ or system failure; or
(c) suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
(d) suffering from a drug overdose, toxic substance or toxin effect; or
(e) experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or

(f) suffering acute severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or

(g) suffering acute significant haemorrhage requiring urgent assessment and treatment; and

(h) treated in, or via, a bona fide emergency department in a hospital.

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

6. REFERRAL OF PATIENTS TO SPECIALISTS OR CONSULTANT PHYSICIANS

6.1 Purpose

6.1.1 For certain services provided by specialists and consultant physicians the Medicare benefit payable is dependent on acceptable evidence that the service has been provided following referral from another practitioner.

6.1.2 A reference to a referral in this Section does not refer to written requests made for pathology services or diagnostic imaging services.

6.2 What is a Referral

6.2.1 A "referral" is a request to a specialist or a consultant physician for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

6.2.2 Subject to the exceptions in paragraph 6.2.3 below, for a valid "referral" to take place:-

(i) the referring practitioner must have turned his or her mind to the patient's need for referral and communicate relevant information about the patient to the specialist or consultant physician (but this does not necessarily mean an attendance on the occasion of the referral);

(ii) the instrument of referral must be in writing by way of a letter or note to a specialist or to a consultant physician and must be signed and dated by the referring practitioner; and

(iii) the specialist or consultant physician to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

6.2.3 The exceptions to the requirements in paragraph 6.2.2 are that:-

(a) sub-paragraphs (i), (ii) and (iii) do not apply to:

. an examination of a patient by a specialist anaesthetist in preparation for the administration of an anaesthetic (Item 17603);

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

. a referral generated within a hospital, in respect of a privately admitted patient for a service within that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or

. an emergency situation where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and

(c) sub-paragraph (iii) does not apply to:

. instances where a written referral was completed by a referring practitioner but was lost, stolen or destroyed.

NOTE: *"For these purposes an emergency is a situation where the patient is treated by the medical practitioner within thirty minutes of presentation, and that patient is:-*

(a) at risk of serious morbidity or mortality requiring urgent assessment and resuscitation; or

(b) suffering from suspected acute organ or system failure; or

(c) suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or

(d) suffering from drug overdose, toxic substance or toxin effect; or

(e) experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or

(f) suffering acute severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or

(g) suffering acute significant haemorrhage requiring urgent assessment and treatment."

6.3 Examination by Specialist Anaesthetists

6.3.1 A referral letter or note is not required in the case of Item 17603 - Examination of a patient in preparation for the administration of an anaesthetic. However, for benefits to be payable at the specialist rate for consultations by specialist anaesthetists (other than for a pre-operative examination) a referral is required.

6.4 Who can Refer

6.4.1 The general practitioner is regarded as the primary source of referrals. Cross referrals between specialists and/or consultant physicians should usually occur in consultation with the patient's general practitioner. (See paragraph 6.6.1).

6.4.2 Referrals are to be made as follows:-

(a) to a recognised consultant physician -

(i) by another medical practitioner; or

(ii) by an approved dental practitioner [1] (oral surgeon), where the referral arises out of a dental service;

(b) to a recognised specialist -

(i) by another medical practitioner; or

(ii) by a registered dental practitioner [2], where the referral arises out of a dental service; or

(iii) by a registered optometrist where the specialist is an ophthalmologist.

[1] See paragraph OB.1 for the definition of an approved dental practitioner.

[2] A registered dental practitioner is a dentist registered with the State or Territory Dental Board of the State or Territory in which s/he practices. A registered dental practitioner may or may not be an approved dental practitioner.

6.5 Billing

Routine Referrals

6.5.1 In addition to the usual information required to be shown on accounts, receipts or assignment forms (see paragraph 7 of these notes), specialists and consultant physicians must show the following details (unless there are special circumstances as indicated in paragraph 6.5.2):-

- name and either practice address or provider number of the referring practitioner;
- date of referral; and
- period of referral (where other than for 12 months) expressed in months, e.g. "3", "6" or "18" months, or "indefinitely" should be shown.

Special Circumstances

6.5.2 (i) Lost, stolen or destroyed referrals.

If a referral has been made but the letter or note of referral has been lost, stolen or destroyed, benefits will be payable at the referred rate if the account, receipt or the assignment form shows the name of the referring medical practitioner, the practice address or provider number of the referring practitioner (if either of these are known to the consultant physician or specialist) and the words 'Lost referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate a duplicate or replacement letter of referral must be obtained by the specialist or the consultant physician.

(ii) Emergency situations - (see note at paragraph 6.2.3 for definition of an emergency situation).

If the referral occurred in an emergency situation, benefit will be payable at the referred rate if the account, receipt or assignment form is endorsed 'Emergency referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate the specialist/consultant physician must obtain a letter of referral.

(iii) Hospital referrals.

• Private Patients - Where a referral is generated within a hospital in respect of a privately admitted patient for a service within that hospital, benefits will be payable at the referred rate if the account, receipt or assignment form is endorsed 'Referral within (name of hospital)' and the patient's hospital records show evidence of the referral (including the referring practitioner's signature). However, in other instances where a medical practitioner within a hospital is involved in referring a patient (eg to a specialist or a consultant physician in private rooms) the normal referral arrangements apply, including the requirement for a referral letter or note and its retention by the specialist or the consultant physician billing for the service.

• Public Hospital Patients - Under the 1998-2003 Australian Health Care Agreements, hospitals are obliged to provide public hospital services to eligible persons in accordance with the provisions of the Agreements.

Direct Billing

6.5.3 Direct billing assignment forms should show the same information as detailed above. However, faster processing of the claim will be facilitated where the provider number (rather than the practice address) of the referring practitioner is shown.

6.6 Period for which Referral is Valid

Specialist Referrals

6.6.1 Where a referral originates from a specialist or a consultant physician, the referral is valid for 3 months, except where the referred patient is an admitted patient. For admitted patients, the referral is valid for 3 months or the duration of the admission whichever is the longer.

6.6.2 As it is expected that the patient's general practitioner will be kept informed of the patient's progress, a referral from a specialist or a consultant physician must include the name of the patient's general practitioners and/or practice. Where a patient is unable or unwilling to nominate a general practitioner or practice this must be stated in the referral.

Referrals by other Practitioners

6.6.3 Where the referral originates from a practitioner other than those listed in 6.6.1, the referral is valid for a period of 12 months, unless the referring practitioner indicates that the referral is for a period more or less than 12 months (eg. 3, 6 or 18 months or valid indefinitely). Referrals for longer than 12 months should only be used where the patient's clinical condition

requires continuing care and management of a specialist or a consultant physician for a specific condition or specific conditions.
6.6.4 The referral is valid for the period specified in the referral which is taken to commence on the date of the specialist's or consultant physician's first service covered by that referral.

6.7 Definition of a Single Course of Treatment
6.7.1 A single course of treatment involves an initial attendance by a specialist or consultant physician and the continuing management/treatment up to the stage where the patient is referred back to the care of the referring practitioner. It also includes any subsequent review of the patient's condition by the specialist or the consultant physician that may be necessary. Such a review may be initiated by either the referring practitioner or the specialist/consultant physician.
6.7.2 The presentation of an unrelated illness, requiring the referral of the patient to the specialist's or the consultant physician's care would initiate a new course of treatment in which case a new referral would be required.
6.7.3 The receipt by a specialist or consultant physician of a new referral following the expiration of a previous referral for the same condition(s) does not necessarily indicate the commencement of a new course of treatment involving the itemisation of an initial consultation. In the continuing management/treatment situation the new referral is to facilitate the payment of benefits at the specialist or the consultant physician referred rates rather than the unreferred rates.
6.7.4 However, where the referring practitioner:-
(a) deems it necessary for the patient's condition to be reviewed; and
(b) the patient is seen by the specialist or the consultant physician outside the currency of the last referral; and
(c) the patient was last seen by the specialist or the consultant physician more than 9 months earlier
the attendance following the new referral initiates a new course of treatment for which Medicare benefit would be payable at the initial consultation rates.

6.8 Retention of Referral Letters
6.8.1 The prima facie evidence that a valid referral exists is the provision of the referral particulars on the specialist's or the consultant physician's account.
6.8.2 A specialist or a consultant physician is required to retain the instrument of referral (and a hospital is required to retain the patient's hospital records which show evidence of a referral) for 18 months from the date the service was rendered.
6.8.3 A specialist or a consultant physician is required, if requested by the Managing Director of the Health Insurance Commission, to produce to a Medical Adviser, who is an officer of the Commission, the instrument of referral within seven days after the request is received. Where the referral originates in an emergency situation or in a hospital, the specialist or consultant physician is required to produce such information as is in his or her possession or control relating to whether the patient was so treated.

6.9 Attendance for Issuing of a Referral
6.9.1 Medicare benefit is attracted for an attendance on a patient even where the attendance is solely for the purpose of issuing a referral letter or note. However, if a medical practitioner issues a referral without an attendance on the patient, no benefit is payable for any charge raised for issuing the referral.

6.10 Locum-tenens Arrangements
6.10.1 It should be noted that where a non-specialist medical practitioner acts as a locum-tenens for a specialist or consultant physician, or where a specialist acts as a locum-tenens for a consultant physician, Medicare benefit is only payable at the level appropriate for the particular locum-tenens, eg, general practitioner level for a general practitioner locum-tenens and specialist level for a referred service rendered by a specialist locum tenens.
6.10.2 Medicare benefits are not payable where a practitioner is not eligible to provide services attracting Medicare benefits acts as a locum-tenens for any practitioner who is eligible to provide services attracting Medicare benefits.
6.10.3 Fresh referrals are not required for locum-tenens acting according to accepted medical practice for the principal of a practice i.e. referrals to the latter are accepted as applying to the former and benefit is not payable at the initial attendance rate for an attendance by a locum-tenens if the principal has already performed an initial attendance in respect of the particular instrument of referral.

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

6.12 Referrals by Dentists or Optometrists
6.12.1 For Medicare benefit purposes, a referral may be made to:-
(i) a recognised specialist:
(a) by a registered dental practitioner, where the referral arises out of a dental service; or
(b) by a registered optometrist where the specialist is an ophthalmologist; or
(ii) a consultant physician, by an approved dental practitioner (oral surgeon), where the referral arises out of a dental service.

6.12.2 In any other circumstances (i.e. a referral to a consultant physician by a dentist, other than an approved oral surgeon, or an optometrist, or a referral by an optometrist to a specialist other than a specialist ophthalmologist), it is not a valid referral. Any resulting consultant physician or specialist attendances will attract Medicare benefits at unreferred rates.
6.12.3 Registered dentists and registered optometrists may refer themselves to specialists in accordance with the criteria above, and Medicare benefits are payable at the levels which apply to their referred patients.

7. BILLING PROCEDURES

7.1 Itemised Accounts

7.1.1 Where the doctor bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to enable a claim to be made for Medicare benefits.
7.1.2 Under the provisions of the Health Insurance Act and Regulations, Medicare benefits are not payable in respect of a professional service unless there is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of the service, the following particulars:-

(i) patient's name;
(ii) the date on which the professional service was rendered;
(iii) a description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment (i.e., accommodation and nursing care) is provided in a hospital or day hospital facility (other than a publice hospital patient), that is, the words 'admitted patient' immediately preceding the description of the service or an asterisk '*' directly after an item number where used;
(iv) the name and practice address or name and provider number of the practitioner who actually rendered the service; (where the practitioner has more than one practice location recorded with the Health Insurance Commission, the provider number used should be that which is applicable to the practice location at or from which the service was given);
(v) the name and practice address or name and provider number of the practitioner claiming or receiving payment of benefits, or assignment of benefit:-
- for services in Groups A1 to A14, D1, T1, T4 to T9 of the General Medical Services, Groups O1 to O7 (Oral and Maxillofacial services), and Group P9 of Pathology - where the person claiming payment is NOT the person who rendered the service;
- for services in Groups D2, T2, T3, I2, to I5 - for every service;

(vi) if the service was a Specified Simple Basic Pathology Test (listed in Category 6 - Pathology, Group P9 of the Schedule) that was determined necessary by a practitioner who is another member of the same group medical practice, the surname and initials of that other practitioner;
(vii) where a practitioner has attended the patient on more than one occasion on the same day and on each occasion rendered a professional service to which an item in Category 1 of the Medicare Benefits Schedule relates (i.e. professional attendances), the time at which each such attendance commenced; and
(viii) where the professional service was rendered by a consultant physician or a specialist in the practice of his/her speciality to a patient who has been referred:- (a) the name of the referring medical practitioner; (b) the address of the place of practice or provider number in respect of that place of practice; (c) the date of the referral; and (d) the period of referral (where other than for 12 months) expressed in months, e.g. "3", "6" or "18" months, or "indefinitely".

(NOTE: If the information required to be recorded on accounts, receipts or assignment of benefit forms is included by an employee of the practitioner, the practitioner claiming payment for the service bears responsibility for the accuracy and completeness of the information).
7.1.3 Practitioners should note that payment of claims could be delayed or disallowed where it is not possible from account details to clearly identify the service as one which qualifies for Medicare benefits, or the practitioner as a registered medical practitioner at the address the service was rendered. Practitioners are therefore encouraged to provide as much detail as possible on their accounts, including Medicare Benefits Schedule item number and provider number.

7.2 Claiming of Benefits

7.2.1 The patient, upon receipt of a doctor's account, has two courses open for paying the account and receiving benefits.

7.3 Paid Accounts

7.3.1 The patient may pay the account and subsequently present the receipt at a Medicare customer service centre for assessment and payment of the Medicare benefit in cash.
7.3.2 In these circumstances, where a claimant personally attends a Medicare office to obtain a cash or EFT for the payment of Medicare benefits, the claimant is not required to complete a Medicare Patient Claim Form (PC1).
7.3.3 A Medicare patient claim form (PC1) is required to be completed where the claimant is mailing their claim for a cheque or EFT payment of Medicare benefits or arranging for an agent to collect cash on the claimant's behalf at a Medicare office.

7.4 Unpaid Accounts

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

7.4.2 It will be the patient's responsibility to forward the cheque to the doctor and make arrangements for payment of the balance of the account if any. "Pay doctor" cheques involving Medicare benefits, by law, must not be sent direct to medical practitioners or to patients at a doctor's address (even if requested by the claimant to do so). "Pay doctor" cheques are required to be forwarded to the claimant's last known address.

7.4.3 When issuing a receipt to a patient in respect of an account that is being paid wholly or in part by a Medicare "pay doctor" cheque the medical practitioner should indicate on the receipt that a "Medicare" cheque for $..... was involved in the payment of the account.

7.5 Assignment of Benefit (Direct – Billing) Arrangements

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

7.5.2 If a medical practitioner direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient, with the exception of certain vaccines (see paragraph 7.5.4).

7.5.3 Under these arrangements:-

- the patient's Medicare number must be quoted on all direct-bill assignment forms for that patient;
- the assignment forms provided are loose leaf to enable the patient details to be imprinted from the Medicare Card;
- the forms include information required by Regulations under Section 19(6) of the Health Insurance Act;
- the doctor must cause the particulars relating to the professional service to be set out on the assignment form, before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it;
- where a patient is unable to sign the assignment form, the signature of the patient's parent, guardian or other responsible person (other than the doctor, doctor's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable. The reason the patient is unable to sign should also be stated. In the absence of a "responsible person" the patient signature section should be left blank and in the section headed 'Practitioner's Use', an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand etc.) and this note should be signed or initialled by the doctor. If in the opinion of the practitioner the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

7.5.4 Where the patient is direct-billed, an additional charge can **ONLY** be raised against the patient by the practitioner where the patient is provided with a vaccine/vaccines from the practitioner's own supply held on the practitioner's premises. This exemption only applies to general practitioners and other non-specialist practitioners in association with attendance items 3 to 96 (inclusive) and only relates to vaccines that are not available to the patient free of charge through Commonwealth or State funding arrangements or available through the Pharmaceutical Benefits Scheme. The additional charge must only be to cover the supply of the vaccine.

7.6 Use of Medicare Cards in Direct Billing

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

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

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

7.6.4 Where a patient presents without a Medicare card and indicates that he/she has been issued with a card but does not know the details, the practitioner may contact a Medicare telephone enquiry number to obtain the number.
7.6.5 It is important for the practitioner to check the eligibility of patients to Medicare benefits by reference to the card, as enrolees have entitlement limited to the date shown on the card and some enrolees, e.g. certain visitors to Australia, have restricted access to Medicare (see paragraphs 3.4 and 3.5).

7.7 Assignment of Benefit Forms

7.7.1 To meet varying requirements the following types of stationery are available from Medicare. Note that these are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of the Health Insurance Commission.

(1) Form DB2-GP. This form is designed for the use of optical scanning equipment and is used to assign benefits for General Practitioner Services other than requested pathology, specialist and optometrical services. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy. There are 4 pre-printed items with provision for two other items. The form can also be used as an "offer to assign" when a request for pathology services is sent to an approved pathology practitioner and the patient does not attend the laboratory.

(2) Form DB2-OP. This form is designed for the use of optical scanning equipment and is used to assign benefits for optometrical services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. This form may not be used as an offer to assign pathology services.

(3) Form DB2-OT. This form is designed for the use of optical scanning equipment and is used to assign benefits for all specialist services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. There are no pre-printed items on this form.

(4) Form DB3. This is used to assign or offer to assign benefits for pathology tests rendered by approved pathology practitioners. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2, except for content variations. The form may not be used for services other than pathology.

(5) Form DB4. This is a continuous stationery version of the DB2, and has been designed for use on most office accounting machines.

(6) Form DB5. This is a continuous stationery form for pathology services which can be used on most office machines. It cannot be used to assign benefits and must therefore be accompanied by an offer to assign (Form DB2, DB3 or DB4) or other form approved by the Health Insurance Commission for that purpose.

7.8 The Claim for Assigned Benefits (Form DB1, DB1H)

7.8.1 Practitioners who accept assigned benefits must claim from Medicare using either Claim for Assigned Benefits form DB1 or DB1H. The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than public patients). Both forms have been designed to enable benefit for a claim to be directed to a practitioner other than the one who rendered the services. The facility is intended for use in situations such as where a short term locum is acting on behalf of the principal doctor and setting the locum up with a provider number and pay-group link for the principal doctor's practice is impractical. Practitioners should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.
7.8.2 Each claim form must be accompanied by the assignment forms to which the claim relates.
7.8.3 The DB1 and DB1H are also loose leaf to enable imprinting of practitioner details using the special Medicare imprinter. For this purpose, practitioner cards, showing the practitioner's name, practice address and provider number are available from Medicare on request.

7.9 Direct-Bill Stationery

7.9.1 Medical practitioners wishing to direct-bill may obtain information on direct-bill stationery by telephoning 132150.

- Form DB6A. This form is used to order stocks of forms DB3, DB4 and DB5 and where a practitioner uses these forms, DB1 and DB1H. These forms are available from Medicare.
- Form DB6B. This form is used to re-order kits for optical scanning stationery which comprise DB2's (GP, OP and OT), DB1's pre addressed envelopes and an instruction sheet for the use of direct-bill scanning stationery. The scanning stationery is only available in kit form. This form is supplied with the kit and is returned directly to the printer. Medicare is unable to provide information on the status of these orders.

7.10 Time Limits Applicable to Lodgement of Claims for Assigned Benefits

7.10.1 A time limit of six months applies to the lodgement of claims with Medicare under the direct-billing (assignment of benefits) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than six months earlier than the date the claim was lodged with Medicare.

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

8. PROVISION FOR REVIEW OF INDIVIDUAL DOCTORS, INDIVIDUAL CLAIMS AND SCHEDULE SERVICES

Doctors

8.1 Professional Services Review (PSR) Scheme

8.1.1 The Professional Services Review (PSR) Scheme provides for a system of peer review to determine whether a practitioner has inappropriately rendered or initiated services which attract a Medicare benefit, or has inappropriately prescribed under the Pharmaceutical Benefits Scheme (PBS).

8.1.2 Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude would be unacceptable to the general body of the members of the profession in which the practitioner was practising when he or she rendered or initiated the services.

8.1.3 A PSR Committee will normally consist of three medically qualified members of whom two must belong to the same profession as the practitioner whose conduct is the subject of review. However, if considered desirable, up to two additional members may be appointed to a Committee to give it a wider range of clinical expertise.

8.1.4 From 1 August 1999, changes were introduced to improve the administration of the PSR Scheme. These include increased investigation, case preparation and negotiation powers for the Director of PSR and greater legal support for the person under review. The PSR Tribunals have also been removed from the process whilst retaining the right of review on points of law.

8.1.5 Under the PSR Scheme, the decision to establish a PSR Committee is made by the independent Director of PSR after receiving an investigative referral for the review of a practitioner's conduct from the Health Insurance Commission.

8.1.6 When an investigative referral is made, the Director of PSR must conduct an investigation, in such manner as he or she thinks appropriate, into the referred services, including services not dealt with in reasons given by the Commission for the referral. The Director has the power to require the production of documents or the giving of information.

8.1.7 The Director also has the power to dismiss an investigative referral, set up a PSR Committee, negotiate a written agreement with the pratitioner, or take no action.

8.1.8 The various methods available to a PSR Committee to investigate and quantify inappropriate practice have been clarified. In addition to examining identified services, the legislation now provides for the following methodologies:

- Patterns of Services - Where a practitioner reaches or exceeds a volume of services specified in regulations, he or she is deemed to have practised inappropriately. From 1 January 2000, the pattern of services for general practitioners and other medical practitioners specified in the Health Insurance Amendment Regulations 1999 (No. 1) is 80 or more professional attendances on each of 20 or more days in a 12-month period.

- A professional attendance is defined as a service of a kind mentioned in group A1, A2, A5, A6, A7, A13, A14 or A15 of Part 2 of the General Medical Services Table.

- The quantum of inappropriate practice can be reduced if the practitioner can demonstrate exceptional circumstances to the satisfaction of a PSR Committee. Matters that constitute exceptional circumstances include, but are not limited to, those set out in the Regulations. Matters constituting exceptional circumstances, as set out in the regulations, are: an unusual occurrence causing an unusual level of need for professional attendances by the practitioner; and the absence of other medical services for the practitioner's patients (having regard to the location of the practice and the characteristics of the patients).

- Where a practitioner can demonstrate to the satisfaction of a PSR Committee that exceptional circumstances exist, the quantum of inappropriate practice is reduced accordingly. For example, a general practitioner is referred to a PSR Committee for rendering more than 80 services on 28 days in a 12-month period. The practitioner demonstrates to the PSR Committee that exceptional circumstances applied on 10 of those days. The practitioner would still be found to have engaged in inappropriate practice in respect of the remaining 18 days.

- Sampling - A PSR Committee can apply a statistically valid sampling methodology to examine the conduct of a practitioner in relation to particular identifiable services and to extrapolate the results

to a larger number of similar services within the referral period.

- Generic findings - If a PSR Committee cannot conduct its inquiry using the patterns of services or sampling provisions, it can make a generic finding of inappropriate practice. This will apply where a PSR Committee is unable to obtain sufficient clinical or practice records from the practitioner to conduct its investigation.

8.1.9 In determining whether a practitioner has engaged in inappropriate practice, from 1 November 1999 a PSR Committee is also required to have regard to whether or not the practitioner kept adequate and contemporaneous patient records (see details at Note 15.).
8.1.10 The new PSR arrangements apply in relation to new cases referred by the HIC to the Director of PSR after 1 August 1999. Existing cases will be dealt with under the previous arrangements.

8.2 Medicare Participation Review Committee (MPRC)
8.2.1 The Medicare Participation Review Committee determine what administrative action should be taken against a practitioner who has been successfully prosecuted for medifraud.
8.2.2 The Committees have a discretionary range of options from taking no further administrative action against the practitioner to counselling and reprimand and full or partial disqualification from participating in the Medicare benefit arrangements for up to five years.

Schedule Services

8.3 Medicare Benefits Advisory Committee (MBAC)
8.3.1 This Committee is established under the provisions of Section 66 of the Health Insurance Act. Membership of the Committee consists of representatives of the medical profession and the Commonwealth Government. There are eight members on the Committee, five of whom must be medical practitioners.
8.3.2 The functions of the Committee are to consider references to it by the Minister under Sections 19A and 3C of the Health Insurance Act relating to whether Medicare benefits should be payable for a particular procedure or treatment.

8.4 Medicare Benefits Consultative Committee (MBCC)
8.4.1 The MBCC is an informal advisory committee established by agreement between the Minister and the Australian Medical Association. The Committee consists of representatives of the Department, the Health Insurance Commission, the Australian Medical Association and relevant craft groups of the medical profession.
8.4.2 The major function undertaken by the Committee is the review of particular services or groups of services within the Medicare Benefits Schedule, including consideration of appropriate fee levels.

8.5 Medicare Services Advisory Committee (MSAC)
8.5.1 The Medicare Services Advisory Committee was established in April 1998 to advise the Minister on the strength of evidence relating to the safety, effectiveness and cost effectiveness of new and emerging medical services and technologies and under what circumstances public funding, including listing on the Medicare Benefits Schedule, should be supported.
8.5.2 Its membership comprises a mix of clinical expertise covering pathology, surgery, internal medicine and general practice, plus clinical epidemiology and clinical trials, health economics, consumers, and health administration and planning.
8.5.3 The assessment of evidence has been an integral part of the listing process of medical technologies and services on the Schedule via a mix of specialist consultative and advisory bodies. This measure will strengthen and consolidate the assessment activity under the umbrella of MSAC and will complement the functions and activities of the Medicare Benefits Consultative Committee, Pathology Services Table Committee and the Consultative Committee on Diagnostic Imaging.
8.5.4 Since its establishment MSAC has been developing application and assessment guidelines to assist it to meet its terms of reference. Further information on MSAC's terms of reference, membership, and application and assessment processes and related activities can be found at its internet site: www.health.gov.au/haf/msac
8.5.5 Contact with MSAC can be made via email on **msac.secretariat@health.gov.au** or by phoning the MSAC secretariat on 1800 020 103.

8.6 Pathology Services Table Committee (PSTC)
8.6.1 This Committee is established under Section 136 of the National Health Act 1953. It consists of five representatives from the interested professions and five from the Commonwealth.
8.6.2 The Committee's primary role is to advise the Minister on the need for changes to the structure and content of the Pathology Services Table (except new medical services and technologies - see paragraph 8.5 above) including the level of fees.

8.7 Review of Claims Requiring Prior Approval for Payment of Benefits
8.7.1 There are a number of items in the Schedule which contain a requirement that it must be 'demonstrated' that there is a clinical need for the service before Medicare benefits are payable. Services requiring prior approval are those covered by Items 11222/11225, 12207, 14120-14132, 18033, 30214, 32501, 42783, 42786, 42789, 42792, 45019/45020, 45528, 45544, 45585, 45588, 45639, 50125 and 55728.

8.7.2 Claims for benefits for services covered by these items should be lodged with Medicare for referral to the Central Office of the Health Insurance Commission for assessment, and must be accompanied by sufficient clinical and/or photographic evidence to enable the Commission to determine the eligibility of the service for payment of benefits. Claims can only be considered for services which fulfil the requirements of the item descriptors.
8.7.3 Practitioners may also apply to the Commission for prospective approval in respect of proposed surgery.
8.7.4 The address of the Commission is GPO Box 9822 in your Capital City or PO Box 1001, Tuggeranong ACT 2901.

9. PENALTIES AND LIABILITIES

9.1 Penalties

9.1.1 Penalties of up to $10,000 or imprisonment for up to five years, or both, may be imposed on any person who makes a statement (either orally or in writing) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used in connection with a claim for benefits. In addition, any practitioner who is found guilty of such offences by a court (on or after 22 February 1986) shall be subject to examination by a Medicare Participation Review Committee and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.
9.1.2 A penalty of up to $1000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct-billing form without the necessary details having been entered on the form before signature or who fails to cause a patient to be given a copy of the completed form.

GENERAL NOTES FOR GUIDANCE OF USERS

10. SCHEDULE FEES AND MEDICARE BENEFITS

10.1 Schedule Fees and Medicare Benefits

10.1.1 Medicare benefits are based on fees determined for each medical service, with uniform fees for each service in each State. The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in the Schedule is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered. In some cases two levels of fees are applied to the same service in General Medical Services, with each level of fee being allocated a separate item number. The item identified by the letter "S" applies in the case where the procedure has been rendered by a recognised specialist in the practice of his or her speciality and the patient has been referred. The item identified by the letter "G" applies in any other circumstances.
10.1.2 As a general rule Schedule fees are adjusted on an annual basis. The current Schedule fees came into operation on 1 November 2000.
10.1.3 The Schedule fee and Medicare benefit levels for the medical services contained in the Schedule are located with the item descriptions. Where appropriate, the calculated benefit has been rounded to the nearest higher 5 cents. However, in no circumstances will the benefit payable for any service exceed the amount of the fee actually charged for that service.
There are presently two levels of Medicare benefit payable, that is :-

(i) for professional services rendered while hospital treatment (i.e., accommodation and nursing care) is provided to a patient who has been admitted to a hospital or day hospital facility (other than public patients), the level of Medicare benefit is 75% of the Schedule fee for each item with no maximum patient gap between the Medicare benefit and the Schedule fee. The Health Insurance Regulations provide that medical practitioners must indicate on their accounts, etc, where a medical service is rendered in these circumstances. This requirement will be met by placing the word "admitted patient" immediately preceding the description of each service or, alternatively, where an item number is used, by placing an asterisk "*" directly after the item number for each service.

(ii) for all other professional services, the Medicare benefit is 85% of the Schedule fee, or the Schedule fee less $52.50 (indexed annually) whichever is the greater.

10.1.4 Public hospital services are available free of charge to eligible persons who choose to be treated as public patients, in accordance with the provisions of the 1998-2003 Australian Health Care Agreements.
10.1.5 A medical service rendered to a patient on the day of admission to, or day of discharge from hospital, but prior to admission or subsequent to discharge, will attract benefits at the 85% level not 75%. This also applies to a pathology service rendered to a patient prior to admission. Attendances on patients at a hospital (other than patients covered by paragraph 10.1.3 (i) above) attract benefits at the 85% level.
10.1.6 The 75% benefit level applies even though a portion of the service (eg. aftercare) may be rendered outside the hospital. With regard to obstetric items, benefits would be attracted at the 75% level where the confinement takes place in hospital.
10.1.7 Pathology tests performed after discharge from hospital on bodily specimens taken during hospitalisation also attract the 75% level of benefits.
10.1.8 It should be noted that the Health Insurance Act makes provision for private medical insurance to cover the "patient gap" (i.e., the difference between the Medicare rebate and the Schedule fee) for services attracting benefits at the 75% level. Patient's may insure with private health insurance organisations for the gap between the 75% Medicare benefits and the Schedule fee or for amounts in excess of the Schedule fee where the patient has an arrangement with their health fund.

10.1.9 Where it can be established that payments of $285.00 (indexed annually from 1 January) have been made by a family group or an individual during a calendar year in respect of the difference between the Medicare benefit and the Schedule fee for out-of-hospital services, benefits will be paid for expenses incurred for professional services rendered during the rest of that year up to 100% of the Schedule fee.

11. SERVICES NOT LISTED IN THE SCHEDULE

11.1 Services not Listed in Schedule

11.1.1 Benefits are not generally payable for services not listed in the Schedule. However, there are some procedural services which are not specifically listed because they are regarded as forming part of a consultation or else attract benefits on an attendance basis. Such services would include intramuscular injections, aspiration needle biopsy, treatment of solar keratoses and closed reduction of toe fracture. Further services for which benefits are payable on a consultation basis are identified in the indexes to this book.

11.1.2 Enquiries concerning services not listed or on matters of interpretation should be directed to the appropriate office of the Health Insurance Commission. Postal addresses are listed in paragraph 2.9 of these notes. Telephone enquiries should be directed to the numbers below which are reserved for enquiries concerning the Schedule:

NSW -	132 150
VIC -	03 9605 7964
QLD -	07 3004 5280
SA -	08 8274 9788
NT -	08 8274 9788
WA -	132 150
TAS -	03 6215 5740
ACT -	02 6124 7611

11.2 Ministerial Determinations

11.2.1 Section 3C of the Health Insurance Act empowers the Minister to determine an item and Schedule fee (for the purposes of the Medicare benefits arrangements) for a service not included in the health insurance legislation. This arrangement is particularly useful in facilitating payment of benefits for newly developed techniques where close monitoring is desirable and where quick remedial action may become necessary. Services which have been so determined by the Minister are located in their relevant Groups in the Schedule but are identified by the notation "(Ministerial Determination)".

12. SERVICES ATTRACTING MEDICARE BENEFITS

12.1 Professional Services

12.1.1 Professional services which attract Medicare benefits include medical services rendered by or on behalf of a medical practitioner. Medical services which may be rendered "on behalf of" a medical practitioner include services where a portion of the service is performed by a technician employed by or, in accordance with accepted medical practice, acting under the supervision of the medical practitioner.

12.1.2 The health insurance regulations specify that the following medical services will attract benefits only if they have been personally performed by a medical practitioner on not more than one patient on the one occasion (i.e. two or more patients cannot be attended simultaneously although patients may be seen consecutively), other than an attendance on a person in the course of a group session (i.e. Items 170-172). The requirement of "personal performance" is met whether or not assistance is provided in the performance of the service according to accepted medical standards:-

(a) All Category 1 (Professional Attendances) items (except 170-172, 342-346);
(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11212, 11304, 11500, 11600, 11601, 11627, 11701, 11712, 11724, 11921, 12000, 12003;
(c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13709, 13750-13760, 13915-13948, 14050, 14053, 14218 and 14221);
(d) Item 15600 in Group T2 (Radiation Oncology);
(e) All Group T3 (Therapeutic Nuclear Medicine) items;
(f) All Group T4 (Obstetrics) items (except 16514);
(g) All Group T5 (Assistance in Administration of an Anaesthetic) items;
(h) All Group T6 (Anaesthetics) items;
(i) All Group T7 (Regional or Field Nerve Block) items;
(j) All Group T8 (Operations) items;
(k) All Group T9 (Assistance at Operations) items.

12.1.3 For the group psychotherapy and family group therapy services covered by Items 170, 171, 172, 342, 344 and 346, benefits are payable only if the services have been conducted personally by the medical practitioner.

12.1.4 Medicare benefits are not payable for these group items or any of the items listed in (a)-(k) above when the service is rendered by a medical practitioner employed by the proprietor of a hospital, not being a private hospital, other than when the

practitioner is exercising his or her right of private practice or is performing a medical service outside the hospital. For example, benefits are not attracted when a hospital intern or registrar performs a service at the request of a staff specialist or visiting medical officer.

12.2 Services Rendered "On Behalf Of" Medical Practitioners

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

(i) a medical practitioner;

(ii) a person, other than a medical practitioner, who is employed by a medical practitioner or, in accordance with accepted medical practice, acts under the supervision of a medical practitioner.
(see Category 6 Notes for Guidance for arrangements relating to Pathology services).

12.2.2 In order that a service rendered by an employee or under the supervision of a medical practitioner can attract a Medicare rebate, the service must be billed in the name of the practitioner who must accept full responsibility for the service. The Health Insurance Commission would need to be satisfied with the employment and supervision arrangements. In this regard, while the supervising medical practitioner need not be present for the entire service, he or she must have a direct involvement in at least part of the service. Although the supervision requirements would vary depending on the test or examination being performed, they would, as a general rule, be satisfied where the medical practitioner has:-

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

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

12.2.3 Benefits are not payable for these services when a medical practitioner refers patients to self-employed paramedical personnel, such as radiographers and audiologists, who either bill the patient or the practitioner requesting the service.

13. SERVICES WHICH DO NOT ATTRACT MEDICARE BENEFITS

13.1 Services Not Attracting Benefits

13.1.1 Medicare benefits are not payable for telephone consultations, for the issue of repeat prescriptions when the patient is not in attendance, and for group attendances (other than group attendances covered by Items 170, 171, 172, 342, 344 and 346) such as counselling, health education, weight reduction or fitness.

13.1.2 There are other services which are not regarded as being 'medical services' for the purposes of the payment of Medicare benefits. Services performed for cosmetic reasons, such as face lifts, eye-lid reduction, hair transplants (except in certain circumstances), etc do not attract benefits. Certain other services such as manipulations performed by physiotherapists do not qualify for Medicare benefit even though they may be done on the advice of a medical practitioner.

13.1.3 Medicare benefits are not payable for the performance of euthanasia, including any service directly related to the procedure. However, services rendered for counselling/assessment in relation to euthanasia would attract benefits.

13.2 Where Medicare Benefits are not Payable

13.2.1 Medicare benefits are not payable in respect of a professional service in the following circumstances:-

(a) where the medical expenses for the service are paid or payable to a recognised (public) hospital;

(b) where the medical expenses for the services are in relation to a compensable injury or illness for which the patient's insurer or compensation payer has accepted liability. However, if medical expenses relate to a compensable injury or illness and the insurer or compensation payer is disputing liability, Medicare benefits are payable until liability is accepted;

(c) where the service is a medical examination for the purposes of - life insurance, superannuation or provident account scheme, or admission to membership of a friendly society;

(d) where the service was rendered in the course of the carrying out of mass immunisation.

13.2.2 Unless the Minister otherwise directs, Medicare benefits are not payable in respect of a professional service where:-

(a) the service has been rendered by or on behalf of, or under an arrangement with, the Commonwealth, a State or a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory;

(b) the medical expenses were incurred by the employer of the person to whom the service was rendered;

(c) the person to whom that service was rendered was employed in an industrial undertaking and that service was rendered to him/her for purposes connected with the operation of that undertaking; or

(d) the service was a health screening service (see para 13.3 below).

13.2.3 The legislation empowers the Minister to make regulations to preclude the payment of Medicare benefits for professional services rendered in prescribed circumstances. Such regulations, however, may only be made in accordance with a recommendation made by the Medicare Benefits Advisory Committee (other than pathology services).

13.2.4 Regulations are currently in force to preclude the payment of Medicare benefits in the following circumstances:-

(a) professional services rendered in relation to the provision of chelation therapy (that is to say the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts) otherwise than for the treatment of heavy-metal poisoning;

(b) professional services rendered in association with the injection of human chorionic gonadotrophin in the management of obesity;

(c) professional services rendered in relation to the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;

(d) professional services rendered for the purpose of, or in relation to, the removal of tattoos; and

(e) professional services rendered for the purposes of, or in relation to:-

(i) the transplantation of a thoracic or abdominal organ, other than a kidney, or of a part of an organ of that kind; or

(ii) the transplantation of a kidney in conjunction with the transplantation of a thoracic or other abdominal organ, or part of an organ of that kind;

if the services are rendered to an admitted patient of a hospital;

(f) professional services rendered for the purposes of, or in relation to, the removal from a cadaver of kidneys for transplantation;

(g) professional services rendered in respect of body fluids in relation to detection of the presence of the human immunodeficiency virus.

13.3 Health Screening Services

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

13.3.2 A health screening service is defined as a medical examination or test that is not reasonably required for the management of the medical condition of the patient. Services covered by this proscription include such items as - multiphasic health screening; mammography screening (except as provided for in Items 59300/59303); testing of fitness to undergo physical training programs, vocational activities or weight reduction programs; compulsory examinations and tests to obtain a flying, commercial driving or other licence, entrance to schools and other educational facilities, for travel requirements and for the purposes of legal proceedings; compulsory examinations for admission to aged persons' accommodation and pathology services associated with clinical ecology.

13.3.3 Ministerial directions have been issued in respect of the following categories of health screening services that enable Medicare benefits to be payable for:-

- a medical examination or a test on a symptomless patient by that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain his/her state of health. In such cases benefits would be payable for the attendance and such tests which would be considered reasonably necessary according to the circumstances of the patient such as age, physical condition, past personal and family history. Examples would be Papanicolaou test in a woman (see para. 13.3.4), blood lipid estimation where a person has a family history of lipid disorder. However, it would not be accepted that a routine check up would necessarily be accompanied by an extensive battery of diagnostic investigations;
- a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;
- medical examinations for reason of age or medical condition, for drivers to obtain or renew a licence to drive a private motor vehicle;
- medical examinations to obtain a certificate of hearing disability required for sales tax exemption for a television decoding device;
- a medical or optometrical examination provided to a person who is an unemployed person for the purposes of the Social Security Act 1991, at the request of a person to whom the unemployed person has applied for employment;
- a medical examination of, and/or the collection of blood for testing from, persons occupationally exposed to sexual transmission of disease where the purpose of such an examination or collection is the collection of specimens for testing in accordance with conditions determined by the health authority of the State or Territory in which the service is performed, (1 examination/collection per person per week). Benefits are not attracted in respect of pathology tests resulting from such examination/collection;
- a medical examination to adopt or foster children;
- a medical examination which is required to claim eligibility for certain Social Security benefits or allowances.

13.3.4 The agreed National Policy on screening for the Prevention of Cervical Cancer, as endorsed by the Royal Australian College of General Practitioners, the Royal Australian College of Obstetricians and Gynaecologists, the Royal College of Pathologists of Australasia, the Australian Cancer Society and the National Health and Medical Research Council, is as follows:-

- an examination interval of 2 years for women who have no symptoms or history suggestive of abnormal cervical cytology, commencing between the ages of 18 to 20 years, or 1 or 2 years after first sexual intercourse, whichever is later;
- cessation of cervical smears at 70 years for women who have had 2 normal results within the last 5 years. Women over 70 who have never been examined, or who request a cervical smear, should be examined.

Note: As separate items exist for routine examination of cervical smears, treating practitioners are asked to clearly identify on the request form to the pathologist, if the smear has been taken as a routine examination or for the management of a previously detected abnormality (see paragraph PP.4 of Pathology Services Explanatory Notes in Category 6).

13.4 Services Rendered to a Doctor's Dependants, Practice Partner, or Practice Partner's Dependants

13.4.1 Generally, Medicare benefits are not payable in respect of professional services rendered by a medical practitioner to dependants or partners or a partner's dependants. There can be no medical expense for which Medicare benefits will apply unless a legally enforceable debt is incurred. In such a case, the matter should be referred to the Health Insurance Commission for assessment.

13.5 Workers' Compensation, Third Party Insurance, Damages, etc.

13.5.1 From 1 February 1996, Medicare benefits are payable for medical expenses for professional services that are wholly covered by workers compensation or damages under a Commonwealth or State or Territory law.

13.5.2 The only exception to this is where a person has entered into a *reimbursement arrangement* with a compensation insurer. In such cases, a Medicare benefit is not payable. (A *reimbursement arrangement* is an agreement between a compensation claimant and the insurer stating that the medical expenses of the person will be paid by the insurer as and when they arise.)

13.5.3 The practitioner has the option to either bulk-bill Medicare or give the patient a private account as would normally occur with any other consultation.

13.5.4 There are arrangements in place to recover any Medicare benefits paid as a result of the injury once a settlement or judgement is made on the compensation claim. The recovery is done between the insurer or compensation payer, the compensable person and the Health Insurance Commission. These recovery arrangements do not impact on practitioners.

14. INTERPRETATION OF THE SCHEDULE - GENERAL NOTES

14.1 Principles of Interpretation

14.1.1 Each professional service listed in the Schedule is a complete medical service in itself. However, it may also form part of a more comprehensive service covered by another item, in which case the benefit provided for the latter service covers the former as well. For example, benefit is not payable for a bronchoscopy (Schedule Item 41889) where a foreign body is removed from the bronchus (Schedule Item 41895) since the bronchoscopy is an integral part of the removal operation.

14.1.2 Where a service is rendered partly by one medical practitioner and partly by another, only the one amount of benefit is payable. This may be instanced by the case in which a radiographic examination is partly completed by one medical practitioner and finalised by another, the only benefit payable being that for the total examination. Another example is where aftercare is carried out by other than the practitioner who performed the operation. The fee for the operation also covers any consequential aftercare and only the one benefit is payable. Where separate services covered by individual items in the Schedule are rendered by different medical practitioners the individual items apply.

14.2 Services Attracting Benefits on an Attendance Basis

14.2.1 There are some services which are not listed in the Schedule because they are regarded as forming part of a consultation or else attract benefits on an attendance basis. These services are identified in the indexes to this book.

14.3 Consultation and Procedures Rendered at the One Attendance

14.3.1 Where there are rendered, during the course of a single attendance, a consultation (under Category 1 of the Medicare Benefits Schedule) and another medical service (under any other Category of the Schedule), benefits are payable subject to certain exceptions, for both the consultation and the other service. Medicare benefits are not payable for the consultation in addition to an item rendered on the same occasion where the item description is qualified by words such as "each attendance", "attendance at which", "including associated attendances/consultations", and all items in Group T5, T6 and T9. However, in the case of radiotherapy treatment (Group T2 of Category 3) benefits are payable for both the radiotherapy and an initial referred consultation.

14.3.2 In cases where the level of benefit for an attendance depends upon consultation time (e.g., attendance by consultant physicians in psychiatry), the time spent in carrying out a procedure, which is covered by another item in the Schedule, must not be included in the consultation time.

14.3.3 Medical practitioners should ensure that a fee for a consultation is charged only when a consultation actually takes place. It is not expected that a consultation fee will be charged on every occasion a procedure is performed.

14.4 Aggregate Items

14.4.1 The Schedule includes a number of items which apply only in conjunction with another specified service listed in the Schedule. These items provide for the application of a fixed loading or factor to the fee and benefit for the service with which they are rendered. Item 15003 - Superficial radiotherapy of two or more Fields - is an example.

14.4.2 When these particular procedures are rendered in conjunction, the legislation provides for the procedures to be regarded as one service and for a single patient gap to apply. The Schedule fee for the service will be ascertained in accordance with the particular rules shown in the relevant items.

14.5 Residential Aged Care Facility

14.5.1 A residential aged care facility is a facility in which residential care services are provided, as defined in the *Aged Care Act 1997*, including facilities which were formerly known as nursing homes and hostels.

15. PRACTITIONERS SHOULD MAINTAIN ADEQUATE AND CONTEMPORANEOUS RECORDS FROM 1 NOVEMBER 1999

15.1 Requirements

15.1.1 All practitioners who provide, or initiate, a service in respect of which a Medicare benefit is payable, should ensure they maintain adequate and contemporaneous records. (Note: 'Practitioner' is defined in Section 81 of the *Health Insurance Act 1973* and includes: dentists, optometrists, chiropractors, physiotherapists and podiatrists.)

15.1.2 From 1 November 1999 PSR Committees will have regard to whether or not the practitioner kept adequate and contemporaneous records when determining whether a practitioner has engaged in inappropriate practice.

15.1.3 The standards which a record must meet to constitute an adequate and contemporaneous patient or clinical record are prescribed in regulations.

15.1.4 To be ***adequate***, the patient or clinical record should be:

- sufficient to contribute to the quality and continuity of care received by the patient (*The record of a single visit may be quite brief. However, where a patient has made several visits to the same practice - even for simple conditions - then a more complete patient history would be expected.)*;

- sufficiently clear and detailed, so that another practitioner can safely and effectively undertake the patient's ongoing care on the basis of the information contained in the record *(The record must be understandable by other practitioners. Note, this does not preclude the use of diagrams.)*; and

- capable of identifying the service that was provided, or initiated. *(Sufficient clinical information must be recorded to justify the service rendered.)*

15.1.5 To be ***contemporaneous***, the patient or clinical record should be completed at the time that the service was provided or as soon as practicable afterwards. Records for hospital patients are usually kept by the hospital and the practitioner could rely on these records to document in-patient care.

15.1.6 It will be left to the peer judgment of the PSR Committee to decide if the practitioner's records meet the prescribed standards. The failure to keep adequate records will be an important consideration for a PSR Committee in determining whether a practitioner's conduct was inappropriate (see paragraph 8.1.9).

GENERAL MEDICAL SERVICES

CATEGORIES 1, 2 and 3

PROFESSIONAL ATTENDANCES

CATEGORY 1

CATEGORY 1 - PROFESSIONAL ATTENDANCES

EXPLANATORY NOTES

SCHEDULE OF SERVICES

CATEGORY 1 - PROFESSIONAL ATTENDANCES

EXPLANATORY NOTES

A.1 Personal Attendance by Practitioner

A.1.1 The personal attendance of the medical practitioner upon the patient is necessary before a "consultation" may be regarded as a professional attendance. In itemising a consultation covered by an item which refers to a period of time, only that time during which a patient is receiving active attention should be counted. Periods such as when a patient is resting between blood pressure readings, waiting for pupils to dilate after the instillation of a mydriatic, or receiving short wave therapy etc., should not be included in the time of the consultation. Similarly, the time taken by a doctor to travel to a patient's home should not be taken into consideration in the determination of the length of the consultation. While the doctor is free to charge a fee for "travelling time" when patients are seen away from the surgery, benefits are payable only in respect of the time a patient is receiving active attention.

A.2 Professional Attendances

A2.1 Professional attendances by medical practitioners cover consultations during which the practitioner evaluates the patient's problem (which may include certain health screening services - see paragraph 13.3 of the General Explanatory Notes) and formulates a management plan, in relation to one or more conditions present in the patient. The service also includes advice to the patient and/or relatives and the recording of appropriate detail of the particular services - (see also paragraphs A.5.6 - A.5.7)

A.3 Services Not Attracting Medicare Benefits

A.3.1 Telephone consultations, letters of advice by medical practitioners, the issue of repeat prescriptions when the patient is not in attendance, post mortem examinations, the issue of death or cremation certificates, counselling of relatives (Note - Items 348, 350 and 352 are not counselling services), group attendances (other than group attendances covered by Items 170, 171, 172, 342, 344 and 346) such as group counselling, health education, weight reduction or fitness classes do not qualify for benefit.

A.4 Multiple Attendances

A.4.1 Payment of benefit may be made for each of several attendances on a patient on the same day by the same medical practitioner provided the subsequent attendances are not a continuation of the initial or earlier attendances.

A.4.2 However, there should be a reasonable lapse of time between such attendances before they can be regarded as separate attendances.

A.4.3 Where two or more attendances are made on the one day by the same medical practitioner the time of each attendance should be stated on the account (e.g., 10.30 a.m. and 3.15 p.m.) in order to assist in the assessment of benefits.

A.4.4 In some circumstances a subsequent attendance on the same day does in fact constitute a continuation of an earlier attendance. For example, a preliminary eye examination may be concluded with the instillation of a mydriatic and then an hour or so later eye refraction is undertaken. These sessions are regarded as being one attendance for benefit purposes. Further examples are the case of skin sensitivity testing, and the situation where a patient is issued a prescription for a vaccine and subsequently returns to the surgery for the injection.

A.5 Attendances by General Practitioners (Items 1-51, 193, 195, 601, 602)

A.5.1 Items 1 to 51 and 193, 195, 601, 602 relate specifically to attendances rendered by medical practitioners who are either:

- listed on the Vocational Register of General Practitioners maintained by the Health Insurance Commission;
- holders of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) and who participate in, and meet the requirements for, quality assurance and continuing medical education as defined in the RACGP Quality Assurance and Continuing Education Programme; or
- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP or recognised by the RACGP as being at an equivalent standard.

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

A.5.2 Items 1 to 51 cover four categories of general practitioner attendance based largely on the tasks undertaken by the practitioner during the attendance on the patient rather than simply on the time spent with the patient.

A.5.3 The attendances are divided into four categories relating to the level of complexity, namely:

(i) Level A - (10 relative value units)
(ii) Level B - (21 relative value units)
(iii) Level C - (38 relative value units)
(iv) Level D - (56 relative value units)

A.5.4 To assist medical practitioners in selecting the appropriate item number for Medicare benefit purposes the following notes and examples in respect of the various levels are given. The fact that a particular case is used as an example does not

mean that such cases would always be claimed at the level used in the example. Other modifying circumstances might prevail and each case must be treated on its merits.

LEVEL A
These items are for the obvious and straightforward cases and the practitioner's records would reflect this. In this context 'limited examination' means examination of the affected part if required, and 'management' the action taken.
Example: Triple Antigen or Tetanus Immunisation

LEVEL B
The descriptions of these items introduce the words 'selective history' and 'implementation of a management plan in relation to one or more problems'. In this context a 'selective history' means a history relating to a specific problem or condition; and 'implementation of a management plan' includes formulation of the decision or plan of management and any immediate action necessary such as advising or counselling the patient, ordering tests, or referring the patient to a specialist medical practitioner or other allied health professional. The essential difference between Levels A and B relate not to time but to complexity.
Example: Otitis media presenting as earache

LEVEL C
Further levels of complexity are implied in these items by the introduction of 'taking a detailed history' and 'examination of multiple systems'. A physical attendance of at least 20 minutes is necessary to qualify for a Level C attendance. The words following 'OR' in the items for Levels B and C allow for the situation where an attendance involves some components of a more complex level but the time taken is less than specified in the higher level. Benefit is claimable at the appropriate lower level, e.g.; if an attendance involved a detailed history and examination of multiple systems, arranging investigations and implementing a management plan, but the time taken was less than 20 minutes, it would constitute a Level B attendance.
Example: Essential hypertension presenting as headache

LEVEL D
These items cover the difficult problems where the diagnosis is elusive and highly complex, requiring consideration of several possible differential diagnoses, and the making of decisions about the most appropriate investigations and the order in which they should be performed. These items also cover cases which need prolonged discussion. Physical attendance of at least 40 minutes is necessary to qualify for a Level D attendance.
Examples: Migraine with peripheral neurological signs
Depression presenting as insomnia or headaches
Complex psychological or family relationship problems

Counselling or Advice to Patients or Relatives
A.5.5 For Items 23 to 51 'implementation of a management plan' includes counselling services.
A.5.6 Items 1 to 51 include advice to patients and/or relatives during the course of an attendance. The advising of relatives at a later time does not extend the time of attendance.

Recording Clinical Notes
A.5.7 In relation to the time taken in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added at a later time, such as reports of investigations.

Other Services at the Time of Attendance
A.5.8 Where, during the course of a single attendance by a general practitioner, both a consultation and another medical service are rendered, Medicare benefits are generally payable for both the consultation and the other service. Exceptions are in respect of medical services which form part of the normal consultative process, or services which include a component for the associated consultation (see paragraph 14.3 of the General Explanatory Notes for further details).

After Hours Services
A.5.9 There are no differential Schedule fees for medical services rendered after hours, except in relation to the items for emergencies i.e. Items 1, 2, 601, 602. However, use of these emergency after hours items are restricted to situations as outlined in paragraph A.10 below.

Locum-Tenens
A.5.10 Where a general practitioner engages, either as an assistant or as a locum tenens, a medical practitioner who is not a general practitioner, Medicare benefits in respect of attendances rendered by the latter are attracted under Items 52-96 and not under Items 1-51.

A.6 Professional Attendances at an Institution (Items 13, 25, 38, 48, 81, 83, 84, 86)
A.6.1 For the purposes of these items an "institution" means a place (not being a hospital or residential aged care facility) at which residential accommodation or day care or both such accommodation and such care is made available to:-

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

Note: See also paragraph A.9

A.7 Attendances at a Hospital (Items 19, 33, 40, 50, 87, 89, 90, 91)

A.7.1 These items refer to attendances on patients admitted to a hospital or day hospital facility. Where medical practitioners have made arrangements with a local hospital to routinely use out-patient facilities to see their private patients, surgery consultation items would apply.

Note: See also paragraph A.9

A.8 Residential Aged Care Facility Attendances (Items 20, 35, 43, 51, 92, 93, 95, 96)

A.8.1 These items refer to attendances on patients in residential aged care facilities.

A.8.2 Where a medical practitioner attends a patient in a self-contained unit, within a residential aged care facility complex, the attendance attracts benefits under the appropriate home visit item.

A.8.3 Where a patient living in a self-contained unit attends a medical practitioner at consulting rooms situated within the precincts of the residential aged care facility, or at free standing consulting rooms within the residential aged care facility complex, the appropriate surgery consultation item applies.

A.8.4 If a patient who is accommodated in the residential aged care facility visits a medical practitioner at consulting rooms situated within the residential aged care facility complex, whether free standing or situated within the residential aged care facility precincts, benefits would be attracted under the appropriate residential aged care facility attendance item.

Note: See also paragraph A.9

A.9 Attendances at Hospitals, Residential Aged Care Facility and Institutions and Home Visits

A.9.1 To facilitate assessment of the correct Medicare rebate in respect of a number of patients attended on the one occasion at one of the above locations, it is important that the total number of patients seen be recorded on each individual account, receipt or assignment form. For example, where ten patients were visited (for a brief consultation) in the one residential aged care facility on the one occasion, each account, receipt or assignment form would show "Item 20 - 1 of 10 patients" for a General Practitioner.

A.9.2 The number of patients seen should not include attendances which do not attract a Medicare rebate (eg. public in-patients, attendances for normal after-care), or where a Medicare rebate is payable under an item other than these derived fee items (eg. health assessments, care planning, emergency after-hours attendance – first patient).

A.10 Emergency After-Hours Attendances (Items 1, 2, 97, 98, 601, 602, 697, 698)

A.10.1 Items 1, 2, 97, 98, 601, 602, 697, 698 should only be itemised in the following instances -

- the consultation is initiated by or on behalf of the patient in the same unbroken after-hours period (see para A.10.3);
- the patient's medical condition must require immediate treatment; and
- if more than one patient is seen on the one occasion, Items 1, 2, 97, 98, 601, 602, 697, 698 can be used but only in respect of the first patient. The normal items for the particular location should be itemised in respect of the second and subsequent patients attended on the same occasion.

Where the patient is seen at a public hospital the following additional provisions would apply in relation to Items 1, 97, 601 and 697 -

- the first or only patient is a private in-patient; or
- the first or only patient is seen in the Out-patient or Casualty Department and the hospital does not provide at the time a medical Out-patient or Casualty service.

Where any of the above conditions do not apply the normal Schedule items should be itemised.

A.10.2 Items 2, 98, 602 and 698 are intended to allow benefit for returning to and specially opening up consulting rooms to attend a patient who needs immediate treatment after hours. As the extra benefit is for the inconvenience of actually returning to and opening the surgery it is payable only once on any one occasion - to the first patient seen after opening up. If other patients are seen on the same occasion they are itemised as ordinary surgery attendances. In this respect Items 2, 98, 602 and 698 are the same as Items 1, 97, 601 and 697.

Definition of After Hours

A.10.3 An after hours consultation or visit is a reference to an attendance on a public holiday, on a Sunday, before 8 a.m. or after 1 p.m. on a Saturday, or at any time other than between 8 a.m. and 8 p.m. on a week day not being a public holiday.

A.10.4 Where a practice or clinic routinely conducts its business during hours other than those quoted above, it would be necessary for the emergency service to be initiated and rendered outside the hours normally observed by that practice or clinic for it to attract a Medicare rebate under Items 1, 2, 97, 98, 601, 602, 697 or 698.
A.10.5 Items 601, 602, 697 and 698 are intended to allow benefit for emergency attendances in the 'unsociable hours', that is, 11pm-7am on any day of the week. Apart from the time restriction, the conditions applying to Items 601 and 697 are the same as those applying to Items 1 and 97, and the conditions applying to Items 602 and 698 are the same as those applying to Items 2 and 98.

A.11 Minor Attendance by a Consultant Physician (Items 119, 131)
A.11.1 The Health Insurance Regulations provide that a minor consultation is regarded as being a consultation in which the assessment of the patient does not require the physical examination of the patient and does not involve a substantial alteration to the patient's treatment. Examples of consultations which could be regarded as being 'minor consultations' are listed below (this is by no means an exhaustive list) :-

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

A.12 Prolonged Attendance in Treatment of a Critical Condition (Items 160-164)
A.12.1 The conditions to be met before services covered by Items 160-164 attract benefits are:-

(i) the patient must be in imminent danger of death;
(ii) the constant presence of the medical practitioner must be necessary for the treatment to be maintained; and
(iii) the attention rendered in that period must be to the exclusion of all other patients.

A.13 Family Group Therapy (Items 170, 171, 172)
A.13.1 These items refer to family group therapy supervised by medical practitioners other than consultant psychiatrists. To be used, these items require that a formal intervention with a specific therapeutic outcome, such as improved family function and/or communication, is undertaken. Other types of group attendances do not attract benefits. It should be noted that only one fee applies in respect of each group of patients.

A.14 Acupuncture (Item 173, 193, 195)
A.14.1 The service of "acupuncture" must be performed by a medical practitioner and itemised under Item 173, 193 or 195 to attract benefits. These items cover not only the performance of the acupuncture but include any consultation on the same occasion and any other attendance on the same day for the condition for which acupuncture was given. Items 193 and 195 may only be performed by a general practitioner, (see Note 4 of 'Medicare Benefit Arrangements' for a definition).
A.14.2 Other items in Category 1 of the Schedule should not be itemised for professional attendances when the service "acupuncture" is provided.
A.14.3 For the purpose of payment of Medicare benefits "acupuncture" is interpreted as including treatment by means other than the use of acupuncture needles where the same effect is achieved without puncture, e.g., by application of ultrasound, laser beams, pressure or moxibustion, etc.

A.15 Psychiatric Attendances (Item 319)
A.15.1 Medicare benefits are attracted under Item 319 only where patients are diagnosed as suffering from:

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

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

A.15.2 It is not sufficient for the patient's illness to fall within the diagnostic criteria. It must be evident that a significant level of impairment exists which interferes with the patient's quality of life. For persons 18 years and over, the level of impairment must be within the range 1 to 50 of the Global Assessment of Functioning (GAF) Scale contained in the DSM-IV (ie. the patient is displaying at least "serious" symptoms). The GAF score, incorporating the parameters which have led to the score, should be recorded at the time of commencement of the current course of treatment. Once a patient is identified as meeting the criteria of item 319, he/she continues to be eligible under that item for the duration of the current course of

treatment (provided that attendances under 300 to 308 and 319 do not exceed 160 in a calendar year). Where a patient commences a new course of treatment, the GAF score in relation to item 319 is the patient's score as assessed during the new course of treatment.

A.15.3 In addition to the above diagnostic criteria and level of functional impairment, it is also expected that other appropriate psychiatric treatment has been used for a suitable period and the patient has shown little or no response to such treatment. It is expected that such treatment would include, but not be limited to: shorter term psychotherapy; less frequent but long term psychotherapy; pharmacological therapy; cognitive behaviour therapy.

A.15.4 It is the responsibility of the psychiatrist to ensure that the patient meets these criteria. The Health Insurance Commission will be closely monitoring the use of Item 319.

A.15.5 When a patient who meets the criteria defined in Item 319 attends a psychiatrist on more than 160 occasions in 12 months such attendances would be covered by Items 310 to 318.

A.15.6 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has undertaken to establish an appropriate mechanism to enable use of Item 319 by suitably trained psychiatrists. In the interim it is expected that psychiatrists whose usual practice includes long term intensive treatment of patients whose diagnoses meet the criteria defined in the item will be using Item 319.

A.15.7 On the basis of advice from the RANZCP it is expected that it would be generally inappropriate in normal clinical practice for psychiatric treatment performed out of hospital to extend beyond 220 sessions in any 12 month period. In this regard the Health Insurance Commission will be monitoring providers' practice patterns with a view to the referral of possible cases of inappropriate practice to the Director of Professional Services Review.

A.16 Interview of Person other than a Patient by Consultant Psychiatrist (Items 348, 350, 352)

A.16.1 Items 348 and 350 refer to investigative interviews of a patient's relatives or close associates to determine whether the particular problem with which the patient presented was focused in the patient or in the interaction between the patient and the person being interviewed. These items do not cover counselling of family or friends of the patient. The term "in the course of initial diagnostic evaluation of the patient" should normally be interpreted as extending for up to one month from the date of the initial consultation. There is no strict limit to the number of interviews or persons interviewed in that period. These items should not be used for interviews concerned with the continuing management of the patient. (see para A.16.2)

A.16.2 Item 352 refers to investigative interviews of a patient's relatives or close associates to focus on a particular clinically relevant problem arising in the continuing management of the patient. This item does not cover counselling of family or friends of the patient. The payment of Medicare benefits under this item is limited to four in any twelve month period.

A.16.3 Benefits are payable for Item 348, 350 or 352 and for a consultation with a patient (Items 300 - 328) on the same day provided that separate attendances are involved.

A.16.4 For Medicare benefit purposes, charges relating to services covered by Items 348, 350 and 352 should be raised against the patient rather than against the person interviewed.

A.17 Consultant Occupational Physician attendances (Items 385 to 388)

A.17.1 Attendances by consultant occupational physicians will attract Medicare benefits only where the attendance relates to one or more of the following:

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

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

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

A.18 Contact Lenses (Items 10801-10809)

A.18.1 Benefits are paid for consultations concerned with the prescription and fitting of contact lenses only if patients fall into specified categories (ie. patients with certain conditions). The classes of patients eligible for benefits for contact lens consultations are described in Items 10801 to 10809. Benefits are not payable for Item 10809 in circumstances where patients want contact lenses only for:

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

A.18.2 Benefits are payable for an initial referred consultation rendered in association with the fitting and prescribing of the lenses.

A.18.3 Subsequent follow-up attendances attract benefits on a consultation basis.

A.19 Refitting of Contact Lenses (Item 10816)

A.19.1 This item covers the refitting of contact lenses where this becomes necessary within the thirty-six month time limit where the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structure or functional change in the eye or an allergic response.

A.20 Health Assessments (Items 700 to 706)

A.20.1 These items do not apply to in-patients of a hospital, day hospital facility or care recipients in residential aged care facilities.

A.20.2 A health assessment should generally only be undertaken by the medical practitioner, or a practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

A.20.3 The information collection component of the assessment may be rendered by a nurse or other assistant in accordance with accepted medical practice, acting under the supervision of the medical practitioner. The other components of the health assessment must include a personal attendance by the medical practitioner.

A.20.4 For the purposes of A20.3, the services of a third party service provider such as a nurse or other assistant may only be used to assist in the information collection component of health assessments where:

(a) use of the third party service provider is initiated by the patient's medical practitioner, after the patient has agreed to a health assessment and to the use of a third party to collect information for the assessment.

(b) the patient is made aware whether information collected about them for the health assessment will be retained by the third party service provider

(c) The third party service provider must act under the supervision of the practitioner. The practitioner should:

- be satisified that the third party service provider has the necessary skills, expertise and training to collect the information required for the health assessment,
- have established how the information is to be collected and recorded (including any forms used),
- set or approve the quality assurance procedures for the information collection,
- be consulted on any issues arising during the information collection,
- review and analyse the information collected to prepare their report of the health assessment and communicate to the patient their recommendations about matters covered by the health assessment.

A.20.5 For items 704 and 706, a person is of Aboriginal or Torres Strait Islander descent if the person identifies himself or herself as being of that descent. Patients should be asked to self-identify their Indigenous status and state their age for the purposes of these items, either verbally or by completing a form. Difficulties may arise in relation to establishing the age of the patient. Knowledge of a person's age or date of birth is sometimes considered irrelevant by Indigenous people and as such some people may not be able to answer with a high degree of accuracy. The person's Indigenous status and age should be accepted on the basis of their self-identification.

A.20.6 A ***health assessment*** means the assessment of a patient's health and physical, psychological and social function and whether preventative health care and education should be offered to the patient, to improve that patient's health and physical, psychological and social function.

A.20.7 The assessment must include:

(a) measurement of the patient's blood pressure, pulse rate and rhythm; and

(b) an assessment of the patient's medication; and

(c) an assessment of the patient's continence; and

(d) an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus; and

(e) an assessment of the patient's physical function, including the patient's activities of daily living, and whether or not the patient has had a fall in the last 3 months; and

(f) an assessment of the patient's psychological function, including the patient's cognition and mood; and

(g) an assessment of the patient's social function, including the availability and adequacy of paid and unpaid help, and whether the patient is responsible for caring for another person.

A.20.8 The assessment must also include keeping a record of the health assessment, signed by the patient and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment.

A.20.9 In circumstances where the patient's usual medical practitioner or practice, as defined in A20.2, does not undertake the health assessment, a copy of the health assessment report should be forwarded to that medical practitioner or practice (subject to the patient's agreement).

A.20.10 The annual health assessment should not take the form of a health screening service, in particular the assessment should not include category 5 (diagnostic imaging) services or category 6 (pathology) services unless the health assessment detects problems that require clinically relevant diagnostic imaging or pathology services. (See General Notes 13.3.)

A.20.11 Practitioners should not conduct a separate consultation in conjunction with a health assessment unless it is clinically indicated that a problem must be treated immediately.

A.20.12 Practitioners should establish a register of their patients seeking annual health assessments and remind registered patients when their next health assessment is due.

A.20.13 Where a component of the health assessment is conducted at consulting rooms and a component is conducted in the patient's home the latter item should be claimed.

A.20.14 The balance between the patient's health and physical, psychological and social function domains is a matter for professional judgement in relation to each patient. Practitioners should consider the following:

Medical:

Medication review

This should include a review of medications taken including OTCs and prescriptions from other doctors; medications prescribed but not taken; interactions; and review of indications. In this age group, side effects and interactions occur more frequently and at lower dosage than in younger adults.

Blood pressure and pulse rate and rhythm

Where the assessment identifies a spot high blood pressure reading or evidence of atrial fibrillation (irregularly irregular pulse), a follow up consultation should be arranged to determine further management.

Continence

Continence problems are under reported and a major cause of reduced quality of life in this age group. They are usually easily detectable by direct questioning, and when first diagnosed are frequently amenable to improved management. If identified, a follow up consultation should be arranged to investigate the underlying pathology and arrange management.

Immunisation status (Influenza, Tetanus, Pneumococcus)

Refer to the current Australian Standard Vaccination Schedule (NHMRC) for appropriate vaccination schedules for individuals in this age group.

Physical function:

Activities of Daily Living

Assessment of activities of daily living is concerned with the interaction between the patient, their impairment (if any) and their environment. As a minimum, the patient's ability to transfer between bed, chair and toilet, bathe, dress, prepare food and eat should be assessed. The assessment should also include whether the patient can: use the telephone; get to the shops or the bank; read books; watch TV; listen to the radio or recorded music; and look after the house (cleaning, minor repairs etc).

Where significant functional impairment is identified, the use of a formal instrument such as the Index of Independence in Activities of Daily Living; the Modified Barthel Index; or the Medical Outcome Study Physical Functioning Measure should be considered.

Falls in last 3 months

The patient should be asked whether they have suffered any falls in the previous three months. A recent fall is the strongest predictor of future fall related injury.

Psychological function:

Cognition

Unrecognised dementia is common in this age group. Detailed diagnosis can often improve quality of life. Cognition can be assessed with a recognised tool such as the Folstein Mini Mental State Examination or the Hodkinson Abbreviated Mental Assessment.

Mood

At a minimum, the assessment should include enquires about depressed affect. If mental symptoms are present (eg abnormal affect or memory loss), the use of a formal depression scale such as the Geriatric Depression Scale should be considered.

Social function:

Availability and adequacy of paid and unpaid help when needed and wanted

This is the central component of an assessment of the patient's social support. People's social networks tend to become smaller as they age, and the role of formal services may need to increase correspondingly.

Caring for another person

Being a carer for another person can significantly affect physical and psychological health and substantially reduce opportunities to maintain social networks. When the person being assessed is a carer, the assessment should include: an evaluation of the effect of this role on health and functioning; and the provision of information about local carer support services, including regular or emergency respite care.

NB: The tools referred to in the preceding explanatory notes should be used at the clinical discretion of the practitioner. Practitioners using such tools should be familiar with their use and if not, should seek appropriate education/training.

A.20.15 In addition, the assessment will usually cover additional matters of particular relevance to the patient. The medical literature and consensus medical opinion support the following additional components: multi-system review; fitness to drive; hearing; vision; oral health; diet and nutritional status; smoking; foot care; sleep; need for community services; home safety; cardiovascular risk factors, including blood pressure; and alcohol use.

A.21 Care Planning (Items 720 to 730)

A.21.1 Items 720, 724 and 726 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and is not an in-patient of a hospital, day hospital facility, or a care recipient in a residential aged care facility.

A.21.2 Items 722 and 728 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and is an in-patient of a hospital or day hospital facility, and is not a care recipient in a residential aged care facility.

A.21.3 Item 730 applies only to a service in relation to a care recipient in a residential aged care facility who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal.

A.21.4 For the purposes of items 720 to 730 a medical practitioner should generally be the medical practitioner or a practitioner working in the medical practice that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

Preparation of a multidisciplinary care plan

A.21.5 For items 720, 722, 724, 726, 728 and 730 preparation of a multidisciplinary care plan means the preparation of a written plan describing the following matters:

(a) an assessment of the patient and their health care needs; and
(b) an assessment of the kinds of treatment, health services and health care that the patient is likely to need; and
(c) an assessment of any other kind of services and care that the patient is likely to need (for example, home and community care services); and
(d) arrangements for giving the treatment, services and care referred to in paragraph (b); and
(e) management goals with which the patient agrees; and
(f) arrangements to review the plan by a day specified in the plan.

A.21.6 Preparation of the plan must also include:

(a) a meeting with the patient to discuss the preparation of the plan; and
(b) telling the patient who will be included in the multidisciplinary care plan team; and
(c) recording the plan and the patient's agreement to the preparation of the plan; and
(d) giving copies of relevant parts of the plan to persons who, under the plan, will give the patient the treatment, service and care mentioned in the plan; and
(e) offering a copy of the plan (and evidence of the contribution made to the plan by members of the team) to the patient; and
(f) if the patient is eligible to be provided with treatment under Part V of the *Veterans' Entitlement Act 1986*, giving a copy of the plan to the Department of Veterans' Affairs.

A.21.7 A multidisciplinary care plan team includes a medical practitioner and at least 2 other members who contribute to the plan, each of whom provides a different kind of care or service to the patient, and 1 of whom may be another medical practitioner (normally a specialist or consultant physician).

Example

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

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers; probation officers.

The patient, or his or her informal carer, is not counted toward the minimum of three.

A.21.8 In making arrangements for implementation of the plan, the medical practitioner should specify the type of care to be provided and ascertain the availability of care from other providers. The documentation of the care plan should note the agreement of the other providers specified in the plan. This may be in the form of the medical practitioner's note of a telephone conversation.

A.21.9 While the patient must be present for a needs assessment by the medical practitioner in order to develop the care plan, the patient need not be present while formal documentation is prepared and members of the multidisciplinary care plan team are contacted.

A.21.10 When discussing the preparation of the plan with the patient, practitioners should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers; and
- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to, or withheld from, the other members of the multidisciplinary care plan team;
- Inform the patient that he or she will incur a charge for the service provided by the practitioner for which a Medicare rebate will be payable;
- Inform the patient of any additional costs he or she will incur.

A.21.11 While no standard format for the care plan is mandated, practitioners should consider a recognised care planning tool, for example those developed by the Royal Australian College of General Practitioners (RACGP).

A.21.12 It is recommended that a community care plan be prepared only once per year. However, a new plan may be prepared if the patient's clinical condition has changed markedly since the previous plan, but not within 6 months of the previous plan. Any changes to the plan required after 3 months of the plan being prepared would attract a benefit under the review item 724 (see paragraphs A.21.16 and A.21.17).

A.21.13 Ongoing implementation and maintenance of the plan by the medical practitioner will be covered under normal consultation items.

Discharge care plans

A.21.14 For items 722 and 728 a multidisciplinary discharge care plan is a multidisciplinary care plan that is prepared for a patient before the patient is discharged from a hospital.

A.21.15 Preparation of a discharge care plan (item 722) may be provided for private in-patients only, and must be prepared by the medical practitioner who is providing in-patient care (in most cases this should be the patient's usual medical practitioner).

Review of care plans

A.21.16 For item 724, review of a multidisciplinary care plan means a process by which the medical practitioner who prepared the care plan:

(a) reviews a community care plan or discharge care plan prepared under item 720 or 722 including reviewing the matters mentioned in A.21.5; and
(b) considers whether the arrangements for treatment, service and care have been carried out; and
(c) consults with other members of the multidisciplinary care plan team to consider whether different arrangements need to be made to achieve the management goals mentioned in the plan; and
(d) if different arrangements need to be made, prepares a revised multidisciplinary care plan, stating those arrangements.

A.21.17 The review of the plan must also include:

(a) discussing the review of the plan with the patient; and
(b) recording the patient's agreement to reviewing the plan; and
(c) offering a copy of relevant parts of the revised multidisciplinary care plan (if any) to the patient, and giving copies to persons who, under the revised plan, will give the patient the treatment, service and care mentioned in the plan; and
(d) if the patient holds an entitlement for treatment under Part V of the *Veterans' Entitlements Act 1986*, giving a copy of the revised multidisciplinary care plan (if any) to the Department of Veterans' Affairs.

Contribution to care plans

A.21.18 For items 726 and 728, a contribution to a care plan must be at the request of the person who prepares the plan, and may include preparation of a part of the plan that relates to the treatment, service or care that the medical practitioner will give to the patient and giving advice to the person who prepares the plan.

A.21.19 Contribution to a care plan does not include preparation of a multidisciplinary ***community*** care plan, a multidisciplinary discharge care plan or a care plan in a residential aged care facility, but can include contribution to a review of a care plan organised by another provider.

A.21.20 A medical practitioner's contribution to a ***community*** care plan, a discharge plan or a care plan in a residential aged care facility can be made by either face-to-face meeting, telephone, fax, e-mail, written correspondence or other means.

A.21.21 The medical practitioner should request a copy of the completed plan, or an extract of the plan relating to the medical practitioner's contribution, for the patient's medical record. The medical practitioner must include a record of his or her contribution in the patient's medical record.

A.21.22 For item 730, a contribution to a care plan in a residential aged care facility must be at the request of the residential aged care facility. It is expected that a medical practitioner would not normally be required to contribute to an individual care plan in a residential aged care facility more than four times in a 12 month period. The medical practitioner's contribution should be documented in the care plan maintained by the residential aged care facility and a record of the contribution included in the care recipient's medical record.

General requirements

A.21.23 In circumstances where the patient's usual medical practitioner, as defined in A21.4, is not a member of the multidiscplinary care team, a copy of the care plan should be forwarded to that medical practitioner (subject to patient's agreement).

A.21.24 Before commencing a care plan, the medical practitioner should ascertain whether the patient currently has another active care plan and if so, should not duplicate that plan.

A.21.25 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided (see general notes 7.6).

A.22 Case Conferences by medical practitioners (other than specialist or consultant physician) (Items 734 to 779)

A.22.1 Items 740, 742, 744, 759, 762 and 765 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and is not an in-patient of a hospital, day hospital facility or a care recipient in a residential aged care facility.

A.22.2 Items 746, 749, 757, 768, 771 and 773 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and is an in-patient of a hospital or day hospital facility and is not a care recipient in a residential aged care facility.

A.22.3 Items 734, 736, 738, 775, 778 and 779 apply only to a service in relation to a care recipient in a residential aged care facility who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal.

A.22.4 A case conference is a process by which a case conference team carries out the following activities:

(a) discussing a patient's history; and
(b) identifying the patient's multidisciplinary care needs; and
(c) identifying outcomes to be achieved by members of the case conference team giving care and service to the patient; and
(d) identifying tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and
(e) assessing whether previously identified outcomes (if any) have been achieved.

A.22.5 For items 746, 749, 757, 768, 771 and 773, a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital or day hospital facility.

A.22.6 For the purposes of items 734 to 779 a medical practitioner should generally be the medical practitioner or a practitioner working in the medical practice that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

A.22.7 A case conference team includes a medical practitioner and at least 2 other members, who participate in the case conference, each of whom provides a different kind of care or service to the patient, and 1 of whom may be another medical practitioner (normally a specialist or consultant physician).

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

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers; probation officers.

The patient, or his or her informal carer, is not counted toward the minimum of three.

Organisation of a case conference
A.22.8 Organise and coordinate a case conference means undertaking the following activities in relation to a case conference:
(a) explaining to the patient the nature of a case conference, and asking the patient whether the patient agrees to the case conference taking place; and
(b) recording the patient's agreement to the case conference; and
(c) recording the day on which the conference was held, and the times at which the conference started and ended; and
(d) recording the names of the participants; and
(e) recording the matters mentioned in A.22.4 and putting a copy of that record in the patient's medical records; and
(f) offering the patient, and giving each other member of the team a summary of the conference; and
(g) discussing the outcomes of the case conference with the patient.

A.22.9 Organisation of a discharge case conference (items 746, 749 and 757), may be provided for private in-patients only, and must be organised by the medical practitioner who is providing in-patient care (in most cases this should be the patient's usual medical practitioner).

Participation in a case conference
A.22.10 Participation in a case conference must be at the request of the person who organises and coordinates the case conference and includes undertaking the following activities when participating in a case conference:
(a) explaining to the patient the nature of a case conference, and asking the patient whether he or she agrees to the medical practitioner participating in the case conference; and
(b) recording the patient's agreement to the medical practitioner participating in the case conference; and
(c) recording the day on which the conference was held, and the times at which the conference started and ended; and
(d) recording the names of the participants; and
(e) recording the matters mentioned in A.22.4 in so far as they relate to the medical practitioner's participation in the case conference, and putting a copy of that record in the patient's medical records; and
(f) offering the patient a summary of the conference.

Case conferences in a residential aged care facility

A.22.11 For items 734, 736, 738, 775, 778 and 779, organising or participating in a case conference in a residential aged care facility means undertaking the relevant activities referred to in A.22.4, A.22.8 and A.22.10. For these items the medical practitioner must give a record of the conference, or a record of the medical practitioner's participation in the conference, to the residential aged care facility, place a copy in the patient's medical records, and offer a copy to the patient.

General requirements

A.22.12 In circumstances where the patient's usual medical practitioner, as defined in A21.4, is not a member of the case conference team, a record of the case conference should be forwarded to that medical practitioner (subject to the patient's agreement).

A.22.13 It is expected that a patient would not normally require more than 5 case conferences in a 12-month period.

A.22.14 The case conference must be arranged in advance within a time frame that allows for all the participants to attend. The minimum three care providers must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

A.22.15 In explaining to the patient the nature of a case conference and asking the patient whether he or she agrees to the case conference taking place, the medical practitioner should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers;
- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to or withheld from the other case conference team members; and
- Inform the patient that he or she will incur a charge for the service provided by the practitioner for which a Medicare rebate will be payable.
- Inform the patient of any additional costs he or she will incur.

A.22.16 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. (See General Notes 7.6)

A.23 Public Health Medicine (Items 410 to 417)

A.23.1 Attendances by public health physicians will attract Medicare benefits under the new items only where the attendance relates to one or more of the following:-

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

A.24 Case Conferences by consultant physician (Items 801 to 815)

A.24.1 Items 801, 803, 805 and 807 apply to a community case conference (including a case conference conducted in a residential aged care facility) organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal. Items 801, 803, 805 and 807 do not apply to an in-patient of a hospital or day hospital facility.

A.24.2 For items 809, 811, 813 and 815, a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital or day hospital facility. Items 809, 811, 813 and 815 are payable not more than once for each hospital admission.

A.24.3 The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.

A.24.4 A case conference is a process by which a multidisciplinary team carries out the following activities:

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

A.24.5 For the purposes of these items, a multidisciplinary team requires the involvement of a minimum of four formal care providers from different disciplines. The consultant physician is counted toward the minimum of four. Although they may attend the case conference, neither the patient nor his or her informal carer, or any other medical practitioner (except where the medical practitioner is the patient's usual General Practitioner) can be counted toward the minimum of four.

A.24.6 For the purposes of 1.5 "formal care providers" includes:

- The patient's usual General Practitioner;
- Allied health professionals, being: registered nurse, physiotherapist, occupational therapist, podiatrist, speech pathologist, pharmacist; dietician; psychologist; orthoptist; orthotist and prosthetist, optometrist; audiologist, social worker, Aboriginal health worker, mental health worker; and
- Community service providers being: personal care worker, home and community care service provider, meals on wheels provider, education provider and probation officer.

Organisation of a case conference

A.24.7 For items 801, 803, 809 and 811, organise and coordinate a community case conference means undertaking the following activities in relation to a case conference:

(a) explaining to the patient or the patient's agent the nature of a case conference, and asking the patient or the patient's agent whether he or she agrees to the case conference taking place; and
(b) recording the patient's or agent's agreement to the case conference; and
(c) recording the day on which the conference was held, and the times at which the conference started and ended; and
(d) recording the names of the participants; and
(e) recording the matters mentioned in 1.4 and putting a copy of that record in the patient's medical records; and
(f) giving the patient or the patient's agent, and each other member of the team a summary of the conference; and
(g) giving a copy of the summary of the conference to the patient's usual general practitioner; and
(h) discussing the outcomes of the patient or the patient's agent.

Participation in a case conference

A.24.8 For items 805, 807, 813 and 815, participation in a case conference must be at the request of the person who organises and coordinates the case conference and includes undertaking the following activities when participating in a case conference:

(a) recording the day on which the conference was held, and the times at which the conference started and ended; and
(b) recording the matters mentioned in 1.4 in so far as they relate to the medical practitioner's participation in the case conference, and putting a copy of that record in the patient's medical records.

General requirements

A.24.9 The case conference must be arranged in advance, within a time frame that allows for all the participants to attend. The minimum four care providers must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

A.24.10 A record of the case conference which contains: a list of the participants; the times the conference commenced and concluded; a description of the problems, goals and strategies; and a summary of the outcomes must be kept in the patient's record. The notes and summary of outcomes must be provided to all participants and to the patient's usual general practitioner.

A.24.11 Prior informed consent must be obtained from the patient, or the patient's agent. In obtaining informed consent the consultant physician should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other case conference participants;

- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to, or withheld from, the other care providers;

- Inform the patient that he or she will incur a charge for the service for which a Medicare rebate will be payable.

A.24.12 Medicare benefits are only payable in respect of the service provided by the coordinating consultant physician or the participating consultant physician. Benefits are not payable for participation by other medical practitioners at a case conference, except where a medical practitioner participates in a case conference in accordance with Items 759 to 779.

A.24.13 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. See point 7 of the General Explanatory Notes for further details on billing procedures.

A.24.14 It is expected that a patient would not normally require more than 5 case conferences in a 12 month period.

A.24.15 This item does not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

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

	LEVEL A			LEVEL B		
	FEE	BENEFITS		FEE	BENEFITS	
PATIENTS		85%	75%		85%	75%
ONE	32.00	27.20	24.00	46.15	39.25	34.65
TWO	22.45	19.10	16.85	36.60	31.15	27.45
THREE	19.25	16.40	14.45	33.40	28.40	25.05
FOUR	17.65	15.05	13.25	31.80	27.05	23.85
FIVE	16.70	14.20	12.55	30.85	26.25	23.15
SIX	16.05	13.65	12.05	30.20	25.70	22.65
SEVEN+	14.15	12.05	10.65	28.30	24.10	21.25

	LEVEL C			LEVEL D		
	FEE	BENEFITS		FEE	BENEFITS	
PATIENTS		85%	75%		85%	75%
ONE	67.60	57.50	50.70	91.00	77.35	68.25
TWO	58.05	49.35	43.55	81.45	69.25	61.10
THREE	54.85	46.65	41.15	78.25	66.55	58.70
FOUR	53.25	45.30	39.95	76.65	65.20	57.50
FIVE	52.30	44.50	39.25	75.70	64.35	56.80
SIX	51.65	43.95	38.75	75.05	63.80	56.30
SEVEN+	49.75	42.30	37.35	73.15	62.20	54.90

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

EMERGENCY ATTENDANCES - AFTER HOURS

EMERGENCY ATTENDANCE AFTER HOURS
(on not more than 1 patient on 1 occasion)

1 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.5 and A.10 of explanatory notes to this Category)
Fee: $59.45 **Benefit:** 75% = $44.60 85% = $50.55

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.5 and A.10 of explanatory notes to this Category)
Fee: $59.45 **Benefit:** 75% = $44.60 85% = $50.55

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.5 and A.10 of explanatory notes to this Category)
Fee: $71.10 **Benefit:** 75% = $53.35 85% = $60.45

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.5 and A.10 of explanatory notes to this Category)
Fee: $71.10 **Benefit:** 75% = $53.35 85% = $60.45

GENERAL PRACTITIONER ATTENDANCES

LEVEL 'A'

3 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: $12.85 **Benefit:** 75% = $9.65 85% = $10.95

HOME VISIT
(Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution)
(See para A.5 of explanatory notes to this Category)
‡ 4 **Derived Fee:** The fee for item 3, plus $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $1.30 per patient

CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY
(Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient
(See para A.5 and A.6 of explanatory notes to this Category)
‡ 13 **Derived Fee:** The fee for item 3, plus $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $1.30 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)
19 **Derived Fee:** The fee for item 3, plus $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $1.30 per patient

‡ 20	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a selfcontained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a selfcontained 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 $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $1.30 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:** $27.00 **Benefit:** 75% = $20.25 85% = $22.95
‡ 24	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution) *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for item 23, plus $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $1.30 per patient
‡ 25	**CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient *(See para A.5 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for item 23, plus $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $1.30 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 $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $1.30 per patient
‡ 35	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a selfcontained 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 $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $1.30 per patient
36	**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)* **Fee:** $48.75 **Benefit:** 75% = $36.60 85% = $41.45
‡ 37	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution) *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for item 36, plus $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $1.30 per patient
‡ 38	**CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient *(See para A.5 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for item 36, plus $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $1.30 per patient

40	**CONSULTATION AT A HOSPITAL** (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient *(See para A.5 and A.7 of explanatory notes to this Category)* **Derived Fee:** The fee for item 36, plus $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $1.30 per patient
‡ 43	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a selfcontained unit) on 1 occasion) each patient *(See para A.5 and A.8 of explanatory notes to this Category)* **Derived Fee:** The fee for item 36, plus $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $1.30 per patient
44	**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)* **Fee:** $71.85 **Benefit:** 75% = $53.90 85% = $61.10
‡ 47	**HOME VISIT** (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution) *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for item 44, plus $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $1.30 per patient
‡ 48	**CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient *(See para A.5 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for item 44, plus $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $1.30 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 $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $1.30 per patient
‡ 51	**CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY** (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a selfcontained 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 $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $1.30 per patient

GROUP A2 - OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

SURGERY CONSULTATIONS

(Professional attendance at consulting rooms)

52	**BRIEF CONSULTATION** of not more than 5 minutes duration **Fee:** $11.00 **Benefit:** 75% = $8.25 85% = $9.35
53	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration **Fee:** $21.00 **Benefit:** 75% = $15.75 85% = $17.85
54	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration **Fee:** $38.00 **Benefit:** 75% = $28.50 85% = $32.30
57	**PROLONGED CONSULTATION** of more than 45 minutes duration **Fee:** $61.00 **Benefit:** 75% = $45.75 85% = $51.85

HOME VISITS
(Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution)

‡ 58	**BRIEF HOME VISIT** of not more than 5 minutes duration **Derived Fee:** An amount equal to $8.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $8.50 plus $.70 per patient
59	**STANDARD HOME VISIT** of more than 5 minutes duration but not more than 25 minutes duration **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $.70 per patient
60	**LONG HOME VISIT** of more than 25 minutes duration but not more than 45 minutes duration **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $.70 per patient
65	**PROLONGED HOME VISIT** of more than 45 minutes duration **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $.70 per patient

CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY
(Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient

‡ 81	**BRIEF CONSULTATION** of not more than 5 minutes duration *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $8.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $8.50 plus $.70 per patient
83	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $.70 per patient
84	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $.70 per patient
86	**PROLONGED CONSULTATION** of more than 45 minutes duration *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $.70 per patient

	CONSULTATION AT A HOSPITAL (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient
87	**BRIEF CONSULTATION** of not more than 5 minutes duration *(See para A.7 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $8.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $8.50 plus $.70 per patient
89	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration *(See para A.7 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $.70 per patient
90	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration *(See para A.7 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $.70 per patient
91	**PROLONGED CONSULTATION** of more than 45 minutes duration *(See para A.7 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $.70 per patient
	CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a selfcontained unit) on 1 occasion) - each patient
‡ 92	**BRIEF CONSULTATION** of not more than 5 minutes duration *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $8.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $8.50 plus $.70 per patient
93	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $.70 per patient
95	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $.70 per patient
96	**PROLONGED CONSULTATION** of more than 45 minutes duration *(See para A.8 of explanatory notes to this Category)* **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $.70 per patient

EMERGENCY ATTENDANCE - AFTER HOURS

(on not more than 1 patient on 1 occasion)

97	Professional attendance after hours **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 of explanatory notes to this Category)* **Fee:** $50.95	**Benefit:** 75% = $38.25	85% = $43.35
98	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:** $50.95	**Benefit:** 75% = $38.25	85% = $43.35
697	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 of explanatory notes to this Category)* **Fee:** $61.55	**Benefit:** 75% = $46.20	85% = $52.35
698	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 of explanatory notes to this Category)* **Fee:** $61.55	**Benefit:** 75% = $46.20	85% = $52.35

GROUP A3 - SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

SPECIALIST, REFERRED CONSULTATION - SURGERY OR HOSPITAL
(Professional attendance at consulting rooms or hospital by a specialist in the practice of his or her specialty where the patient is referred to him or her)

‡ 104	- **INITIAL** attendance in a single course of treatment, not being a service to which item 106 applies **Fee:** $66.60	**Benefit:** 75% = $49.95	85% = $56.65
105	Each attendance **SUBSEQUENT** to the first in a single course of treatment **Fee:** $33.40	**Benefit:** 75% = $25.05	85% = $28.40
106	- **INITIAL ATTENDANCE** in a single course of treatment, being an attendance at which refraction is performed by a specialist ophthalmologist, and the attendance results in the issuing of a prescription for spectacles or contact lenses, including any consultation on the same occasion and any other attendance on the same day (other than a service to which items 10801 to 10816 apply) **Fee:** $54.85	**Benefit:** 75% = $41.15	85% = $46.65

SPECIALIST, REFERRED CONSULTATION - HOME VISITS
(Professional attendance at a place other than consulting rooms or hospital by a specialist in the practice of his or her specialty where the patient is referred to him or her)

‡ 107	- **INITIAL** attendance in a single course of treatment **Fee:** $97.65	**Benefit:** 75% = $73.25	85% = $83.05
108	Each attendance **SUBSEQUENT** to the first in a single course of treatment **Fee:** $61.80	**Benefit:** 75% = $46.35	85% = $52.55

GROUP A4 - CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY), REFERRED CONSULTATION - SURGERY OR HOSPITAL
(Professional attendance at consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than in psychiatry) where the patient is referred to him or her by a medical practitioner)

‡ 110	- **INITIAL** attendance in a single course of treatment **Fee:** $117.45	**Benefit:** 75% = $88.10	85% = $99.85
116	- Each attendance (other than a service to which item 119 applies) **SUBSEQUENT** to the first in a single course of treatment **Fee:** $58.80	**Benefit:** 75% = $44.10	85% = $50.00
119	- Each **MINOR** attendance **SUBSEQUENT** to the first in a single course of treatment *(See para A.11 of explanatory notes to this Category)* **Fee:** $33.40	**Benefit:** 75% = $25.05	85% = $28.40

CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY), REFERRED CONSULTATION - HOME VISITS
(Professional attendance at a place other than consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than in psychiatry) where the patient is referred to him or her by a medical practitioner)

‡ 122	- **INITIAL** attendance in a single course of treatment **Fee:** $142.60	**Benefit:** 75% = $106.95	85% = $121.25
128	- Each attendance (other than a service to which item 131 applies) **SUBSEQUENT** to the first in a single course of treatment **Fee:** $86.15	**Benefit:** 75% = $64.65	85% = $73.25
131	- Each **MINOR** attendance **SUBSEQUENT** to the first in a single course of treatment *(See para A.11 of explanatory notes to this Category)* **Fee:** $62.05	**Benefit:** 75% = $46.55	85% = $52.75

GROUP A5 - PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

PROLONGED PROFESSIONAL ATTENDANCES

(Professional attendance (not being a service to which another item in this Category applies) on a patient in imminent danger of death requiring continuous attendance on the patient to the exclusion of all other patients)

	- For a period of not less than 1 hour but less than 2 hours *(See para A.12 of explanatory notes to this Category)*		
160	**Fee:** $164.05	**Benefit:** 75% = $123.05	85% = $139.45
	- For a period of not less than 2 hours but less than 3 hours *(See para A.12 of explanatory notes to this Category)*		
161	**Fee:** $273.45	**Benefit:** 75% = $205.10	85% = $232.45
	- For a period of not less than 3 hours but less than 4 hours *(See para A.12 of explanatory notes to this Category)*		
162	**Fee:** $382.85	**Benefit:** 75% = $287.15	85% = $331.95
	- For a period of not less than 4 hours but less than 5 hours *(See para A.12 of explanatory notes to this Category)*		
163	**Fee:** $492.30	**Benefit:** 75% = $369.25	85% = $441.40
	- For a period of 5 hours or more *(See para A.12 of explanatory notes to this Category)*		
164	**Fee:** $547.05	**Benefit:** 75% = $410.30	85% = $496.15

GROUP A6 - GROUP THERAPY

FAMILY GROUP THERAPY

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

	- each group of 2 patients *(See para A.13 of explanatory notes to this Category)*		
170	**Fee:** $93.45	**Benefit:** 75% = $70.10	85% = $79.45
	- each group of 3 patients *(See para A.13 of explanatory notes to this Category)*		
171	**Fee:** $98.50	**Benefit:** 75% = $73.90	85% = $83.75
	- each group of 4 or more patients *(See para A.13 of explanatory notes to this Category)*		
172	**Fee:** $119.80	**Benefit:** 75% = $89.85	85% = $101.85

GROUP A7 - ACUPUNCTURE

173	ATTENDANCE at which ACUPUNCTURE is performed by a medical practitioner by application of stimuli on or through the surface of the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed *(See para A.14 of explanatory notes to this Category)* **Fee:** $21.65 **Benefit:** 75% = $16.25 85% = $18.45
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.5 and A.14 of explanatory notes to this Category)* **Fee:** $27.00 **Benefit:** 75% = $20.25 85% = $22.95
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.5 and A.14 of explanatory notes to this Category)* **Derived Fee:** The fee for item 193, plus $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 193 plus $1.30 per patient

GROUP A8 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION, CONSULTING ROOMS

(Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY where the patient is referred to him or her by a medical practitioner)

300	- An attendance of not more than 15 minutes duration at consulting rooms, where that attendance and any other attendance to which item 300, 302, 304, 306 or 308 apply have not exceeded the sum of 50 attendances in a calendar year.		
	Fee: $33.70	**Benefit:** 75% = $25.30	85% = $28.65
302	- An attendance of more than 15 minutes duration but not more than 30 minutes duration at consulting rooms, where that attendance and any other attendance to which item 300, 302, 304, 306 or 308 apply have not exceeded the sum of 50 attendances in a calendar year.		
	Fee: $67.35	**Benefit:** 75% = $50.55	85% = $57.25
304	- An attendance of more than 30 minutes duration but not more than 45 minutes duration at consulting rooms, where that attendance and any other attendance to which item 300, 302, 304, 306 or 308 apply have not exceeded the sum of 50 attendances in a calendar year.		
	Fee: $98.70	**Benefit:** 75% = $74.05	85% = $83.90
306	- An attendance of more than 45 minutes duration but not more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which item 300, 302, 304, 306 or 308 apply have not exceeded the sum of 50 attendances in a calendar year.		
	Fee: $136.25	**Benefit:** 75% = $102.20	85% = $115.85
308	- An attendance of more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which item 300, 302, 304, 306 or 308 apply have not exceeded the sum of 50 attendances in a calendar year.		
	Fee: $166.00	**Benefit:** 75% = $124.50	85% = $141.10
310	- An attendance of not more than 15 minutes duration at consulting rooms, where that attendance and any other attendance to which item 300, 302, 304, 306, 308, 310, 312, 314, 316 or 318 apply exceed 50 attendances in a calendar year.		
	Fee: $16.85	**Benefit:** 75% = $12.65	85% = $14.35
312	- An attendance of more than 15 minutes duration but not more than 30 minutes duration at consulting rooms, where that attendance and any other attendance to which item 300, 302, 304, 306, 308, 310, 312, 314, 316 or 318 apply exceed 50 attendances in a calendar year.		
	Fee: $33.70	**Benefit:** 75% = $25.30	85% = $28.65
314	- An attendance of more than 30 minutes duration but not more than 45 minutes duration at consulting rooms, where that attendance and any other attendance to which item 300, 302, 304, 306, 308, 310, 312, 314, 316 or 318 apply exceed 50 attendances in a calendar year.		
	Fee: $49.35	**Benefit:** 75% = $37.05	85% = $41.95
316	- An attendance of more than 45 minutes duration but not more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which item 300, 302, 304, 306, 308, 310, 312, 314, 316 or 318 apply exceed 50 attendances in a calendar year.		
	Fee: $68.15	**Benefit:** 75% = $51.15	85% = $57.95
318	- An attendance of more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which item 300, 302, 304, 306, 308, 310, 312, 314, 316 or 318 apply exceed 50 attendances in a calendar year.		
	Fee: $83.05	**Benefit:** 75% = $62.30	85% = $70.60
319	- An attendance of more than 45 minutes duration at consulting rooms, where the patient has: (i) been diagnosed as suffering severe personality disorder, anorexia nervosa, bulimia nervosa, dysthymic disorder, substance-related disorder, somatoform disorder or a pervasive development disorder; and (ii) for persons 18 years and over, been rated with a level of functional impairment within the range 1 to 50 according to the Global Assessment of Functioning Scale where that attendance and any other attendance to which items 300 to 308 apply do not exceed 160 attendances in a calendar year. *(See para A.15 of explanatory notes to this Category)*		
	Fee: $136.25	**Benefit:** 75% = $102.20	85% = $115.85

	CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION, HOSPITAL (Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY where the patient is referred to him or her by a medical practitioner)
‡ 320	- An attendance of not more than 15 minutes duration at hospital. **Fee:** $33.70 **Benefit:** 75% = $25.30 85% = $28.65
‡ 322	- An attendance of more than 15 minutes duration but not more than 30 minutes duration at hospital **Fee:** $67.35 **Benefit:** 75% = $50.55 85% = $57.25
‡ 324	- An attendance of more than 30 minutes duration but not more than 45 minutes duration at hospital **Fee:** $98.70 **Benefit:** 75% = $74.05 85% = $83.90
‡ 326	- An attendance of more than 45 minutes duration but not more than 75 minutes duration at hospital **Fee:** $136.25 **Benefit:** 75% = $102.20 85% = $115.85
‡ 328	- An attendance of more than 75 minutes duration at hospital **Fee:** $166.00 **Benefit:** 75% = $124.50 85% = $141.10
	CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION, HOME VISITS (Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY where the patient is referred to him or her by a medical practitioner)
‡ 330	- An attendance of not more than 15 minutes duration where that attendance is at a place other than consulting rooms or hospital **Fee:** $61.90 **Benefit:** 75% = $46.45 85% = $52.65
‡ 332	- An attendance of more than 15 minutes duration but not more than 30 minutes duration where that attendance is at a place other than consulting rooms or hospital **Fee:** $97.10 **Benefit:** 75% = $72.85 85% = $82.55
‡ 334	- An attendance of more than 30 minutes duration but not more than 45 minutes duration where that attendance is at a place other than consulting rooms or hospital **Fee:** $134.70 **Benefit:** 75% = $101.05 85% = $114.50
‡ 336	- An attendance of more than 45 minutes duration but not more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital **Fee:** $162.95 **Benefit:** 75% = $122.25 85% = $138.55
‡ 338	- An attendance of more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital **Fee:** $194.25 **Benefit:** 75% = $145.70 85% = $165.15
	CONSULTANT PSYCHIATRIST - GROUP PSYCHOTHERAPY Group psychotherapy (including any associated consultation with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hours duration given under the continuous direct supervision of a consultant physician in the practice of his or her specialty of psychiatry where the patients are referred to him or her by a medical practitioner. - GROUP PSYCHOTHERAPY on a group of 2 to 9 unrelated patients OR FAMILY GROUP psychotherapy on a group of more than 3 patients, EACH PATIENT
342	**Fee:** $38.40 **Benefit:** 75% = $28.80 85% = $32.65
344	- FAMILY GROUP PSYCHOTHERAPY on a group of 3 patients, EACH PATIENT **Fee:** $51.00 **Benefit:** 75% = $38.25 85% = $43.35
346	- FAMILY GROUP PSYCHOTHERAPY on a group of 2 patients, EACH PATIENT **Fee:** $75.40 **Benefit:** 75% = $56.55 85% = $64.10

	CONSULTANT PSYCHIATRIST - INTERVIEW OF A PERSON OTHER THAN A PATIENT - SURGERY, HOSPITAL OR RESIDENTIAL AGED CARE FACILITY Professional attendance by a consultant physician in the practice of his or her recognised specialty of psychiatry, where the patient is referred to him or her by a medical practitioner involving an interview of a person other than the patient of not less than 20 minutes duration but less than 45 minutes duration, in the course of initial diagnostic evaluation of a patient, where that interview is at consulting rooms, hospital or residential aged care facility *(See para A.16 of explanatory notes to this Category)*		
‡ 348	**Fee:** $40.75	**Benefit:** 75% = $30.60	85% = $34.65
	- An attendance of not less than 45 minutes duration *(See para A.16 of explanatory notes to this Category)*		
350	**Fee:** $91.60	**Benefit:** 75% = $68.70	85% = $77.90
	CONSULTANT PSYCHIATRIST - INTERVIEW OF A PERSON OTHER THAN A PATIENT - IN THE COURSE OF CONTINUING MANAGEMENT OF A PATIENT Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a medical practitioner, involving an interview of a person other than the patient of not less than 20 minutes duration, in the course of continuing management of a patient - payable not more than 4 times in any 12 month period *(See para A.16 of explanatory notes to this Category)*		
352	**Fee:** $40.75	**Benefit:** 75% = $30.60	85% = $34.65

	GROUP A12 - CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
385	**CONSULTANT OCCUPATIONAL PHYSICIAN, REFERRED CONSULTATION - SURGERY OR HOSPITAL** (Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine where the patient is referred to him or her by a medical practitioner) **-INITIAL** attendance in a single course of treatment *(See para A.17 of explanatory notes to this Category)* **Fee:** $66.60 **Benefit:** 75% = $49.95 85% = $56.65
386	- Each attendance **SUBSEQUENT** to the first in a single course of treatment *(See para A.17 of explanatory notes to this Category)* **Fee:** $33.40 **Benefit:** 75% = $25.05 85% = $28.40
387	**CONSULTANT OCCUPATIONAL PHYSICIAN, REFERRED CONSULTATION - HOME VISITS** (Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine where the patient is referred to him or her by a medical practitioner) **- INITIAL** attendance in a single course of treatment *(See para A.17 of explanatory notes to this Category)* **Fee:** $97.65 **Benefit:** 75% = $73.25 85% = $83.05
388	- Each attendance **SUBSEQUENT** to the first in a single course of treatment *(See para A.17 of explanatory notes to this Category)* **Fee:** $61.80 **Benefit:** 75% = $46.35 85% = $52.55

GROUP A13 - PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

PUBLIC HEALTH PHYSICIAN ATTENDANCES - SURGERY

(Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine)

	- Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management *(See para A.23 of explanatory notes to this Category)*		
410	**Fee:** $12.85	**Benefit:** 75% = $9.65	85% = $10.95
	- Attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR an attendance of less than 20 minutes duration involving components of a service to which item 412 applies *(See para A.23 of explanatory notes to this Category)*		
411	**Fee:** $27.00	**Benefit:** 75% = $20.25	85% = $22.95
	- Attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR an attendance of less than 40 minutes duration involving components of a service to which item 413 applies *(See para A.23 of explanatory notes to this Category)*		
412	**Fee:** $48.75	**Benefit:** 75% = $36.60	85% = $41.45
	- Attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR an attendance of at least 40 minutes duration for implementation of a management plan *(See para A.23 of explanatory notes to this Category)*		
413	**Fee:** $71.85	**Benefit:** 75% = $53.90	85% = $61.10

PUBLIC HEALTH PHYSICIAN ATTENDANCES - OTHER THAN AT CONSULTING ROOMS

(Professional attendance at other than consulting rooms by a public health physician in the practice of his or her specialty of public health medicine)

	- Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management *(See para A.23 of explanatory notes to this Category)*
414	**Derived Fee:** The fee for item 410, plus $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 410 plus $1.30 per patient
	- Attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR an attendance of less than 20 minutes duration involving components of a service to which item 416 applies *(See para A.23 of explanatory notes to this Category)*
415	**Derived Fee:** The fee for item 411, plus $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 411 plus $1.30 per patient
	- Attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR an attendance of less than 40 minutes duration involving components of a service to which item 417 applies *(See para A.23 of explanatory notes to this Category)*
416	**Derived Fee:** The fee for item 412, plus $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 412 plus $1.30 per patient
	- Attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR an attendance of at least 40 minutes duration for implementation of a management plan *(See para A.23 of explanatory notes to this Category)*
417	**Derived Fee:** The fee for item 413, plus $19.15 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 413 plus $1.30 per patient

GROUP A14 - HEALTH ASSESSMENTS

‡ 700 — Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **AT CONSULTING ROOMS** for a health assessment - of a patient who is **at least 75 years old** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 702, 704 or 706**
(See para A.20 of explanatory notes to this Category)
Fee: $146.25 **Benefit:** 75% = $109.70 85% = $124.35

‡ 702 — Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **NOT BEING AN ATTENDANCE AT CONSULTING ROOMS, A HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY** for a health assessment - of a patient who is **at least 75 years old** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 700, 704 or 706**
(See para A.20 of explanatory notes to this Category)
Fee: $206.85 **Benefit:** 75% = $155.15 85% = $175.85

‡ 704 — Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **AT CONSULTING ROOMS** for a health assessment - of a patient who is **at least 55 years old and of Aboriginal or Torres Strait Islander descent** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 700, 702 or 706**
(See para A.20 of explanatory notes to this Category)
Fee: $146.25 **Benefit:** 75% = $109.70 85% = $124.35

‡ 706 — Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **NOT BEING AN ATTENDANCE AT CONSULTING ROOMS, A HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY,** for a health assessment - of a patient who is **at least 55 years old and of Aboriginal or Torres Strait Islander descent** - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 700, 702 or 704**
(See para A.20 of explanatory notes to this Category)
Fee: $206.85 **Benefit:** 75% = $155.15 85% = $175.85

GROUP A15 - MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES

SUBGROUP 1 - MULTIDISCIPLINARY CARE PLANS

PREPARATION by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), in consultation with a multidisciplinary care plan team, of a multidisciplinary **COMMUNITY CARE PLAN** for a patient (not being a service associated with a service to which **items 734 to 779** apply) - payable not more than once in any 6 month period

‡ *(See para A.21 of explanatory notes to this Category)*

720 **Fee:** $188.05 **Benefit:** 75% = $141.05 85% = $159.85

PREPARATION by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), in consultation with a multidisciplinary care plan team, of a multidisciplinary **CARE PLAN** for a patient (not being a service associated with a service to which **items 734 to 779** apply) - payable not more than once for each HOSPITAL ADMISSION

‡ *(See para A.21 of explanatory notes to this Category)*

722 **Fee:** $188.05 **Benefit:** 75% = $141.05 85% = $159.85

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), to **REVIEW** a multidisciplinary **COMMUNITY CARE PLAN** or a **DISCHARGE CARE PLAN** prepared by that medical practitioner for a patient and claimed for under item 720 or 722 (not being a payment for a service to which **items 734 to 779** apply) - payable not more than once in any 3 month period, and not being an attendance in relation to a patient:

(a) for whom, in the preceding 3 months, a payment has been made under **item 720**; or

(b) for whom, in the preceding month, a payment has been made under **item 722**

‡ *(See para A.21 of explanatory notes to this Category)*

724 **Fee:** $94.05 **Benefit:** 75% = $70.55 85% = $79.95

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary care plan team, to contribute to a multidisciplinary **COMMUNITY CARE PLAN** or to a **REVIEW** of a multidisciplinary **COMMUNITY CARE PLAN** prepared by another provider (not being a payment for a service to which **items 734 to 779** apply) - not being an attendance in relation to a patient for whom, in the preceding 6 months, a payment has been made under **item 720**

‡ + *(See para A.21 of explanatory notes to this Category)*

726 **Fee:** $37.90 **Benefit:** 75% = $28.45 85% = $32.25

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary care plan team, to **CONTRIBUTE** to a multidisciplinary **DISCHARGE CARE PLAN** or to a **REVIEW** of a multidisciplinary **DISCHARGE CARE PLAN** prepared by another provider (not being a service associated with a service to which **items 722, 740 to 773** apply)

+ *(See para A.21 of explanatory notes to this Category)*

728 **Fee:** $37.90 **Benefit:** 75% = $28.45 85% = $32.25

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary care plan team, to make a **CONTRIBUTION** to a multidisciplinary **CARE PLAN IN A RESIDENTIAL AGED CARE FACILITY** or to a **REVIEW** of a multidisciplinary **CARE PLAN IN A RESIDENTIAL AGED CARE FACILITY** prepared by the residential aged care facility (not being a payment in respect of a service to which **items 734 to 779** apply)

† *(See para A.21 of explanatory notes to this Category*

730 **Fee:** $37.90 **Benefit:** 75% = $28.45 85% = $32.25

SUBGROUP 2 - CASE CONFERENCES

CASE CONFERENCE - MEDICAL PRACTITIONER (OTHER THAN A SPECIALIST OR CONSULTANT PHYSICIAN)

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **item 730** applies)

† *(See para A.22 of explanatory notes to this Category*

734 **Fee:** $73.15 **Benefit:** 75% = $54.90 85% = $62.20

Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **item 730** applies)

† *(See para A.22 of explanatory notes to this Category*

736 **Fee:** $109.70 **Benefit:** 75% = $82.30 85% = $93.25

† 738	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, where the conference time is at least 45 minutes, (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $146.25	**Benefit:** 75% = $109.70	85% = $124.35
‡ 740	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.22 of explanatory notes to this Category)* **Fee:** $73.15	**Benefit:** 75% = $54.90	85% = $62.20
‡ 742	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.22 of explanatory notes to this Category)* **Fee:** $109.70	**Benefit:** 75% = $82.30	85% = $93.25
‡ 744	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE**, where the conference time is at least 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.22 of explanatory notes to this Category)* **Fee:** $146.25	**Benefit:** 75% = $109.70	85% = $124.35
‡ 746	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.22 of explanatory notes to this Category)* **Fee:** $73.15	**Benefit:** 75% = $54.90	85% = $62.20
‡ 749	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.22 of explanatory notes to this Category)* **Fee:** $109.70	**Benefit:** 75% = $82.30	85% = $93.25
‡ 757	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE**, where the conference time is at least 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.22 of explanatory notes to this Category)* **Fee:** $146.25	**Benefit:** 75% = $109.70	85% = $124.35
‡ 759	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE**, (other than to organise and co-ordinate the conference), where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.22 of explanatory notes to this Category)* **Fee:** $52.20	**Benefit:** 75% = $39.15	85% = $44.40
‡ 762	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.22 of explanatory notes to this Category)* **Fee:** $83.55	**Benefit:** 75% = $62.70	85% = $71.05
‡ 765	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) *(See para A.22 of explanatory notes to this Category)* **Fee:** $114.90	**Benefit:** 75% = $86.20	85% = $97.70

‡ 768	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.22 of explanatory notes to this Category)* **Fee:** $52.20 **Benefit:** 75% = $39.15 85% = $44.40
‡ 771	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.22 of explanatory notes to this Category)* **Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05
‡ 773	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** (other than to organise and co-ordinate the conference), where the conference time is at least 45 minutes (not being a service associated with a service to which **items 720 to 730** apply) - payable not more than once for each HOSPITAL ADMISSION *(See para A.22 of explanatory notes to this Category)* **Fee:** $114.90 **Benefit:** 75% = $86.20 85% = $97.70
† 775	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, (other than to organise and co-ordinate the conference), where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $52.20 **Benefit:** 75% = $39.15 85% = $44.40
† 778	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, (other than to organise and co-ordinate the conference), where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05
† 779	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to **PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY**, (other than to organise and co-ordinate the conference), where the conference time is at least 45 minutes, (not being a service associated with a service to which **item 730** applies) *(See para A.22 of explanatory notes to this Category* **Fee:** $114.90 **Benefit:** 75% = $86.20 85% = $97.70
	CASE CONFERENCE - CONSULTANT PHYSICIAN
† 801	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE** of at least 30 minutes but less than 60 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.6 on permissible combinations) *(See para A.24 of explanatory notes to this Category)* **Fee:** $183.00 **Benefit:** 75% = $137.25 85% = $155.55
† 803	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE** of more than 60 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.6 on permissible combinations) *(See para A.24 of explanatory notes to this Category)* **Fee:** $244.00 **Benefit:** 75% = $183.00 85% = $207.40
† 805	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and to coordinate the conference) of at least 30 minutes but less than 60 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.6 on permissible combinations) *(See para A.24 of explanatory notes to this Category)* **Fee:** $152.00 **Benefit:** 75% = $114.00 85% = $129.20

† 807	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and to coordinate the conference) of more than 60 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.6 on permissible combinations) *(See para A.24 of explanatory notes to this Category)* **Fee:** $202.60 **Benefit:** 75% = $151.95 85% = $172.25
† 809	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE** of at least 30 minutes but less than 60 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.6 on permissible combinations) *(See para A.24 of explanatory notes to this Category)* **Fee:** $183.00 **Benefit:** 75% = $137.25 85% = $155.55
† 811	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE** of more than 60 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.6 on permissible combinations) *(See para A.24 of explanatory notes to this Category)* **Fee:** $244.00 **Benefit:** 75% = $183.00 85% = $207.40
† 813	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** of at least 30 minutes but less than 60 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.6 on permissible combinations) *(See para A.24 of explanatory notes to this Category)* **Fee:** $152.00 **Benefit:** 75% = $114.00 85% = $129.20
† 815	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** of more than 60 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.6 on permissible combinations) *(See para A.24 of explanatory notes to this Category)* **Fee:** $202.60 **Benefit:** 75% = $151.95 85% = $172.25

GROUP A9 - ATTENDANCES

CONTACT LENSES FOR SPECIFIED CLASSES OF PATIENTS

Note: Benefits may not be claimed under Item 10809 where the patient wants the contact lenses for appearance, sporting, work or psychological reasons

ATTENDANCE FOR THE INVESTIGATION and EVALUATION of a patient for the fitting of CONTACT LENSES, with keratometry and testing with trial lenses and the issue of a prescription - 1 SERVICE IN ANY PERIOD OF 36 CONSECUTIVE MONTHS

	- patients with ***myopia of 5.0 dioptres or greater*** (spherical equivalent) in 1 eye *(See para A.18 of explanatory notes to this Category)*		
10801	**Fee:** $94.80	**Benefit:** 75% = $71.10	85% = $80.60
	- patients with ***manifest hyperopia of 5.0 dioptres or greater*** (spherical equivalent) in 1 eye *(See para A.18 of explanatory notes to this Category)*		
10802	**Fee:** $94.80	**Benefit:** 75% = $71.10	85% = $80.60
	- patients with ***astigmatism of 3.0 dioptres or greater*** in 1 eye *(See para A.18 of explanatory notes to this Category)*		
10803	**Fee:** $94.80	**Benefit:** 75% = $71.10	85% = $80.60
	- patients with ***irregular astigmatism*** in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens *(See para A.18 of explanatory notes to this Category)*		
10804	**Fee:** $94.80	**Benefit:** 75% = $71.10	85% = $80.60
	- patients with ***anisometropia of 3.0 dioptres or greater*** (difference between spherical equivalents) *(See para A.18 of explanatory notes to this Category)*		
10805	**Fee:** $94.80	**Benefit:** 75% = $71.10	85% = $80.60
	- patients with ***corrected visual acuity of 0.7 logMAR (6/30) or worse*** in both eyes, being patients for whom a contact lens is prescribed as part of a ***telescopic system*** *(See para A.18 of explanatory notes to this Category)*		
10806	**Fee:** $94.80	**Benefit:** 75% = $71.10	85% = $80.60
	- patients for whom a wholly or segmentally ***opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia*** caused by: (i) pathological mydriasis; or (ii) aniridia; or (iii) coloboma of the iris; or (iv) pupillary malformation or distortion; or (v) significant ocular deformity or corneal opacity whether congenital, traumatic or surgical in origin *(See para A.18 of explanatory notes to this Category)*		
10807	**Fee:** $94.80	**Benefit:** 75% = $71.10	85% = $80.60
	- patients who, by reason of physical deformity, are ***unable to wear spectacles*** *(See para A.18 of explanatory notes to this Category)*		
10808	**Fee:** $94.80	**Benefit:** 75% = $71.10	85% = $80.60
	- patients who have a ***medical or optical condition*** (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10806, 10807 or 10808 applies) requiring the use of a contact lens for correction, where the ***condition is specified*** on the patient's account *(See para A.18 of explanatory notes to this Category)*		
10809	**Fee:** $94.80	**Benefit:** 75% = $71.10	85% = $80.60
	ATTENDANCE FOR THE REFITTING OF CONTACT LENSES with keratometry and testing with trial lenses and the issue of a prescription, where the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structural or functional change in the eye or an allergic response **within 36 months of the fitting of a contact lens to which Items 10801 to 10809 apply** *(See para A.19 of explanatory notes to this Category)*		
10816	**Fee:** $94.80	**Benefit:** 75% = $71.10	85% = $80.60

DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

CATEGORY 2

CATEGORY 2 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

EXPLANATORY NOTES

SCHEDULE OF SERVICES

CATEGORY 2 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

EXPLANATORY NOTES

MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

D1.1 Neuromuscular Diagnosis (Item 11012)
D1.1.1 Based on advice from the Australian Association of Neurologists, Medicare benefits are not payable under Item 11012 for quantitative sensory nerve testing using "Neurometer CPT" diagnostic devices. The advice indicated that the device was still in the evaluation and research stage and did not have widespread clinical application.

D1.2 Investigation of Central Nervous System Evoked Responses (Items 11024 and 11027)
D1.2.1 In the context of these items a study refers to one or more averaged samples of electrical activity recorded from one or more sites in the central nervous system in response to the same stimulus.
D1.2.2 Second or subsequent studies refer to either stimulating the point of stimulation (e.g. right eye or left median nerve) with a different stimulus or stimulating another point of stimulation (e.g. left eye or right median nerve).
D1.2.3 Items 11024 and 11027 are not intended to cover bio-feedback techniques.

D1.3 Computerised Perimetry (Items 11222 and 11225)
D1.3.1 These items relate to computerised perimetry (bilateral or unilateral) where a third or subsequent examination becomes necessary in a 12 month period. As indicated in the descriptions, these items apply only where a further examination is indicated in the presence of one of the following conditions:-

- established glaucoma where surgery is being considered or has been performed, and where there has been definite progression of damage over a 12 month period;
- progressive neurologic disease; or
- for the monitoring of systemic drug toxicity, where there is also other disease such as glaucoma or neurologic disease.

D1.3.2 Claims for benefits in respect of Items 11222 and 11225 should be accompanied by clinical details confirming the presence of one of the above conditions. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

D1.4 Electrocochleography (Item 11304)
D1.4.1 This item refers to electrochleography with insertion of electrodes through the tympanic membrane.

D1.5 Non-determinate Audiometry (Item 11306)
D1.5.1 This refers to screening audiometry covering those services, one or more, referred to in Items 11309-11321 when not performed under the conditions set out in paragraph D1.6.1.

D1.6 Audiology Services (Items 11309 - 11321)
D1.6.1 A medical service specified in Items 11309 to 11321 shall be taken to be a medical service for the purposes of payment of benefits if, and only if, it is rendered:

(a) in conditions that allow the establishment of determinate thresholds;
(b) in a sound attenuated environment with background noise conditions that comply with Australian Standard AS 1269-1983 of the Standards Association of Australia, being that Standard as in force or existing on 1 August 1987; and
(c) using calibrated equipment that complies with Australian Standard AS 2586-1983 of the Standards Association of Australia, being that Standard as in force or existing on 1 August 1987.

D1.7 Oto-Acoustic Emission Audiometry (Item 11332)
D1.7.1 Medicare benefits are not payable under Item 11332 for routine screening of infants. The equipment used to provide this service must be capable of displaying the recorded emission and not just a pass/fail indicator.

D1.8 Respiratory Function Tests (Item 11503)
D1.8.1 The investigations listed hereunder would attract benefits under Item 11503. This list has been prepared in consultation with the Thoracic Society of Australia and New Zealand.

(a) Carbon monoxide diffusing capacity by any method
(b) Absolute lung volumes by any method
(c) Assessment of arterial carbon dioxide tension or cardiac output - re breathing method
(d) Assessment of pulmonary distensibility involving measurement of lung volumes and oesophageal pressure

(e) Measurement of airway or pulmonary resistance by any method
(f) Measurement of respiratory muscle strength involving the measurement of trans-diaphragmatic or oesophageal pressures
(g) Assessment of phrenic nerve function involving percutaneous stimulation and measurement of the compound action potential of the diaphragm
(h) Measurement of the resistance of the anterior nares or pharynx
(i) Inhalation provocation testing, including pre-provocation spirometry, the construction of a dose response curve, using histamine, cholinergic agents or non-istonic fluids and post-bronchodilator spirometry
(j) Exercise testing using incremental workloads with monitoring of ventilatory and cardiac responses at rest, during exercise and recovery on premises equipped with a mechanical ventilator and defibrillator
(k) Tests of distribution of ventilation involving inhalation of inert gases
(l) Measurement of gas exchange involving simultaneous collection of arterial blood and expired air with measurements of the partial pressures of oxygen and carbon dioxide in gas and blood
(m) Multiple inert gas elimination techniques for measuring ventilation perfusion ratios in the lung
(n) Continuous monitoring of pulmonary function other than spirometry, tidal breathing and minute ventilation, of at least 6 hours duration
(o) Ventilatory and/or occlusion pressure responses to progressive hypercapnia and progressive hypoxia
(p) Monitoring pulmonary arterial pressure at rest or during exercise
(q) Measurement of the strength of inspiratory and expiratory muscles at multiple lung volumes
(r) Measurement of the respiratory muscle endurance/fatigability by any technique
(s) Measurement of respiratory muscle strength before and after intravenous injection of placebo and anticholinesterase drugs
(t) Simulated altitude test involving exposure to hypoxic gas mixtures and measurement of ventilation, heart rate and oxygen saturation at rest and/or during exercise and observation of the effect of supplemental oxygen
(u) Inhalation provocation testing to specific sensitising agents
(v) Spirometry performed before and after simple exercise testing undertaken as a provocation test for the investigation of asthma, in premises capable of performing complex lung function tests and equipped with a mechanical ventilator and defibrillator.

D1.9 Investigations of Vascular Disease (Items 11603-11624)
D1.9.1 These items relate to examinations performed in the investigation of vascular disease. The fees include components for interpretation of the results and provision of the report which must be performed by a medical practitioner.

D1.10 Twelve-lead Electrocardiography (Item 11700)
D1.10.1 Benefits are precluded under this item unless a full 12-lead ECG is performed. Examinations involving less than twelve leads are regarded as part of the accompanying consultation. A 12-lead ECG refers to the recordings produced of 12 views of the heart by various combinations of placement of electrodes.

D1.11 Twelve-lead Electrocardiography, Report Only (Item 11701)
D1.11.1 This item provides a benefit where tracings are referred to a medical practitioner for a report without an attendance on the patient by that practitioner. Where a patient is referred to a consultant for a consultation and takes ECG tracings with him/her, a separate benefit is not payable for the consultant's interpretation of the tracings.

D1.12 Electrocardiographic (ECG) Recording of Ambulatory Patient (Items 11708, 11709)
D1.12.1 Medicare benefits are not payable for ambulatory blood pressure monitoring (under Item 11708 or 11709 or any other item). Likewise, where blood pressure monitoring and continuous ECG recording are undertaken conjointly on an ambulatory patient for 12 hours or more, benefits are not payable for the blood pressure monitoring or for the continuous ECG recording under Item 11708 or 11709.
D1.12.2 Items 11708 and 11709 require the continuous ECG recording of an ambulatory patient for twelve hours or more. Benefits are only payable under these items if the ECG data is analysed and reported on by a specialist physician or consultant physician.
D1.12.3 The changing of a tape or batteries is regarded as a continuation of the service and does not constitute a separate service for benefit purposes. Where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode would be regarded as a separate service.

D1.13 Signal Averaged ECG Recording (Item 11713)
D1.13.1 Benefits are only payable under this item if the ECG data is analysed and reported on by a specialist physician or a consultant physician.

D1.14 Epicutaneous Patch Testing (Items 12012, 12015 & 12018)
D1.14.1 A standard epicutaneous patch test battery refers to the European Standard Series or the International Contact Research Group Standard Series.

D1.15 Investigations for Sleep Apnoea (Items 12203 and 12207)

D1.15.1 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 paragraph (d) above.

D1.15.2 In relation to paragraph (d) of these items, generally, the patient should be seen in consultation by the supervising medical practitioner to determine the necessity for the investigation unless the necessity has been clearly established by other means.

D1.15.3 Item 12207 relates to overnight investigation for sleep apoena where a fourth or subsequent investigation becomes necessary in a twelve month period where all of the following conditions apply:-

- the patient has severe cardio-respitory failure; **and**
- previous studies have demonstrated failure of continous positive airway pressure or oxygen; **and**
- the study is for the adjustment and/or testing of the effectiveness of a positive pressure ventilatory support device (other than nasal continuous positive airway pressure)

D1.15.4 Claims for benefits in respect of Item 12207 should be accompanied by clinical details confirming the presence of the above conditions. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

D1.16 Bone Densitometry (Items 12306 to 12321)

D1.16.1 Item 12321 is intended to allow for bone mineral density measurement following a significant change in therapy - e.g. a change in the class of drugs - rather than for a change in the dosage regimen.

D1.16.2 An examination under any of these items covers the measurement of 2 or more sites, interpretation and provision of a report. Two or more sites must include the measurement of bone density of the lumbar spine and proximal femur. If technical difficulties preclude measurement at these sites, other sites can be used for the purpose of measurements. The measurement of bone mineral density at both forearms or both heels or in combination is excluded for the purpose of Medicare benefit.

Referrals

D1.16.3 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 Items 12306, 12309, 12312, 12315, 12318 and 12321.

D1.16.4 For Items 12306 and 12309 the referral should specify the indication for the test, namely:

(a) 1 or more fractures occurring after minimal trauma; or
(b) monitoring of low bone mineral density proven by previous bone densitometry.

D1.16.5 For Item 12312 the referral should specify the indication for the test, namely:

(a) prolonged glucocorticoid therapy;
(b) conditions associated with excess glucocorticoid secretion;
(c) male hypogonadism; or
(d) female hypogonadism lasting more than 6 months before the age of 45.

D1.16.6 For Item 12315 the referral should specify the indication for the test, namely:

(a) primary hyperparathyroidism;
(b) chronic liver disease;
(c) chronic renal disease;
(d) proven malabsorptive disorders;
(e) rheumatoid arthritis; or
(f) conditions associated with thyroxine excess.

D1.16.7 For Item 12318 the referral should specify the indication for the test, namely:

(a) prolonged glucocorticoid therapy;
(b) conditions associated with excess glucocorticoid secretion;
(c) male hypogonadism;
(d) female hypogonadism lasting more than 6 months before the age of 45;
(e) primary hyperparathyroidism;
(f) chronic liver disease;
(g) chronic renal disease;
(h) proven malabsorptive disorders;
(i) rheumatoid arthritis; or
(j) conditions associated with thyroxine excess.

Definitions

D1.16.8 Low bone mineral density is present when the bone (organ) mineral density falls more than 1.5 standard deviations below the age matched mean or more than 2.5 standard deviations below the young normal mean at the same site and in the same gender.

D1.16.9 For Items 12312 and 12318

(a) 'Prolonged glucocorticoid therapy' is defined as the commencement of a dosage of inhaled glucocorticoid equivalent to or greater than 800 micrograms beclomethasone dipropionate or budesonide per day; or
(b) a supraphysiological glucocorticoid dosage equivalent to or greater than 7.5 mg prednisolone in an adult taken orally per day for a period anticipated to last for at least 4 months.

D1.16.10 For Items 12312 and 12318

(a) Male hypogonadism is defined as serum testosterone levels below the age matched normal range.
(b) Female hypogonadism is defined as serum oestrogen levels below the age matched normal range.

D1.16.11 For Items 12315 and 12318

A malabsorptive disorder is defined as one or more of the following:

(a) malabsorption of fat, defined as faecal fat estimated at greater than 18 gm per 72 hours on a normal fat diet; or
(b) bowel disease with presumptive vitamin D malabsorption as indicated by a sub-normal circulating 25-hydroxyvitamin D level; or
(c) histologically proven Coeliac disease.

GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

SUBGROUP 1 - NEUROLOGY

11000	ELECTROENCEPHALOGRAPHY, not being a service: (a) associated with a service to which item 11003, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices (Anaes. 17708 = 5B + 3T) **Fee:** $95.80	**Benefit:** 75% = $71.85	85% = $81.45
11003	ELECTROENCEPHALOGRAPHY, prolonged recording of at least 3 hours duration, not being a service: (a) associated with a service to which item 11000, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices **Fee:** $253.60	**Benefit:** 75% = $190.20	85% = $215.60
11006	ELECTROENCEPHALOGRAPHY, temporosphenoidal, not being a service involving quantitative topographic mapping using neurometrics or similar devices **Fee:** $130.00	**Benefit:** 75% = $97.50	85% = $110.50
11009	ELECTROCORTICOGRAPHY **Fee:** $177.30	**Benefit:** 75% = $133.00	85% = $150.75
11012	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 1 nerve OR ELECTROMYOGRAPHY of 1 or more muscles using concentric needle electrodes OR both these examinations (not being a service associated with a service to which item 11015 or 11018 applies) *(See para D1.1 of explanatory notes to this Category)* **Fee:** $87.15	**Benefit:** 75% = $65.40	85% = $74.10
11015	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 2 or 3 nerves with or without electromyography (not being a service associated with a service to which item 11012 or 11018 applies) **Fee:** $116.75	**Benefit:** 75% = $87.60	85% = $99.25
11018	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 4 or more nerves with or without electromyography OR recordings from single fibres of nerves and muscles OR both of these examinations (not being a service associated with a service to which item 11012 or 11015 applies) **Fee:** $174.35	**Benefit:** 75% = $130.80	85% = $148.20
11021	NEUROMUSCULAR ELECTRODIAGNOSIS repetitive stimulation for study of neuromuscular conduction OR electromyography with quantitative computerised analysis OR both of these examinations **Fee:** $116.75	**Benefit:** 75% = $87.60	85% = $99.25
11024	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials - 1 or 2 studies *(See para D1.2 of explanatory notes to this Category)* **Fee:** $88.70	**Benefit:** 75% = $66.55	85% = $75.40
11027	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials - 3 or more studies *(See para D1.2 of explanatory notes to this Category)* **Fee:** $131.50	**Benefit:** 75% = $98.65	85% = $111.80

SUBGROUP 2 - OPHTHALMOLOGY

11200	PROVOCATIVE TEST OR TESTS FOR GLAUCOMA, including water drinking **Fee:** $31.75	**Benefit:** 75% = $23.85	85% = $27.00
11203	TONOGRAPHY in the investigation or management of glaucoma, 1 or both eyes using an electrical tonography machine producing a directly recorded tracing **Fee:** $53.70	**Benefit:** 75% = $40.30	85% = $45.65
11206	ELECTRORETINOGRAPHY of 1 or both eyes OR ELECTROOCULOGRAPHY of 1 or both eyes **Fee:** $85.60	**Benefit:** 75% = $64.20	85% = $72.80
11209	ELECTRORETINOGRAPHY of 1 or both eyes AND ELECTROOCULOGRAPHY of 1 or both eyes **Fee:** $126.90	**Benefit:** 75% = $95.20	85% = $107.90
11212	OPTIC FUNDI, examination of, following intravenous dye injection **Fee:** $54.65	**Benefit:** 75% = $41.00	85% = $46.50

11215	RETINAL PHOTOGRAPHY, multiple exposures of 1 eye with intravenous dye injection **Fee:** $95.70	**Benefit:** 75% = $71.80	85% = $81.35
11218	RETINAL PHOTOGRAPHY, multiple exposures of both eyes with intravenous dye injection **Fee:** $118.25	**Benefit:** 75% = $88.70	85% = $100.55
11221	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold) performed by or on behalf of a specialist in the practice of his or her specialty, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, bilateral - ***to a maximum of 2 examinations*** (including examinations to which item 11224 applies) ***in any 12 month period*** *Fee: $52.75*	*Benefit: 75% = $39.60*	*85% = $44.85*
11222	FULL QUANTITATIVE COMPUTERISED PERIMETRY (automated absolute static threshold), performed by or on behalf of a specialist in the practice of his or her specialty, with assessment and report, bilateral, ***where it can be demonstrated that a further examination is indicated in the same 12 month period to which Item 11221 applies due to presence of 1 of the following conditions:-*** established glaucoma (where surgery is being considered or has been performed) where there has been definite progression of damage over a 12 month period; progressive neurologic disease; or for the monitoring of systemic drug toxicity, where there is also other disease such as glaucoma or neurologic disease - ***each additional examination*** *(See para D1.3 of explanatory notes to this Category)* **Fee:** $52.75	**Benefit:** 75% = $39.60	85% = $44.85
11224	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold) performed by or on behalf of a specialist in the practice of his or her specialty, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, unilateral - ***to a maximum of 2 examinations*** (including examinations to which item 11221 applies) ***in any 12 month period*** *Fee: $31.80*	*Benefit: 75% = $23.85*	*85% = $27.05*
11225	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold), performed by or on behalf of a specialist in the practice of his or her specialty, with assessment and report, unilateral, ***where it can be demonstrated that a further examination is indicated in the same 12 month period to which item 11224 applies due to presence of one of the following conditions:-*** established glaucoma (where surgery is being considered or has been performed) where there has been definite progression of damage over a 12 month period; progressive neurologic disease; or for the monitoring of systemic drug toxicity, where there is also other disease such as glaucoma or neurologic disease - ***each additional examination*** *(See para D1.3 of explanatory notes to this Category)* **Fee:** $31.80	**Benefit:** 75% = $23.85	85% = $27.05
11235	EXAMINATION OF THE EYE BY IMPRESSION CYTOLOGY OF CORNEA for the investigation of ocular surface dysplasia, including the collection of cells, processing and all cytological examinations and preparation of report **Fee:** $95.45	**Benefit:** 75% = $71.60	85% = $81.15
11240	ORBITAL CONTENTS, ultrasonic echography of, unidimensional, not being a service associated with a service to which items in Group I1 apply **Fee:** $63.40	**Benefit:** 75% = $47.55	85% = $53.90
	SUBGROUP 3 - OTOLARYNGOLOGY		
11300	BRAIN stem evoked response audiometry (Anaes. 17707 = 5B + 2T) **Fee:** $149.85	**Benefit:** 75% = $112.40	85% = $127.40
11303	ELECTROCOCHLEOGRAPHY, extratympanic method, 1 or both ears **Fee:** $149.85	**Benefit:** 75% = $112.40	85% = $127.40
11304	ELECTROCOCHLEOGRAPHY, transtympanic membrane insertion technique, 1 or both ears *(See para D1.4 of explanatory notes to this Category)* **Fee:** $246.75	**Benefit:** 75% = $185.10	85% = $209.75
11306	Nondeterminate AUDIOMETRY *(See para D1.5 of explanatory notes to this Category)* **Fee:** $17.10	**Benefit:** 75% = $12.85	85% = $14.55

11309	AUDIOGRAM, air conduction *(See para D1.6 of explanatory notes to this Category)* **Fee:** $20.45	**Benefit:** 75% = $15.35	85% = $17.40
11312	AUDIOGRAM, air and bone conduction or air conduction and speech discrimination *(See para D1.6 of explanatory notes to this Category)* **Fee:** $28.90	**Benefit:** 75% = $21.70	85% = $24.60
11315	AUDIOGRAM, air and bone conduction and speech *(See para D1.6 of explanatory notes to this Category)* **Fee:** $38.35	**Benefit:** 75% = $28.80	85% = $32.60
11318	AUDIOGRAM, air and bone conduction and speech, with other Cochlear tests *(See para D1.6 of explanatory notes to this Category)* **Fee:** $47.25	**Benefit:** 75% = $35.45	85% = $40.20
11321	GLYCEROL INDUCED COCHLEAR FUNCTION CHANGES assessed by a minimum of 4 air conduction and speech discrimination tests (Klockoff's tests) *(See para D1.6 of explanatory notes to this Category)* **Fee:** $89.80	**Benefit:** 75% = $67.35	85% = $76.35
11324	IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner - not being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies **Fee:** $25.60	**Benefit:** 75% = $19.20	85% = $21.80
11327	IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner - being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies **Fee:** $15.35	**Benefit:** 75% = $11.55	85% = $13.05
11330	IMPEDANCE AUDIOGRAM where the patient is not referred by a medical practitioner - 1 examination in any 4 week period **Fee:** $6.15	**Benefit:** 75% = $4.65	85% = $5.25
11332	OTO-ACOUSTIC EMISSION AUDIOMETRY for the detection of permanent congenital hearing impairment, performed by or on behalf of a specialist or consultant physician, on an infant or child who is at risk due to one or more of the following factors:- (i) admission to a neonatal intensive care unit; or (ii) family history of hearing impairment; or (iii) intra-uterine or perinatal infection (either suspected or confirmed); or (iv) birthweight less than 1.5kg; or (v) craniofacial deformity: or (vi) birth asphyxia; or (vii) chromosomal abnormality, including Down's Syndrome; or (viii) exchange transfusion; and where:- - the patient is referred by another medical practitioner; and - middle ear pathology has been excluded by specialist opinion *(See para D1.7 of explanatory notes to this Category)* **Fee:** $45.55	**Benefit:** 75% = $34.20	85% = $38.75
11333	CALORIC TEST OF LABYRINTH OR LABYRINTHS **Fee:** $34.70	**Benefit:** 75% = $26.05	85% = $29.50
11336	SIMULTANEOUS BITHERMAL CALORIC TEST OF LABYRINTHS **Fee:** $34.70	**Benefit:** 75% = $26.05	85% = $29.50
11339	ELECTRONYSTAGMOGRAPHY **Fee:** $34.70	**Benefit:** 75% = $26.05	85% = $29.50
	SUBGROUP 4 - RESPIRATORY		
11500	BRONCHOSPIROMETRY, including gas analysis **Fee:** $130.00	**Benefit:** 75% = $97.50	85% = $110.50

11503	MEASUREMENT OF THE MECHANICAL OR GAS EXCHANGE FUNCTION OF THE RESPIRATORY SYSTEM, OR OF RESPIRATORY MUSCLE FUNCTION, OR OF VENTILATORY CONTROL MECHANISMS, using measurements of various parameters including pressures, volumes, flow, gas concentrations in inspired or expired air, alveolar gas or blood, electrical activity of muscles (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) each occasion at which 1 or more such tests are performed *(See para D1.8 of explanatory notes to this Category)* **Fee:** $107.95	**Benefit:** 75% = $81.00	85% = $91.80
11506	MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing performed before and after inhalation of bronchodilator each occasion at which 1 or more such tests are performed **Fee:** $16.00	**Benefit:** 75% = $12.00	85% = $13.60
11509	MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex respiratory function tests (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) each occasion at which 1 or more such tests are performed **Fee:** $27.80	**Benefit:** 75% = $20.85	85% = $23.65
11512	CONTINUOUS MEASUREMENT OF THE RELATIONSHIP BETWEEN FLOW AND VOLUME DURING EXPIRATION OR INSPIRATION involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex lung function tests (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) each occasion at which 1 or more such tests are performed **Fee:** $48.10	**Benefit:** 75% = $36.10	85% = $40.90
	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 type of pressure up to a maximum of 4 pressures (not being a service to which item 13876 applies) (Anaes. 17703 = 2B + 1T) **Fee:** $53.95	**Benefit:** 75% = $40.50	85% = $45.90
11601	BLOOD PRESSURE MONITORING (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - for each type of pressure up to a maximum of 4 pressures (not being a service to which item 13876 applies) performed in association with the administration of an anaesthetic relating to another discrete operation on the same day (Anaes. 17703 = 2B + 1T) **Fee:** $53.95	**Benefit:** 75% = $40.50	85% = $45.90
11603	EXAMINATION OF PERIPHERAL VESSELS AT REST (unilateral or bilateral) excluding the cavernosal artery and dorsal artery of the penis, with hard copy recordings of wave forms, involving 1 of the following techniques Doppler recordings (pulsed, continuous wave, or both) of blood flow velocity with or without pulse volume recordings; Doppler recordings involving real time fast fourier transform analysis; venous occlusion plethysmography; strain-gauge plethysmography; impedance plethysmography; or photo plethysmography; (not being a service to which item 11612 or 11615 applies) 1 examination and report *(See para D1.9 of explanatory notes to this Category)* **Fee:** $40.25	**Benefit:** 75% = $30.20	85% = $34.25
11606	- 2 examinations of the kind referred to in item 11603 and report (not being a service associated with a service to which item 11612 or 11615 applies) *(See para D1.9 of explanatory notes to this Category)* **Fee:** $57.05	**Benefit:** 75% = $42.80	85% = $48.50
11609	- 3 or more examinations of the kind referred to in item 11603 and report (not being a service to which item 11612 or 11615 applies) *(See para D1.9 of explanatory notes to this Category)* **Fee:** $74.00	**Benefit:** 75% = $55.50	85% = $62.90
11612	EXAMINATION OF PERIPHERAL VESSELS and report, involving any of the techniques referred to in item 11603, with hard copy recording of wave forms before measured exercise using a treadmill or bicycle ergometer, and measurement of pressure after exercise for 10 minutes or until pressure is normal (unilateral or bilateral) *(See para D1.9 of explanatory notes to this Category)* **Fee:** $74.00	**Benefit:** 75% = $55.50	85% = $62.90
11615	MEASUREMENT OF DIGITAL TEMPERATURE, 1 or more digits, (unilateral or bilateral) and report, with hard copy recording of temperature before and for 10 minutes or more after cold stress testing *(See para D1.9 of explanatory notes to this Category)* **Fee:** $59.05	**Benefit:** 75% = $44.30	85% = $50.20

11618	EXAMINATION OF CAROTID OR VERTEBRAL VESSELS, or both (unilateral or bilateral) with hard copy recordings of wave forms, involving 1 of the following techniques Doppler real time fast fourier transform analysis; oculoplethysmography, phonoangiography or both; or periorbital Doppler examination (not being a service associated with a service to which item 55274, 55288 or 55290 applies) - 1 examination and report *(See para D1.9 of explanatory notes to this Category)* **Fee:** $52.50	**Benefit:** 75% = $39.40	85% = $44.65
11621	- 2 examinations of the kind referred to in item 11618 and report (not being a service associated with a service to which item 55274, 55288 or 55290 applies) *(See para D1.9 of explanatory notes to this Category)* **Fee:** $79.10	**Benefit:** 75% = $59.35	85% = $67.25
11624	- 3 or more examinations of the kind referred to in item 11618 and report (not being a service associated with a service to which item 55274, 55288 or 55290 applies) *(See para D1.9 of explanatory notes to this Category)* **Fee:** $105.05	**Benefit:** 75% = $78.80	85% = $89.30
11627	PULMONARY ARTERY pressure monitoring during open heart surgery, in a person under 12 years of age **Fee:** $178.00	**Benefit:** 75% = $133.50	85% = $151.30
	SUBGROUP 6 - CARDIOVASCULAR		
11700	TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing and report *(See para D1.10 of explanatory notes to this Category)* **Fee:** $24.30	**Benefit:** 75% = $18.25	85% = $20.70
11701	TWELVE-LEAD ELECTROCARDIOGRAPHY, report only where the tracing has been forwarded to another medical practitioner, not in association with a consultation on the same occasion *(See para D1.11 of explanatory notes to this Category)* **Fee:** $12.15	**Benefit:** 75% = $9.15	85% = $10.35
11702	TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing only **Fee:** $12.15	**Benefit:** 75% = $9.15	85% = $10.35
11706	PHONOCARDIOGRAPHY with electrocardiograph lead with indirect arterial or venous pulse tracing, with or without apex cardiogram - interpretation and report **Fee:** $56.10	**Benefit:** 75% = $42.10	85% = $47.70
11708	CONTINUOUS ECG RECORDING of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), NOT IN ASSOCIATION WITH AMBULATORY BLOOD PRESSURE MONITORING, involving microprocessor based analysis equipment, interpretation and report of recordings by a specialist physician or consultant physician, not being a service to which item 11709 applies *(See para D1.12 of explanatory notes to this Category)* **Fee:** $99.55	**Benefit:** 75% = $74.70	85% = $84.65
11709	CONTINUOUS ECG RECORDING (Holter) of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), NOT IN ASSOCIATION WITH AMBULATORY BLOOD PRESSURE MONITORING, utilising a system capable of superimposition and full disclosure printout of at least 12 hours of recorded ECG data, microprocessor based scanning analysis, with interpretation and report by a specialist physician or consultant physician *(See para D1.12 of explanatory notes to this Category)* **Fee:** $130.40	**Benefit:** 75% = $97.80	85% = $110.85
11710	AMBULATORY ECG MONITORING, patient activated, single or multiple event recording, utilising a looping memory recording device which is connected continuously to the patient for 12 hours or more and is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period **Fee:** $40.35	**Benefit:** 75% = $30.30	85% = $34.30
11711	AMBULATORY ECG MONITORING for 12 hours or more, patient activated, single or multiple event recording, utilising a memory recording device which is capable of recording for at least 30 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period **Fee:** $22.00	**Benefit:** 75% = $16.50	85% = $18.70

11712	MULTI CHANNEL ECG MONITORING AND RECORDING during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts) or pharmacological stress, involving the continuous attendance of a medical practitioner for not less than 20 minutes, with resting ECG, and with or without continuous blood pressure monitoring and the recording of other parameters, on premises equipped with mechanical respirator and defibrillator **Fee:** $118.40	**Benefit:** 75% = $88.80	85% = $100.65
11713	SIGNAL AVERAGED ECG RECORDING involving not more than 300 beats, using at least 3 leads with data acquisition at not less than 1000Hz of at least 100 QRS complexes, including analysis, interpretation and report of recording by a specialist physician or consultant physician *(See para D1.13 of explanatory notes to this Category)* **Fee:** $54.30	**Benefit:** 75% = $40.75	85% = $46.20
11715	BLOOD DYE DILUTION INDICATOR TEST **Fee:** $94.05	**Benefit:** 75% = $70.55	85% = $79.95
11718	IMPLANTED PACEMAKER TESTING involving electrocardiography, measurement of rate, width and amplitude of stimulus, including reprogramming when required, not being a service associated with a service to which item 11700 or 11721 applies **Fee:** $27.00	**Benefit:** 75% = $20.25	85% = $22.95
11721	IMPLANTED PACEMAKER TESTING of atrioventricular (AV) sequential, rate responsive, or antitachycardia pacemakers, including reprogramming when required, not being a service associated with a service to which Item 11700 or 11718 applies **Fee:** $54.30	**Benefit:** 75% = $40.75	85% = $46.20
11724	UP-RIGHT TILT TABLE TESTING for the investigation of syncope of suspected cardiothoracic origin, including blood pressure monitoring, continuous ECG monitoring and the recording of the parameters, and involving an established intravenous line and the continuous attendance of a specialist or consultant physician - on premises equipped with a mechanical respirator and defibrillator **Fee:** $131.50	**Benefit:** 75% = $98.65	85% = $111.80
	SUBGROUP 7 - GASTROENTEROLOGY & COLORECTAL		
11800	OESOPHAGEAL MOTILITY TEST, manometric **Fee:** $135.90	**Benefit:** 75% = $101.95	85% = $115.55
11810	CLINICAL ASSESSMENT of GASTRO-OESOPHAGEAL REFLUX DISEASE involving 24 hour pH monitoring, including analysis, interpretation and report and including any associated consultation **Fee:** $135.90	**Benefit:** 75% = $101.95	85% = $115.55
11830	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex **Fee:** $145.35	**Benefit:** 75% = $109.05	85% = $123.55
11833	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency **Fee:** $194.45	**Benefit:** 75% = $145.85	85% = $165.30
	SUBGROUP 8 - GENITO/URINARY PHYSIOLOGICAL INVESTIGATIONS		
11900	URINE FLOW STUDY including peak urine flow measurement, not being a service associated with a service to which item 11918 applies **Fee:** $21.45	**Benefit:** 75% = $16.10	85% = $18.25
11903	CYSTOMETROGRAPHY, not being a service associated with a service to which item 11912, 11915, 11918, 11012-11027, 11921, 36800 or any item in Group I3 applies **Fee:** $86.50	**Benefit:** 75% = $64.90	85% = $73.55
11906	URETHRAL PRESSURE PROFILOMETRY, not being a service associated with a service to which item 11909, 11918, 11012-11027, 11921, 36800 or any item in Group I3 applies **Fee:** $86.50	**Benefit:** 75% = $64.90	85% = $73.55
11909	URETHRAL PRESSURE PROFILOMETRY WITH simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which item 11906, 11915, 11918, 36800 or any item in Group I3 applies **Fee:** $128.50	**Benefit:** 75% = $96.40	85% = $109.25
11912	CYSTOMETROGRAPHY with simultaneous measurement of rectal pressure, not being a service associated with a service to which item 11903, 11915, 11918, 11012-11027, 11921, 36800 or any item in Group I3 applies (Anaes. 17704 = 3B + 1T) **Fee:** $128.50	**Benefit:** 75% = $96.40	85% = $109.25

11915	CYSTOMETROGRAPHY with simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which item 11903, 11909, 11912, 11918, 11012-11027, 11921, 36800 or any item in Group I3 applies (Anaes. 17704 = 3B + 1T) **Fee:** $128.50 **Benefit:** 75% = $96.40 85% = $109.25
11918	CYSTOMETROGRAPHY IN CONJUNCTION WITH IMAGING, with measurement of any 1 or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all imaging associated with cystometrography, not being a service associated with a service to which items 11012-11027, 11900-11915, 11921 and 36800 apply (Anaes. 17704 = 3B + 1T) **Fee:** $333.45 **Benefit:** 75% = $250.10 85% = $283.45
11921	BLADDER WASHOUT TEST for localisation of urinary infection not including bacterial counts for organisms in specimens **Fee:** $58.40 **Benefit:** 75% = $43.80 85% = $49.65
	SUBGROUP 9 - ALLERGY TESTING
12000	SKIN SENSITIVITY TESTING for allergens, USING 1 TO 20 ALLERGENS, not being a service associated with a service to which item 12012, 12015, 12018 or 12021 applies **Fee:** $30.30 **Benefit:** 75% = $22.75 85% = $25.80
12003	SKIN SENSITIVITY TESTING for allergens, USING MORE THAN 20 ALLERGENS, not being a service associated with a service to which item 12012, 12015, 12018 or 12021 applies **Fee:** $45.80 **Benefit:** 75% = $34.35 85% = $38.95
12012	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis using less than the number of allergens included in a standard patch test battery *(See para D1.14 of explanatory notes to this Category)* **Fee:** $16.20 **Benefit:** 75% = $12.15 85% = $13.80
12015	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis using all of the allergens in a standard patch test battery *(See para D1.14 of explanatory notes to this Category)* **Fee:** $48.60 **Benefit:** 75% = $36.45 85% = $41.35
12018	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis using all of the allergens in a standard patch test battery and additional allergens to a total of up to and including 50 allergens *(See para D1.14 of explanatory notes to this Category)* **Fee:** $62.60 **Benefit:** 75% = $46.95 85% = $53.25
12021	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis, performed by or on behalf of a specialist in the practice of his or her specialty, using more than 50 allergens **Fee:** $91.75 **Benefit:** 75% = $68.85 85% = $78.00
	SUBGROUP 10 - OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
12200	COLLECTION OF SPECIMEN OF SWEAT by iontophoresis **Fee:** $28.95 **Benefit:** 75% = $21.75 85% = $24.65
12203	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 D1.15 of explanatory notes to this Category)* **Fee:** $462.35 **Benefit:** 75% = $346.80 85% = $411.45

12207	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 D1.15 of explanatory notes to this Category)* **Fee:** $462.35 **Benefit:** 75% = $346.80 85% = $411.45
12306	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry**, for: . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma; or . for the monitoring of low bone mineral density proven by bone densitometry at least 12 months previously. Measurement of 2 or more sites - **1 service only in a period of 24 months** - including interpretation and report; not being a service associated with a service to which item 12309, 12312, 12315, 12318 or 12321 applies (Ministerial Determination) *(See para D1.16 of explanatory notes to this Category)* **Fee:** $81.00 **Benefit:** 75% = $60.75 85% = $68.85
12309	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using quantitative computerised tomography**, for: . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma; or . for the monitoring of low bone mineral density proven by bone densitometry at least 12 months previously. Measurement of 2 or more sites - **1 service only in a period of 24 months** - including interpretation and report; not being a service associated with a service to which item 12306, 12312, 12315, 12318 or 12321 applies (Ministerial Determination) *(See para D1.16 of explanatory notes to this Category)* **Fee:** $81.00 **Benefit:** 75% = $60.75 85% = $68.85
12312	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry**, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions: . prolonged glucocorticoid therapy; . conditions associated with excess glucocorticoid secretion; . male hypogonadism; or . female hypogonadism lasting more than 6 months before the age of 45. Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - **1 service only in a period of 12 consecutive months** - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12315, 12318 or 12321 applies (Ministerial Determination) *(See para D1.16 of explanatory notes to this Category)* **Fee:** $81.00 **Benefit:** 75% = $60.75 85% = $68.85

12315	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry**, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions: . primary hyperparathyroidism; . chronic liver disease; . chronic renal disease; . proven malabsorptive disorders; . rheumatoid arthritis; or . conditions associated with thyroxine excess. Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - **1 service only in a period of 24 consecutive months** - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12318 or 12321 applies (Ministerial Determination) *(See para D1.16 of explanatory notes to this Category)* **Fee:** $81.00 **Benefit:** 75% = $60.75 85% = $68.85
12318	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using quantitative computerised tomography**, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions: . prolonged glucocorticoid therapy; . conditions associated with excess glucocorticoid secretion; . male hypogonadism; . female hypogonadism lasting more than 6 months before the age of 45; . primary hyperparathyroidism; . chronic liver disease; . chronic renal disease; . proven malabsorptive disorders; . rheumatoid arthritis; or . conditions associated with thyroxine excess. Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - **1 service only in a period of 24 consecutive months** - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315 or 12321 applies (Ministerial Determination) *(See para D1.16 of explanatory notes to this Category)* **Fee:** $81.00 **Benefit:** 75% = $60.75 85% = $68.85
12321	Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), **using dual energy X-ray absorptiometry**, for the **measurement** of bone density 12 months following a significant change in therapy for: . established low bone mineral density; or . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma. Measurement of 2 or more sites - **1 service only in a period of 12 consecutive months** - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315 or 12318 applies (Ministerial Determination). *(See para D1.16 of explanatory notes to this Category)* **Fee:** $81.00 **Benefit:** 75% = $60.75 85% = $68.85

GROUP D2 - NUCLEAR MEDICINE (NON-IMAGING)

12500	BLOOD VOLUME ESTIMATION **Fee:** $168.60	**Benefit:** 75% = $126.45	85% = $143.35
12503	ERYTHROCYTE RADIOACTIVE UPTAKE SURVIVAL TIME TEST OR IRON KINETIC TEST **Fee:** $330.75	**Benefit:** 75% = $248.10	85% = $281.15
12506	GASTROINTESTINAL BLOOD LOSS ESTIMATION involving examination of stool specimens **Fee:** $236.10	**Benefit:** 75% = $177.10	85% = $200.70
12509	GASTROINTESTINAL PROTEIN LOSS **Fee:** $168.60	**Benefit:** 75% = $126.45	85% = $143.35
12512	RADIOACTIVE B12 ABSORPTION TEST 1 isotope **Fee:** $81.70	**Benefit:** 75% = $61.30	85% = $69.45
12515	RADIOACTIVE B12 ABSORPTION TEST 2 isotopes **Fee:** $179.00	**Benefit:** 75% = $134.25	85% = $152.15
12518	THYROID UPTAKE (using probe) **Fee:** $81.70	**Benefit:** 75% = $61.30	85% = $69.45
12521	PERCHLORATE DISCHARGE STUDY **Fee:** $98.60	**Benefit:** 75% = $73.95	85% = $83.85
12524	RENAL FUNCTION TEST (without imaging procedure) **Fee:** $123.25	**Benefit:** 75% = $92.45	85% = $104.80
12527	RENAL FUNCTION TEST (with imaging and at least 2 blood samples) **Fee:** $66.10	**Benefit:** 75% = $49.60	85% = $56.20
12530	WHOLE BODY COUNT not being a service associated with a service to which another item applies **Fee:** $98.60	**Benefit:** 75% = $73.95	85% = $83.85
12533	CARBON-LABELLED UREA BREATH TEST using oral C-13 or C-14 urea, performed by a specialist or consultant physician, including the measurement of exhaled $^{13}CO_2$ or $^{14}CO_2$, for either:- (a) the confirmation of *Helicobactor pylori* colonisation, where: (i) suitable biopsy material for diagnosis cannot be obtained at endoscopy in patients with peptic ulcer disease, or here the diagnosis of peptic ulcer has been made on barium meal; or (ii) in patients with past history of duodenal ulcer, gastric ulcer or gastric neoplasia, where endoscopy is not indicated, OR (b) the monitoring of the success of eradication of *Helicobactor pylori* in patients with peptic ulcer disease - where any request for the test by another medical practitioner who collects the breath sample specifically identifies in writing one or more of the clinical indications for the test **Fee:** $65.85	**Benefit:** 75% = $49.40	85% = $56.00

THERAPEUTIC PROCEDURES

CATEGORY 3

CATEGORY 3 - THERAPEUTIC PROCEDURES

EXPLANATORY NOTES

Surgical Operations

SCHEDULE OF SERVICES

CATEGORY 3 - THERAPEUTIC PROCEDURES

EXPLANATORY NOTES

MISCELLANEOUS THERAPEUTIC PROCEDURES (Group T1)

T1.1 Hyperbaric Oxygen Therapy (Items 13020, 13025, 13030)

T1.1.1 Hyperbaric Oxygen Therapy not covered by these items would attract benefits on an attendance basis.

T1.1.2 For the purposes of these items, a comprehensive hyperbaric medicine facility means a separate hospital area that, on a 24 hour basis:

(a) is equipped and staffed so that it is capable of providing to a patient:

- hyperbaric oxygen therapy at a treatment pressure of at least 2.8 atmospheric pressure absolute (180 kilo pascal gauge pressure); and
- mechanical ventilation and invasive cardiovascular monitoring within a multiplace chamber for the duration of the hyperbaric treatment.

(b) is supported by:

- at least one specialist anaesthetist, consultant physician or medical practitioner who holds the Diploma of Diving and Hyperbaric Medicine of the South Pacific Underwater Medicine Society who is rostered and immediately available to the hyperbaric facility during normal working hours;
- a registered medical practitioner who is present in the hospital and immediately available to the facility at all times when patients are being treated at the hyperbaric facility; and
- a registered nurse with specific training in hyperbaric patient care to the published standards of the Hyperbaric Technicians and Nurses Association who is present during hyperbaric oxygen therapy.

(c) has defined admission and discharge policies.

T1.2 Haemodialysis (Items 13100, 13103)

T1.2.1 Item 13100 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in the patient who is not stabilised where the total attendance time by the supervising medical specialist exceeds 45 minutes.

T1.2.2 Item 13103 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in a stabilised patient, or in the case of an unstabilised patient, where the total attendance time by the supervising medical specialist does not exceed 45 minutes.

T1.3 Assisted Reproductive Services (Items 13200 - 13221)

T1.3.1 Medicare benefits are not payable in respect of ANY other item in the Medicare Benefits Schedule (including Pathology) in lieu of or in conjunction with Items 13200 - 13221. Specifically, Medicare benefits are not payable for Items 13200 - 13221 in association with Item 104, 105, 14203, 14206, 35637, 66695 - 66713 or 73521 - 73529. Items 14203 and 14206 are not payable for artificial insemination.

T1.3.2 A treatment cycle is a series of treatment for the purposes of in vitro fertilisation (IVF), gamete intrafallopian transfer (GIFT) or similar procedures and is defined as beginning either on the day on which treatment by superovulatory drugs is commenced or on the first day of the patient's menstrual cycle, and ending not more than 30 days later.

T1.3.3 The date of service in respect of treatment covered by Items 13200, 13203, 13206, 13209 and 13218 is **DEEMED** to be the **FIRST DAY** of the treatment cycle, except in the case of Item 13218 where the service is provided to a patient in hospital. In this case, the account should separately identify the actual date of the service.

T1.3.4 For treatment covered by Items 13200, 13203, 13206 and 13218 the account must be provided by the gynaecologist supervising the treatment cycle.

T1.3.5 Embryology laboratory services covered by Items 13200 and 13206 include egg recovery from aspirated follicular fluid, insemination, monitoring of fertilisation and embryo development, and preparation of gametes or embryos for transfer and freezing. It does not include semen preparation.

T1.3.6 Medicare benefits are not payable for assisted reproductive services rendered in conjunction with surrogacy arrangements where surrogacy is defined as 'an arrangement whereby a woman agrees to become pregnant and to bear a child for another person or persons to whom she will transfer guardianship and custodial rights at or shortly after birth'.

T1.3.7 Items 13200, 13206, 13215 and 13218 do not include services provided in relation to artificial insemination using the husband's or donated sperm.

T1.3.8 Items 13200 and 13203 are linked to the supply of hormones under the Section 100 (National Health Act) arrangements. Providers must notify the Health Insurance Commission of Medicare card numbers of patients using hormones under this program, and hormones are only supplied for patients claiming one of these two items.

T1.4 Perfusion (Items 13600-13612)

T1.4.1 Medicare benefits are not payable for the perfusion unless the perfusion is performed by a medical practitioner other than the medical practitioner who renders an associated medical service in Group T8 or the medical practitioner who administers an anaesthetic listed in Group T6. The service must be performed by a medical practitioner in order to attract Medicare benefits. The 'on behalf of' provisions do not extend to these Items.

T1.4.2 Item 13604 applies only to whole body perfusion where the time for the procedure extends beyond 6 hours.

T1.5 Administration of Blood or Bone Marrow already Collected (Item 13706)

T1.5.1 Item 13706 is payable for the transfusion of blood, or platelets or white blood cells or bone marrow or gamma globulins. This item is not payable when gamma globulin is administered intramuscularly.

T1.6 Collection of Blood (Item 13709)

T1.6.1 Medicare benefits are payable under Item 13709 for collection of blood for autologous transfusions in respect of an impending operation (whether or not the blood is used), or when homologous blood is required in an emergency situation.

T1.6.2 Benefits are not payable under Item 13709 for collection of blood for long-term storage for possible future autologous transfusion, or for other forms of directed blood donation.

T1.7 Intensive Care Units (ICU)

T1.7.1 'Intensive Care Unit' means a separate hospital area that:

(a) is equipped and staffed so as to be capable of providing to a patient:

(i) mechanical ventilation for a period of several days; and

(ii) invasive cardiovascular monitoring; and

(b) is supported by:

(i) at least one specialist or consultant physician in the specialty of intensive care who is immediately available and exclusively rostered to the ICU during normal working hours; and

(ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and

(iii) a registered nurse for at least 18 hours in each day; and

(c) has defined admission and discharge policies.

T1.7.2 For Neonatal Intensive Care Units an 'Intensive Care Unit' means a separate hospital area that:

(a) is equipped and staffed so as to be capable of providing to a patient, being a newly-born child:

(i) mechanical ventilation for a period of several days; and

(ii) invasive cardiovascular monitoring; and

(b) is supported by:

(i) at least one consultant physician in the specialty of paediatric medicine, appointed to manage the unit, and who is immediately available and exclusively rostered to the ICU during normal working hours; and

(ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and

(iii) a registered nurse for at least 18 hours in each day; and

(c) has defined admission and discharge policies.

T1.7.3 In respect to T1.7.1(b)(i) above "immediately available" means that the intensivist must be predominantly present in the ICU during normal working hours. Reasonable absences from the ICU would be acceptable to attend conferences, meetings and other commitments which might involve absences of up to 2 hours during the working day.

T1.7.4 Medicare benefits are payable under the 'management' items only once per day irrespective of the number of intensivists involved with the patient on that day. However, benefits are also payable for an attendance by another specialist/consultant physician who is not managing the patient but who has been asked to attend the patient. Where appropriate, accounts should be endorsed to the effect that the consultation was not part of the patient's intensive care management in order to identify which consultations should attract benefits in addition to the intensive care items.

T1.7.5 In respect of Neonatal Intensive Care Units, as defined above, benefits are payable for admissions of babies who meet the following criteria:-

(i) all babies weighing less than 1000gms;

(ii) all babies with an endotracheal tube, and for the 24 hours following endotracheal tube removal;

(iii) all babies requiring Constant Positive Airway Pressure (CPAP) for acute respiratory instability;

(iv) all babies requiring more than 40% oxygen for more than 4 hours;

(v) all babies requiring an arterial line for blood gas or pressure monitoring; or

(vi) all babies having frequent seizures.

T1.7.6 Cases may arise where babies admitted to a Neonatal Intensive Care Unit under the above criteria who, because they no longer satisfy the criteria are ready for discharge, in accordance with accepted discharge policies, but who are physically retained in the Neonatal Intensive Care Unit for other reasons. For benefit purposes such babies must be deemed as being discharged from the Neonatal Intensive Care Unit and not eligible for benefits under items 13870, 13873, 13876, 13879, 13882, 13885 and 13888.

T1.7.7 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.
T1.7.8 Benefits are payable for admissions to an Intensive Care Unit following surgery only where clear clinical justification for post-operative intensive care exists.

T1.8 Procedures Associated with Intensive care (Items 13818, 13842, 13857)
T1.8.1 Item 13818 covers the insertion of a right heart balloon catheter (Swan-Ganz catheter). Benefits are payable under this item only once per day except where a second discrete operation is performed on that day.
T1.8.2 Benefits for monitoring of pressures, up to a maximum of 4 on one day, are payable under Items 11600 and 11601 outside of an ICU and Item 13876 within an ICU. Benefits are payable under items 13876,11600 and 11601 once only for each type of pressure in the one day up to a maximum of 4 pressures.
T1.8.3 If a service covered by Item 13842 is provided outside of an ICU , in association with, for example, an anaesthetic, benefits are payable for Item 13842 in addition to Item 13870 where the services are performed on the same day. Where this occurs, accounts should be endorsed "performed outside of an Intensive Care Unit" against Item 13842.
T1.8.4 Benefits are not payable under Item 13857 where ventilation is initiated in the context of an anaesthetic for surgery even if it is likely that following surgery the patient will be ventilated in an ICU. In such cases the appropriate anaesthetic item/s should be itemised.
T1.8.5 Medicare benefits are not payable for sampling by arterial puncture under Item 13839 in addition to Item 13870 (and 13873) on the same day. Benefits are payable under Item 13842 (Intra-arterial cannulisation) in addition to Item 13870 (and 13973) when performed on the same day.

T1.9 Management and Procedures in Intensive Care Unit (Items 13870, 13873, 13876)
Items 13870 and 13873
T1.9.1 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 electrocardiographic monitoring, 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.
T1.9.2 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
T1.9.3 Item 13876 covers the monitoring of pressures in an ICU.
T1.9.4 Benefits are attracted under Item 13876 only once for each type of pressure on the one day, (up to a maximum of 4 pressures) irrespective of the number of medical practitioners involved in the monitoring of pressures in an ICU.
T1.9.5 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. Benefits are attracted under items 11600 and 11601 only once for each type of pressure on the one day (up to a maximum of 4 pressures) irrespective of the number of practitioners involved in monitoring the pressures.

T1.10 Implanted Pump or Reservoir/Drug Delivery Device (Items 13939 and 13942)
T1.10.1 The fee for Items 13939 and 13942 includes a component to cover accessing of the drug delivery device. Accordingly, benefits are not payable under Item 13945 (Long-term implanted drug delivery device, accessing of) in addition to Items 13939 and 13942.

T1.11 PUVA or UVB Therapy (Items 14050, 14053)
T1.11.1 A component for any necessary subsequent consultation has been included in the Schedule fee for these items. However, the initial consultation preceding commencement of a course of therapy would attract benefits.

T1.12 Laser Photocoagulation (Items 14106 - 14132)
T1.12.1 The Australasian College of Dermatologists has advised that the following ranges (applicable to an average 4 year old child and an adult) should be used as a reference to the treatment areas specified in Items 14106 - 14132:

- Entire forehead 50 -75 cm^2
- Cheek 55 - 85 cm^2
- Nose 10 -25 cm^2
- Chin 10 - 30 cm^2
- Unilateral midline anterior - posterior neck 60 - 220 cm^2
- Dorsum of hand 25 - 80 cm^2
- Forearm 100 - 250 cm^2
- Upper arm 105 - 320 cm^2

T1.12.2 Items 14120 to 14132 apply where additional treatments are indicated in a 12 month period. Claims for benefits should be accompanied by full clinical details, including pre-operative colour photographs, to verify the need for additional services. Where digitial photographs are supplied, they must be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

RADIATION ONCOLOGY (Group T2)

T2.1 General

T2.1.1 The level of benefits for radiotherapy depends not only on the number of fields irradiated but also on the frequency of irradiation. In the items related to additional fields, it is to be noted that treatment by rotational therapy is considered to be equivalent to the irradiation of three fields (i.e., irradiation of one field plus two additional fields). For example, each attendance for orthovoltage rotational therapy at the rate of 3 or more treatments per week would attract benefit under Item 15100 plus twice Item 15103.

T2.1.2 Benefits are attracted for an initial referred consultation and radiotherapy treatment where both take place at the same attendance.

T2.2 Planning Services (Items 15500 - 15536)

T2.2.1 A planning episode involves field setting (ie simulation or localisation) and dosimetry (either using a CT interfacing planning computer or a non-CT interfacing planning computer). One plan only will attract Medicare benefits in a course of treatment. However, where a plan for brachytherapy is undertaken in association with a plan for megavoltage or teletherapy treatment, benefits would be attracted for both services.

T2.2.2 Medicare benefits are attracted for an initial referred consultation and computerised planning where both take place at the same attendance. However, benefits are not payable for subsequent consultations rendered in association with therapy or planning services in the same course of treatment. Benefits are also payable, under the appropriate radiology item in Group I3, in respect of verification films (or port films) taken during the course of treatment.

OBSTETRICS (Group T4)

T4.1 Antenatal Care (Item 16500)

T4.1.1 In addition to routine antenatal attendances covered by Item 16500 the following services, where rendered during the antenatal period, attract benefits:-

(a) Items 16501, 16502, 16504, 16505, 16508, 16509 (but not normally before the 24th week of pregnancy), 16511, 16512, 16514 and 16600 to 16636.
(b) The initial consultation at which pregnancy is diagnosed.
(c) The first referred consultation by a specialist obstetrician when called in to advise on the pregnancy.
(d) All other services, excluding those in Category 1 and Group T4 of Category 3 not mentioned above.
(e) Treatment of an intercurrent condition not directly related to the pregnancy.

T4.1.2 Item 16504 relates to the treatment of habitual miscarriage by injection of hormones. A case becomes one of habitual miscarriage following two consecutive spontaneous miscarriages or where progesterone deficiency has been proved by hormonal assay of cells obtained from a smear of the lateral vaginal wall.

T4.1.3 Item 16514 relates to antenatal cardiotocography in the management of high risk pregnancy. Benefits for this service are not attracted when performed during the course of the labour and delivery.

T4.2 External Cephalic Version for Breech Presentation (Item 16501)

T4.2.1 Contraindications for this item are as follows:

- Antepartum Haemorrhage (APH)
- multiple pregnancy,
- fetal anomaly,
- Intrauterine Growth Retardation (IUGR),
- Caesarean section scar,
- uterine anomalies,
- obvious cephalopelvic disproportion,
- isoimmunization,
- premature rupture of the membranes.

T4.3 Labour and Delivery (Items 16515, 16518, 16519, 16525)

T4.3.1 Benefits for management of labour and delivery covered by Items 16515, 16518, 16519 and 16525 includes the following (where indicated):-

- surgical and/or intravenous infusion induction of labour;
- forceps or vacuum extraction;
- evacuation of products of conception by manual removal (not being an independent procedure);
- episiotomy or repair of tears.

T4.3.2 Item 16519 covers delivery by any means including Caesarean section. If, however, a patient is referred, or her care is transferred to another medical practitioner for the specific purpose of delivery by Caesarean section, whether because of an emergency situation or otherwise, then Item 16520 would be the appropriate item.
T4.3.3 In some instances the obstetrician may not be able to be present at all stages of confinement. In these circumstances, Medicare benefits are payable under Item 16519 provided that the doctor attends the patient as soon as possible during the confinement and assumes full responsibility for the mother and baby.
T4.3.4 Two items in Group T9 provide benefits for assistance by a medical practitioner at a Caesarean section. Item 51306 relates to those instances where the Caesarean section is the only procedure performed, while Item 51309 applies when other operative procedures are performed at the same time.
T4.3.5 As a rule, 24 weeks would be the period distinguishing a miscarriage from a premature confinement. However, if a live birth has taken place before 24 weeks and the foetus survives for a reasonable period, benefit would be payable under the appropriate confinement item.
T4.3.6 Where, during labour, a medical practitioner hands the patient over to another medical practitioner, benefits are payable under Item 16518 for the referring practitioner's services. The second practitioner's services would attract benefits under Item 16515 (i.e., management of vaginal delivery) or Item 16520 (Caesarean section). If another medical practitioner is called in for the management of the labour and delivery, benefits for the referring practitioner's services should be assessed under Item 16500 for the routine antenatal attendances and on a consultation basis for the postnatal attendances, if performed.
T4.3.7 At a high risk delivery benefits will be payable for the attendance of any medical practitioner (called in by the doctor in charge of the delivery) for the purposes of resuscitation and subsequent supervision of the neonate. Examples of high risk deliveries include cases of difficult vaginal delivery, Caesarean section or the delivery of babies with Rh problems and babies of toxaemic mothers.

T4.4 Caesarean Section (Item 16520)
T4.4.1 Benefits under this item are attracted only where the patient has been specifically referred to another medical practitioner for the management of the delivery by Caesarean section and the practitioner carrying out the procedure has not rendered any antenatal care. Caesarean sections performed in any other circumstances attract benefits under Item 16519.

T4.5 Complicated Confinement (Item 16522)
Conditions that pose a significant risk of maternal death referred to in Item 16522 include:

- severe pre-eclampsia as defined in the Consensus Statement on the Management of Hypertension in Pregnancy, published in the Medical Journal of Australia, Volume 158 on 17 May 1993, and as revised;
- cardiac disease (co-managed with a consultant physician or a specialist physician);
- coagulopathy;
- severe autoimmune disease;
- previous organ transplant; or
- pre-existing renal or hepatic failure.

T4.6 Post-Partum Care (Items 16564-16573)
T4.6.1 The Schedule fees and benefits payable for Items 16519 and 16520 cover all postnatal attendances on the mother and the baby, except in the following circumstances:-

(i) where the medical services rendered are outside those covered by a consultation, e.g., blood transfusion;

(ii) where the condition of the mother and/or baby is such as to require the services of another practitioner (e.g., paediatrician, gynaecologist, etc);

(iii) where the patient is transferred, at arms length, to another medical practitioner for routine post-partum, care (eg mother and/or baby returning from a larger centre to a country town or transferring between hospitals following confinement). In such cases routine postnatal attendances attract benefits on an attendance basis. The transfer of a patient within a group practice would not qualify for benefits under this arrangement except in the case of Items 16515 and 16518. These items cover those occasions when a patient is handed over while in labour from the practitioner who under normal circumstances would have delivered the baby, but because of compelling circumstances decides to transfer the patient to another practitioner for the delivery;

(iv) where during the postnatal period a condition occurs which requires treatment outside the scope of normal postnatal care;

(v) in the management of premature babies (i.e. babies born prior to the end of the 37th week of pregnancy or where the birth weight of the baby is less than 2500 grams) during the period that close supervision is necessary.

T4.6.2 Normal postnatal care by a medical practitioner would include:-

(i) uncomplicated care and check of
- lochia
- fundus
- perineum and vulva/episiotomy site
- temperature
- bladder/urination

- bowels

(ii) advice and support for establishment of breast feeding
(iii) psychological assessment and support
(iv) Rhesus status
(v) Rubella status and immunisation
(vi) contraception advice/management

T4.6.3 Examinations of apparently normal newborn infants by consultant or specialist paediatricians do not attract benefits.
T4.6.4 Items 16564 to 16573 relate to postnatal complications and should not be itemised in respect of a normal delivery. To qualify for benefits under these items, the patient is required to be transferred to theatre, or be administered general anaesthesia or epidural injection for the performance of the procedure. Utilisation of the items will be closely monitored to ensure appropriate usage.

T4.7 Interventional Techniques (16600-16636)
T4.7.1 For Items 16600 to 16636, 35518 and 35674 there is no component in the Schedule fee for the associated ultrasound. Benefits are attracted for the ultrasound under the appropriate items in Group I1 of the Diagnostic Imaging Services Table. If diagnostic ultrasound is performed on a separate occasion to the procedure, benefits would be payable under the appropriate ultrasound item.
T4.7.2 Item 51312 provides a benefit for assistance by a medical practitioner at interventional techniques covered by Items 16606, 16609, 16612, 16615, 16627 and 16633.

ASSISTANCE IN THE ADMINISTRATION OF AN ANAESTHETIC (Group T5)

T5.1 Assistance in the administration of anaesthesia in connection with emergency treatment (Item 17503)
T5.1.1 A separate benefit is payable under Item 17503 for the services of an assistant anaesthetist in connection with an operation or combination of operations on a patient in imminent danger of death. This benefit is payable only in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.
T5.1.2 Situations where imminent danger of death requiring an assistant anaesthetist might arise include: complex airway problems, anaphylaxis or allergic reactions, malignant hyperpyrexia, neonatal and complicated paediatric anaesthesia, massive blood loss and subsequent resuscitation, intra-operative cardiac arrest, critically ill patients from intensive care units, inability to wean critically ill patients from pulmonary bypass.

T5.2 Assistance in the administration of elective anaesthesia (Item 17506)
T5.2.1 A separate benefit is payable under Item 17506 for the services of an assistant anaesthetist in connection with elective anaesthesia in the circumstances outlined in the Item descriptor. This benefit is only payable in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.
T5.2.2 For the purposes of Item 17506, a "complex paediatric case" involves one or more of the following:-
(i) the need for invasive monitoring (intravascular or transoesophageal); or
(ii) organ transplantation; or
(iii) craniofacial surgery; or
(iv) major tumour resection; or
(v) separation of conjoint twins.

ANAESTHETICS (Group T6)

T6.1 General
T6.1.1 The Health Insurance Act provides that where an anaesthetic is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of the anaesthetic. The administration of an anaesthetic also includes the pre-operative examination of the patient in preparation for that administration except where such examination entails a separate attendance carried out at a place other than an operating theatre or an anaesthetic induction room.
T6.1.2 Each medical service likely to be performed under anaesthesia has been assigned a number of anaesthetic units which reflect the skill and responsibility exercised by the anaesthetist (known as "basic units") plus the average anaesthetic time taken for each service without regard to the type of anaesthetic technique employed (known as "time units").
T6.1.3 Anaesthetic time is taken to commence when the anaesthetist begins to prepare the patient for anaesthesia care in the operating room or an equivalent area, and ends when the anaesthetist is no longer in professional attendance, that is when the patient is safely placed under the supervision of other personnel. "Time" units have been assigned on the basis of 1 unit equals 15 minutes up to and including 6 hours and 1 unit equals 10 minutes for time beyond 6 hours.
T6.1.4 The Schedule fee for the administration of an anaesthetic in connection with a procedure has been derived by applying a unit value to the total number of anaesthetic units assigned to the procedure. Group T6 of the Schedule lists the item numbers and appropriate anaesthetic units, together with Schedule fees and Medicare benefits. The appropriate anaesthetic item number and the number of "basic" and "time" units (indicated by "B" and "T") are shown immediately following the description of each procedure likely to be performed under anaesthesia.
T6.1.5 The administration of the anaesthetic (other than Item 17974 or a dental anaesthetic listed in Subgroup 3) must be provided in connection with another clinically relevant professional service (as defined in paragraph 1.1.4 of the General

Explanatory Notes) listed in the Schedule (or a prescribed medical service rendered by an approved dental practitioner) if it is to attract benefit. The pre-anaesthetic examination of a patient should be performed in association with a clinically relevant service.

T6.1.6 Except in special circumstances, benefit is not payable for the administration of an anaesthetic listed in Subgroup 2 unless the anaesthetic is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which the anaesthetic is administered.

T6.1.7 Fees and benefits established for anaesthetic services cover all essential components in the administration of the anaesthetic. Separate benefit may be attracted, however, for complementary services such as central venous pressure and direct arterial pressure monitoring or estimations of respiratory function by complicated techniques (but not simple techniques covered by Item 11506). It should be noted that extra benefit is not payable for intravenous infusion or electrocardiographic monitoring, provision for which has been made in the value determined for the anaesthetic units.

T6.1.8 The amount of benefit specified for the administration of an anaesthetic is the benefit payable for that service irrespective of whether one or more than one medical practitioner administers it. However, benefit is provided under Group T5 for the services of one assistant anaesthetist (who must not be either the surgeon or assistant surgeon) where the anaesthetic is administered by the anaesthetist in connection with an operation on a patient in imminent danger of death, or with elective anaesthesia in certain circumstances.

T6.1.9 Before benefit will be paid for the administration of an anaesthetic, or for the services of an assistant anaesthetist, details of the operation, sufficient to identify it with the appropriate item in the Schedule and the name of the medical practitioner who performed the operation must be shown on the anaesthetist's account in addition to the details set out at paragraph 7.1 of the General Explanatory Notes.

T6.1.10 Where a regional nerve block or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block is assessed as an anaesthetic item according to the advice in paragraph T6.1.2. When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

T6.1.11 When a regional nerve block or field nerve block covered by an item in Group T7 of the Schedule is administered by a medical practitioner in the course of a surgical procedure undertaken by him/her, then such a block will attract benefit under the appropriate item in Group T7.

T6.1.12 It is to be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.

T6.1.13 Before an operation is decided on, a surgeon may refer a patient to a specialist anaesthetist for an opinion as to the patient's fitness to undergo anaesthesia. Such an attendance will attract benefit as follows:-

(i) if, as a result of the consultation, anaesthesia and surgery are proceeded with in the ordinary way, then Item 17603 applies;

(ii) if, as a result of the consultation, surgery is contra-indicated or is postponed for some days or weeks, this consultation, and any subsequent consultation by the anaesthetist during the postponement period, attracts benefits under the appropriate attendance item. In such a case, to qualify for the specialist rate of benefit, the patient must present a letter or note of referral by the referring doctor.

T6.1.14 It may happen that the professional service for which the anaesthetic is administered does not itself attract a benefit because it is part of the after-care of an operation. This does not, however, affect the benefit payable for the anaesthetic. Benefit is payable for the anaesthetic administered in connection with such a surgical procedure (or combination of surgical procedures) even though no benefit is payable for the surgical procedure.

T6.1.15 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.

T6.2 Multiple Anaesthetic Rule

T6.2.1 The fee for an anaesthetic administered in connection with two or more operations performed on a patient on the one occasion is calculated by the following rule applied to the anaesthetic items for the individual operations:-

100% for the item with the greatest anaesthetic fee
plus 20% for the item with the next greatest anaesthetic fee
plus 10% for each other item.

Note:

(a) Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents.

(b) Where the anaesthetic items for two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.

(c) The multiple anaesthetic rule also applies to combinations of items in Subgroup 3 (dental anaesthetics) with items in Subgroup 2.

(d) The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

T6.3 Prolonged Anaesthesia in connection with a Medical Service (Items 17800, 17805, 17810)

T6.3.1 Anaesthetic services provided in connection with a medical service must exceed the normal time allocated in the Schedule by the following times to qualify as a prolonged anaesthetic:-

- for procedures up to 3 hours (12 anaesthetic time units) - by more than 1 hour
- for procedures normally taking more than 3 hours and up to 6 hours (13 to 24 anaesthetic time units) - by more than 1 hour and 30 minutes
- for procedures exceeding 6 hours duration (25 or more anaesthetic time units) - by more than 2 hours.

T6.3.2 Additional benefits are payable under Items 17800, 17805 and 17810 to cover the time component of prolonged anaesthesia and should be identified separately from the item covering the administration of the anaesthetic. The derived fee for these items provides for an amount of $14.60 for each time unit in excess of normal anaesthesia time. Claims for benefits for prolonged anaesthesia should include details of the total anaesthetic time and usual anaesthetic time for the procedure.
T6.3.3 Normal anaesthesia time is derived in the usual way. Time units are allocated on the basis of 1 unit per 15 minutes (or part thereof) for services up to 6 hours, and 1 unit for each 10 minutes (or part thereof) for services in excess of 6 hours.
T6.3.4 For multiple procedures, the multiple anaesthetic rule should be applied to time units only in deriving normal anaesthetic time.

Examples:

Single Anaesthetic Services

(a) Item for which anaesthetic service claimed - 32108 (5B+9T) - where actual time taken is 3 hours and 30 minutes

Usual time = 2 hours and 15 minutes (9 time units)
Actual time = 3 hours and 30 minutes (14 time units)

Actual time exceeds usual time by 1 hour and 15 minutes - service qualifies under Item 17800 as follows:-

Additional time = actual time less usual time
= 14 units less 9 units
= 5 units

Schedule fee for additional time (Item 17800): $14.80 x 5 = $74.00

(b) Item for which anaesthetic service claimed - 32748 (8B+16T) - where actual time taken is 6 hours and 25 minutes

Usual time = 4 hours (16 time units)
Actual time = 6 hours and 25 minutes (24 @15mins + 3 @10mins = 27 time units)
Actual time exceeds usual time by 2 hours and 25 minutes - service qualifies under Item 17805 as follows:-

Additional time = actual time less usual time
= 27 units less 16 units
= 11 units

Schedule fee for additional time (Item 17805): $14.80 x 11 = $162.80

(c) Item for which anaesthetic service claimed - 39640 (12B+36T) - where actual time taken is 11 hours

Usual time = 8 hours (24@ 15mins + 12@ 10mins = 36 time units)
Actual time = 11 hours (24@15mins + 30@10mins = 54 time units)

Actual time exceeds usual time by 3 hours - service qualifies under Item 17810 as follows:-

Additional time = actual time less usual time
= 54 units less 36 units
= 18 units

Schedule fee for additional time (Item 17810): $14.80 x 18 = $266.40

Multiple Anaesthetic Services
Items for which anaesthetic service claimed - 36531(7B+12T), 36600(6B+8T), 30378(7B+7T) - where actual time taken is 6 hours

Usual time is calculated by applying the multiple anaesthetic rule, i.e.
36531 - 12T (180 mins) @ 100% = 180 mins

36600 - 8T (120 mins) @ 20% = 24 mins
30378 - 7T (105 mins) @ 10% = 10.5 mins

Usual time = 3 hours and 35 mins or 15 time units (rounded)
Actual time = 6 hours or 24 time units

Actual time exceeds usual time by 2 hours and 25 minutes - service qualifies under Item 17805 as follows:-

Additional time = actual time less usual time
= 24 units less 15 units
= 9 units

Schedule fee for additional time (Item 17805): $14.80 x 9 = $133.20

T6.4 Prolonged Anaesthesia in connection with a Dental Service (Item 18119)
T6.4.1 Item 18119 applies in relation to the administration of an anaesthetic in connection with a dental procedure where the time for the operation exceeds 3 hours. Where the anaesthetic service is prolonged, Item 18119 should be itemised in lieu of the item which would otherwise be used for the administration of the anaesthetic.

T6.5 Anaesthetic in connection with Abandoned Surgery (Item 17970)
T6.5.1 Claims for benefits under Item 17970 should be submitted to Medicare for approval of benefits and should include full details of the circumstances of the operation, including details of the surgery which had been proposed and the reasons for the operation being discontinued.

T6.6 Anaesthetic in connection with procedure not allocated anaesthetic units (Item 18033)
T6.6.1 Payment of benefit for Item 18033 is not restricted to the service being performed in connection with a surgical service in Group T8. Item 18033 may be performed with any item in the Medicare Benefits Schedule that has not been allocated anaesthetic units (including attendances) in circumstances where anaesthesia is considered clinically necessary. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

REGIONAL OR FIELD NERVE BLOCKS (Group T7)

T7.1 General
T7.1.1 A nerve block is interpreted as the anaesthetising of a substantial segment of the body innervated by a large nerve or an area supplied by a smaller nerve where the technique demands expert anatomical knowledge and a high degree of precision.
T7.1.2 Where an anaesthetic combines a regional nerve block with a general anaesthetic for an operative procedure, benefit will be paid only under the anaesthetic item relevant to the operation as set out in Group T6.
T7.1.3 Where a regional or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block attracts benefits under the Group T6 anaesthetic item and not the block item in Group T7.
T7.1.4 Where a regional or field nerve block which is covered by an item in Group T7 is administered by a medical practitioner in the course of a surgical procedure undertaken by that practitioner, then such a block will attract benefit under the appropriate Group T7 item.
T7.1.5 When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.
T7.1.6. Digital ring analgesia, local infiltration into tissue surrounding a lesion or paracervical (uterine) analgesia are not eligible for the payment of Medicare benefits under items within Group T7. Where procedures are carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure.

T7.2 Peri-operative Blocks for Post-operative Pain
T7.2.1 Benefits are only payable for peri-operative nerve blocks performed for the management of post-operative pain where specifically catered for under items in Group T7 (ie. Items 18206 to 18212).

T7.3 Introduction of a Narcotic (Item 18206)
T7.3.1 Benefits are attracted for this procedure irrespective of the stage of the operation at which the narcotic is introduced.

T7.4 Epidural Injection for Control of Post-operative Pain (Item 18209)
T7.4.1 This item provides benefit for the epidural injection of a local anaesthetic in the caudal, lumbar or thoracic region administered towards the end of an operation for the purposes of controlling pain in the post-operative period.

T7.5 Regional or Field Nerve Blocks for Post-operative Pain(Items 18210 - 18212)
T7.5.1 Benefits are payable under Items 18210 to 18212 in addition to the general anaesthetic for the related procedure.

T7.6 Maintenance of Regional or Field Nerve Block (Items 18222, 18225)
T7.6.1 Medicare benefit is attracted under these items only when the service is performed other than by the operating surgeon. This does not preclude benefits for an obstetrician performing an epidural block during labour.
T7.6.2 When the service is performed by the operating surgeon during the post-operative period of an operation it is considered to be part of the normal aftercare. In these circumstances a Medicare benefit is not attracted.

T7.7 Intrathecal or Epidural Injection (Item 18232)
T7.7.1 This items covers caudal infusion/injection.

T7.8 Destruction of Nerve Branch by Neurolytic Agent (18292)
T7.8.1 This item includes the use of botulinus toxin as a neurolytic agent.

SURGICAL OPERATIONS (Group T8)

T8.1 General
T8.1.1 Many items in Group T8 of the Schedule are qualified by one of the following phrases:
"as an independent procedure";
"not being a service associated with a service to which another item in this Group applies"; or
"not being a service to which another item in this Group applies"
An explanation of each of these phrases is as follows.

T8.2 As an Independent Procedure
T8.2.1 The inclusion of this phrase in the description of an item precludes payment of benefits when:-
(i) a procedure so qualified is associated with another procedure that is performed through the same incision, e.g. nephrostomy (Item 36552) in the course of an open operation on the kidney for another purpose;
(ii) such procedure is combined with another in the same body area, e.g. direct examination of larynx (Item 41846) with another operation on the larnyx or trachea;
(iii)the procedure is an integral part of the performance of another procedure, e.g. removal of foreign body (Item 30067/30068) in conjunction with debridement of deep or extensive contaminated wound of soft tissue, including suturing of that wound when performed under general anaesthetic (Item 30023).

T8.3 Not Being a Service Associated with a Service to which another Item in this Group Applies
T8.3.1 "Not being a service associated with a service to which another item in this Group applies" means that benefit is not payable for any other item in that Group when it is performed on the same occasion as this item. eg item 30106.
T8.3.2 "Not being a service associated with a service to which Item ..... applies" means that when this item is performed on the same occasion as the reference item no benefit is payable. eg item 39330.

T8.4 Not Being a Service to which another Item in this Group Applies
T8.4.1 "Not being a service to which another item in this Group applies" means that this item may be itemised if there is no specific item relating to the service performed, e.g. Item 30387 (Laparotomy involving operation on abdominal viscera (including pelvic viscera), not being a service to which another item in this Group applies). Benefits may be attracted for an item with this qualification as well as benefits for another service during the course of the same operation.

T8.5 Multiple Operation Formula
T8.5.1 The fees for two or more operations, other than amputations, performed on a patient on the one occasion (except as provided in paragraph T8.5.3) are calculated by the following rule:-
100% for the item with the greatest Schedule fee
plus 50% for the item with the next greatest Schedule fee
plus 25% for each other item.

Note:
(a) Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents.
(b) Where two or more operations performed on the one occasion have Schedule fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.
(c) The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

(For these purposes the term "operation" includes all items in Group T8 (other than Subgroup 12 of that Group).
T8.5.2 This rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient if the medical practitioner who performed the operation did not also perform or assist at the other operation or any of the other operations, or administer the anaesthetic. In such cases the fees specified in the Schedule apply.
T8.5.3 Where two medical practitioners operate independently and either performs more than one operation, the method of assessment outlined in paragraph T8.5.1 would apply in respect of the services performed by each medical practitioner.

T8.5.4 If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.
T8.5.5 There are a number of items in the Schedule where the description indicates that the item applies only when rendered in association with another procedure. The Schedule fees for such items have therefore been determined on the basis that they would always be subject to the "multiple operation rule".
T8.5.6 Where the need arises for the patient to be returned to the operating theatre on the same day as the original procedure for further surgery due to post-operative complications, which would not be considered as normal aftercare - see paragraph T8.5, such procedures would generally not be subject to the "multiple operation rule". Accounts should be endorsed to the effect that they are separate procedures so that a separate benefit may be paid.

T8.6 Procedure Performed with Local Infiltration or Digital Block
T8.6.1 It is to be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.

T8.7 Aftercare (Post-operative Treatment)
T8.7.1 Section 3(5) of the Health Insurance Act states that services included in the Schedule (other than attendances) include all professional attendances necessary for the purposes of post-operative treatment of the patient (for the purposes of this book, post-operative treatment is generally referred to as "after-care"). However, it should be noted that in some instances the after-care component has been specifically excluded from the item and this is indicated in the description of the item. In such cases benefits would be payable on an attendance basis where post-operative treatment is necessary. In other cases, where there may be doubt as to whether an item actually does include the after-care, this fact has been reinforced by the inclusion of the words "including after-care" in the description of the item.
T8.7.2 After-care is deemed to include all post-operative treatment rendered by medical practitioners and need not necessarily be limited to treatment given by the surgeon or to treatment given by any one medical practitioner.
T8.7.3 The amount and duration of after-care consequent on an operation may vary between patients for the same operation, as well as between different operations which range from minor procedures performed in the medical practitioner's surgery, to major surgery carried out in hospital. As a guide to interpretation, after-care includes all attendances until recovery from the operation (fracture, dislocation etc.) plus the final check or examination, regardless of whether the attendances are at the hospital, rooms, or the patient's home.
T8.7.4 Attendances which form part of after-care, whether at hospitals, rooms, or at the patient's home, should not be shown on the doctor's account. When additional services are itemised, the doctor should show against those services on the account the words "not normal after-care", with a brief explanation of the reason for the additional services.
T8.7.5 Some minor operations are merely stages in the treatment of a particular condition. Attendances subsequent to such operations should not be regarded as after-care but rather as a continuation of the treatment of the original condition and attract benefits. Items to which this policy applies are Items 30219, 30223, 32500, 34521, 34524, 38406, 38409, 39015, 41626, 41656, 42614, 42644, 42650 and 47912. Likewise, there are a number of services which may be performed during the aftercare period of procedures for pain relief which would also attract benefits. Such services would include all items in Groups T6 and T7 and Items 39013, 39100, 39115, 39118, 39121, 39127, 39130, 39133, 39136, 39324 and 39327.
T8.7.6 Where a patient has been operated on in a recognised hospital as a public patient (as defined in Section 3(1) of the Health Insurance Act), and where aftercare is directly related to the episode of admitted care for which the patient was treated free of charge as a public patient, the aftercare should be provided free of charge as part of the public hospital service. However, post-operative attendances by a private medical practitioner at a place other than the hospital may attract Medicare benefits on an attendance basis, subject to the hospital meeting its responsibilities under the 1998-2003 Australian Health Care Agreements relating to the provision of public hospital services.
T8.7.7 When a surgeon delegates after-care to a local doctor, Medicare benefit may be apportioned on the basis of 75% for the operation and 25% for the after-care. Where the benefit is apportioned between two or more medical practitioners, no more than 100% of the benefit for the procedure will be paid.
T8.7.8 In respect of fractures, where the after-care is delegated to a doctor at a place other than the place where the initial reduction is carried out, benefit may be apportioned on a 50:50 basis rather than on the 75:25 basis suggested for surgical operations.
T8.7.9 Where the reduction of a fracture is carried out by hospital staff in the out-patient or casualty department of a recognised hospital and the patient is then referred to a private practitioner for supervision of the after-care, Medicare benefits are payable for the after-care treatment on an attendance basis.
T8.7.10 The following table shows the period which has been adopted as reasonable for the after-care of fractures:-

(Note: This list is a guide only and each case should be judged on individual merits. See paragraphs T8.7.2 to T8.7.4 above.)

Treatment of fracture of	**After-care Period**
Terminal phalanx of finger or thumb	6 weeks
Proximal phalanx of finger or thumb	6 "
Middle phalanx of finger	6 "
One or more metacarpals not involving base of first carpometacarpal joint	6 "

First metacarpal involving carpometacarpal joint (Bennett's fracture)	8 "
Carpus (excluding navicular)	6 "
Navicular or carpal scaphoid	3 months
Colles'/Smith/Barton's fracture of wrist	3 "
Distal end of radius or ulna, involving wrist	8 weeks
Radius	8 "
Ulna	8 "
Both shafts of forearm or humerus	3 months
Clavicle or sternum	4 weeks
Scapula	6 "
Pelvis (excluding symphysis pubis) or sacrum	4 months
Symphysis pubis	4 "
Femur	6 "
Fibula or tarsus (excepting os calcis or os talus)	8 weeks
Tibia or patella	4 months
Both shafts of leg, ankle (Potts fracture) with or without dislocation, os calcis (calcaneus) or os talus	4 months
Metatarsals - one or more	6 weeks
Phalanx of toe (other than great toe)	6 "
More than one phalanx of toe (other than great toe)	6 "
Distal phalanx of great toe	8 "
Proximal phalanx of great toe	8 "
Nasal bones, requiring reduction	4 "
Nasal bones, requiring reduction and involving osteotomies	4 "
Maxilla or mandible, unilateral or bilateral, not requiring splinting	6 "
Maxilla or mandible, requiring splinting or wiring of teeth	3 months
Maxilla or mandible, circumosseous fixation of	3 "
Maxilla or mandible, external skeletal fixation of	3 "
Zygoma	6 weeks
Spine (excluding sacrum), transverse process or bone other than vertebral body requiring immobilisation in plaster or traction by skull calipers	3 months
Spine (excluding sacrum), vertebral body, without involvement of cord, requiring immobilisation in plaster or traction by skull calipers	6 "
Spine (excluding sacrum), vertebral body, with involvement of cord	6 "

T8.8 Abandoned Surgery (Item 30001)

T8.8.1 Item 30001 applies where the procedure has been commenced but is then discontinued for medical reasons or for other reasons which are beyond the surgeon's control (e.g. equipment failure). Claims for benefits under this item should be submitted to Medicare for approval of benefits and should include full details of the circumstances of the operation, including details of the surgery which had been proposed and the reasons for the operation being discontinued.

T8.9 Repair of Wound (Items 30023 - 30049)

T8.9.1 The repair of wound referred to in these items must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. These items do not cover repair of wound at time of surgery.

T8.9.2 Item 30023 covers debridement of "deep and extensively contaminated" wound. Benefits are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

T8.10 Drill Biopsy (Item 30078)

T8.10.1 Needle aspiration biopsy attracts benefit on an attendance basis and not under this item.

T8.11 Lipectomy, Wedge Excision - Two or More Excisions (Item 30171)

T8.11.1 Multiple lipectomies, e.g., both buttocks and both thighs attract benefits under Item 30171 once only, i.e. the multiple operation rule does not apply. Medicare benefits are not payable in respect of liposuction, except in the circumstances outlined in Items 45584 and 45585.

T8.12 Treatment of Keratoses, Warts etc (Items 30186, 30187, 30189, 30192, 36815)

T8.12.1 Treatment of keratoses, warts, etc. attract benefits on an attendance basis, with the exception of the treatment of warts in the circumstances outlined in Items 30186, 30187, 30189, 30192 and 36815.

T8.12.2 The treatment of less than 10 premalignant skin lesions by galvanocautery, electrodesiccation or cryocautery also attracts benefits on an attendance basis.

T8.13 Cryotherapy and Serial Curettage Excision (Items 30196 - 30203)

T8.13.1 In Items 30196 and 30197, serial curettage excision, as opposed to simple curettage, refers to the technique where the margin having been defined, the lesion is carefully excised by a skin curette using a series of dissections and cauterisations so that all extensions and infiltrations of the lesion are removed.

T8.13.2 For the purposes of Items 30196 to 30203 (inclusive), the requirement for histopathological proof of malignancy is satisfied where multiple lesions are to be removed from the one anatomical region if a single lesion from that region is histologically tested and proven for malignancy.

T8.14 Telangiectases or Starburst Vessels (Items 30213, 30214)

T8.14.1 These items are restricted to treatment on the head and/or neck. A session of less than 20 minutes duration attracts benefits on an attendance basis.

T8.14.2 Item 30213 is restricted to a maximum of 6 sessions in a 12 month period. Where additional treatments are indicated in that period, Item 30214 should be used. Claims for benefits under Item 30214 should be accompanied by full clinical details, including pre-operative colour photographs, to verify the need for additional services. Where digitial photographs are supplied, they must be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

T8.15 Dissection of Axillary Lymph Nodes (Items 30335, 30336)

T8.15.1 For the purposes of Items 30335 and 30336, the definitions of lymph node levels referred to are set out below.

T8.15.2 Anatomically, the dissection extends from below upwards as follows:

Level I - dissection of axillary lymph nodes up to the inferior border of pectoralis minor.

Level II – dissection of axillary lymph nodes up to the superior border of pectoralis minor.

Level III - dissection of axillary lymph nodes extending above the superior border of pectoralis minor.

T8.16 Subcutaneous Mastectomy (Items 30354, 30355)

T8.16.1 When, after completing a subcutaneous mastectomy a prosthesis is inserted, benefits are payable for the latter procedure under Item 45527, the multiple operation formula applying.

T8.17 Fine Needle Aspiration of Breast Lesion (Item 30360)

T8.17.1 An impalpable lesion includes those lesions that clinically require definition by ultrasound or mammography for accurate or safe sampling, eg. lesions in association with breast prostheses or in areas of breast thickening.

T8.18 Laparotomy and Other Procedures (Item 30375)

T8.18.1 This item covers several operations on abdominal viscera not dissimilar in time and complexity. Where more than one of the procedures are performed during the one operation, each procedure may be itemised according to the multiple operation formula.

T8.19 Gastrointestinal endoscopic procedures (Items 30473-30481, 30484-30487, 30490-30494, 32084-32095)

T8.19.1 The following are guidelines of appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment. These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

Cleaning, disinfection and sterilisation procedures

T8.19.2 Endoscopic procedures should be performed in facilities where endoscope and accessory reprocessing protocols follow procedures outlined in:-

(i) 'Infection and Endoscopy' (3rd edition), Gastroenterological Society of Australia;
(ii) 'Infection control in the health care setting - Guidelines for the prevention of transmission of infectious diseases', National Health and Medical Research Council; and
(iii) Australian Standard AS 4187-1994 (and Amendments), Standards Association of Australia.

Anaesthetic and resuscitation equipment

T8.19.3 Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post operative and resuscitation facilities should conform to the standards outlined in 'Sedation for Endoscopy', Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons.

T8.19.4 These guidelines will be taken into account in determining appropriate practice in the context of the Professional Services Review process (see paragraph 8.1 of the General Notes for Guidance).

T8.20 Gastrectomy, Sub-total Radical (Item 30523)

T8.20.1 The item differs from total radical Gastrectomy (Item 30524) in that a small part of the stomach is left behind. It involves resection of the greater omentum and posterior abdominal wall lymph nodes with or without splenectomy.

T8.21 Anti-reflux Operations (Items 30527-30533, 31464, 31466)

T8.21.1 These items cover various operations for reflux oesophagitis. Where the only procedure performed is the simple closure of a diaphragmatic hiatus benefit would be attracted under Item 30387 (Laparotomy involving operation on abdominal viscera, including pelvic viscera, not being a service to which another item in this Group applies).

T8.22 Removal of Skin Lesions (Items 31200 - 31355)

T8.22.1 The excision of warts and seborrheic keratoses attracts benefits on an attendance basis. Pre-malignant lesions are covered by Items 31200 to 31240.

T8.22.2 The excision of suspicious pigmented and other skin lesions for diagnostic purposes attract benefits under Items 31205 to 31240. Only if a further more extensive excision is undertaken should the items covering excision of malignancies be used.

T8.22.3 Items 31200 and 31245 *do not require* specimen to be sent for histological confirmation. Items 31205 to 31240 and 31250 *require* that specimen be sent for histological examination. Items 31255 to 31335 *require* that specimen be sent for histological confirmation of malignancy which *must* be received before itemisation of accounts for Medicare benefits purposes.

T8.22.4 Where histological results are available at the time of issuing accounts, the histological diagnosis will decide the appropriate itemisation. If the histological report shows the lesion to be benign, Items 31205 to 31240 should be used. Malignant tumours are covered by Items 31255 to 31335.

T8.22.5 Item 31295 applies to the treatment of residual or recurrent BCCs or SCCs of the head and neck only, where performed by a specialist, or practitioner other than the practitioner who provided the previous treatment. Where the conditions of the item are not met, Items 31255 to 31290 are available to cover removal of residual or recurrent BCCs or SCCs.

T8.22.6 For the purposes of these items, the tumour/lesion size should be determined by the macroscopic measurement of the surface diameter of the tumour/lesion or, for elliptical tumours/lesions, by the average surface diameter. The relevant size of the lesion relates to that measured in situ before excision. Suture of wound following surgical excision also includes closure by tissue adhesive resin, clips or similar.

T8.22.7 Utilisation of the revised structure will be closely monitored and audited by the Health Insurance Commission to ensure appropriate usage of items. It will be necessary for practitioners to retain copies of histological reports.

T8.23 Removal of Skin Lesion From Face (Items 31235-31245, 31265-31275, 31310-31320)

T8.23.1 For the purposes of these items, the face is defined as that portion of the head anterior to the hairline and above the jawline.

T8.24 Dissection of lymph nodes of neck (Items 31423 to 31438)

T8.24.1 For the purposes of these items, the lymph node levels referred to are as follows:-

Level I -	Submandibular and submental lymph nodes
Level II -	Lymph nodes of the upper aspect of the neck including the jugulodigastric node, upper jugular chain nodes and upper spinal accessory nodes
Level III -	Lymph nodes deep to the middle third of the sternomastoid muscle consisting of mid jugular chain nodes, the lower most of which is the jugulo-omohyoid node, lying at the level where the omohyoid muscle crosses the internal jugular vein
Level IV -	Lower jugular chain nodes, including those nodes overlying the scalenus anterior muscle
Level V -	Posterior triangle nodes, which are usually distributed along the spinal accessory nerve in the posterior triangle

Comprehensive dissection involves all 5 neck levels while ***selective*** dissection involves the removal of only certain lymph node groups, for example:-

Item 31426 (removal of 3 lymph node levels) - e.g. supraomohyoid neck dissection (levels I-III) or lateral neck dissection (levels II-IV).

Item 31429 (removal of 4 lymph node levels) - e.g. posterolateral neck dissection (levels II-V) or anterolateral neck dissection (levels I-IV)

Other combinations of node levels may be removed according to clinical circumstances.

T8.25 Varicose veins, Multiple Injections of (Items 32500, 32501)

T8.25.1 Item 32500 is restricted to a maximum of 6 treatments in a 12 month period. Where additional treatments are necessary in that period, Item 32501 applies. Claims for benefits should be accompanied by full clinical details, including pre-operative colour photographs, to verify the need for additional services. Where digitial photographs are supplied, they

must be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

T8.26 Endovascular repair of abdominal aortic aneurysm (Items 33116 and 33119)

T8.26.1 These items were introduced into the Schedule on an interim basis via Ministerial Determination under section 3C of the Health Insurance Act, following a recommendation of the Medicare Services Advisory Committee (MSAC). Interim funding is being provided to facilitate collection of Australian evidence of the medium term safety and effectiveness of these services. An audit of these services is being conducted by the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S). Continuation of funding is dependent on progress of the audit. Therefore providers of these services are strongly encouraged to take part in the audit. Further information on the review of these procedures and the audit is available from the MSAC Secretariat (see para 8.5 of the General Explanatory Notes).

T8.27 Arterial and Venous Patches (Items 33545-33551, 34815)

T8.27.1 Vascular surgery items have been constructed on the basis that arteriotomy and venotomy wounds are closed by simple suture without the use of a patch.

T8.27.2 Where a patch angioplasty is used to enlarge a narrowed vein, artery or arteriovenous fistula, the correct item would be 34815 or 34518. If the vein is harvested for the patch through a separate incision, Item 33551 would also apply, in accordance with the multiple operation rule.

T8.27.3 If a patch graft is involved in conjunction with an operative procedure included in Items 33500 - 33542, 33803, 33806, 33815, 33833 or 34142, the patch graft would attract benefits under Item 33545 or 33548 in addition to the item for the primary operation (under the multiple operation rule). Where vein is harvested for the patch through a separate incision Item 33551 would also apply.

T8.28 Peripheral Arterial or Venous Catheterisation (Item 35317)

T8.28.1 Item 35317 is restricted to the use of those chemotherapeutic agents other than antibiotic or antiviral agents.

T8.29 Colposcopic Examination (Item 35614)

T8.29.1 It should be noted that colposcopic examination (screening) of women during the course of a consultation does not attract Medicare benefits under Item 35614 except in the following circumstances:- (i) where the patient has had an abnormal cervical smear; (ii) where there is a history of ingestion of oestrogen by the patient's mother during her pregnancy; or (iii) where the patient has been referred by another medical practitioner because of suspicious signs of genital cancer.

T8.30 Hysteroscopy (Item 35626)

T8.30.1 Hysteroscopy undertaken in the office/consulting rooms can be claimed under this item where the conditions set out in the description of the item are met.

T8.31 Curettage of Uterus under GA or Major Nerve Block (Items 35639, 35640)

T8.31.1 Uterine scraping or biopsy using small curettes (e.g. Sharman's or Zeppelin's) and requiring minimal dilatation of the cervix, not necessitating a general anaesthesia, does not attract benefits under these items but would be paid under Item 35620 where malignancy is suspected, or otherwise on an attendance basis.

T8.32 Neoplastic Changes of the Cervix (Items 35644-35648)

T8.32.1 The term "previously confirmed intraepithelial neoplastic changes of the cervix" in these items refers to diagnosis made by either cytologic, colposcopic or histologic methods. This may also include persistent human papilloma virus (HPV) changes of the cervix.

T8.33 Sterilisation of Minors (Items 35657, 35687, 35688, 37622, 37623)

T8.33.1 The Human Rights and Equal Opportunity Commissioner has provided the following guidelines/advice on sterilisation procedures conducted on minors:-

(i) It is unlawful throughout Australia to conduct a sterilisation procedure on a minor (under 18 years of age) which is not a by-product of surgery appropriately carried out to treat malfunction or disease (eg malignancies of the reproductive tract). Parents/guardians have no legal authority to consent on behalf of minors to such sterilisation procedures.

(ii) Practitioners may be subject to criminal and civil liability action if the sterilisation procedure is not authorised by the Family Court of Australia or a Court or Tribunal with jurisdiction to give such authorisation.

T8.34 Debulking of Uterus (Item 35658)

T8.34.1 Benefits are payable under Item 35658, using the multiple operation rule, in addition to vaginal hysterectomy.

T8.35 Radical or Debulking Operation for Ovarian Tumour including Omentectomy (Item 35720)

T8.35.1 This item refers to the operation for carcinoma of the ovary where the bulk of the tumour and the omentum are removed. Where this procedure is undertaken in association with hysterectomy benefits are payable under both item numbers with the application of the multiple operation formula.

T8.36 Cardiac Pacemaker Insertion (Items 38209, 38212, 38281, 38284)

T8.36.1 The fees for the insertion of a pacemaker (Items 38281 and 38284) cover the testing of cardiac conduction or conduction threshold, etc related to the pacemaker and pacemaker function. Accordingly, additional benefits are not payable for such routine testing under Item 38209 or 38212 (Cardiac electrophysiological studies).

T8.37 Coronary Artery Bypass (Items 38497 - 38503)

T8.37.1 The fee for Item 38497 includes the harvesting of vein graft material. Harvesting of internal mammary artery and/or vein graft material is covered in the fees for Items 38500 and 38503. Where harvesting of an artery other than the internal mammary artery is undertaken, benefits are payable under Item 38496 on the multiple operation basis. The procedure of coronary artery bypass grafting using arterial graft is covered by Item 38500 or 38503 irrespective of the origin of the arterial graft.

T8.38 Re-operation via Median Sternotomy (Item 38640)

T8.38.1 Medicare benefits are payable for Item 38640 plus the item/s covering the major surgical procedure/s performed at the time of the re-operation, using the multiple operation formula. Benefits are not payable for Item 38640 in association with Item 38656, 38643 or 38647.

T8.39 Skull Base Surgery (Items 39640 - 39662)

T8.39.1 The surgical management of lesions involving the skull base (base of anterior, middle and posterior fossae) often requires the skills of several surgeons or a number of surgeons from different surgical specialties working together or in tandem during the operative session. These operations are usually not staged because of the need for definitive closure of the dura, subcutaneous tissues, and skin to avoid serious infections such as osteomyelitis and/or meningitis.

T8.39.2 Items 39640 to 39662 cover the removal of the tumour, which would normally be performed by a neurosurgeon. Other items are available to cover procedures performed as a part of skull base surgery by practitioners in other specialities, such as ENT and plastic and reconstructive surgery.

T8.40 Intradiscal Injection of Chymopapain (Item 40336)

T8.40.1 The fee for this item includes routine post-operative care. Associated radiological services attract benefits under the appropriate item in Group I3.

T8.41 Removal of Ventilating Tube from Ear (Item 41500)

T8.41.1 Benefits are not payable under Item 41500 for removal of ventilating tube. This service attracts benefits on an attendance basis.

T8.42 Meatoplasty (Item 41515)

T8.42.1 When this procedure is associated with Item 41530, 41548, 41557, 41560 or 41563 the multiple operation rule applies.

T8.43 Reconstruction of Auditory Canal (Item 41524)

T8.43.1 When associated with Item 41557, 41560 or 41563 the multiple operation rule applies.

T8.44 Removal of Nasal Polyp or Polypi (Items 41662, 41665, 41668)

T8.44.1 Where such polyps are removed in association with another intranasal procedure, Medicare benefit is paid under Item 41662. However where the associated procedure is of lesser value than Items 41665/41668, benefit for removal of polypi would be paid under Items 41665/41668.

T8.45 Larynx, Direct Examination (Item 41846)

T8.45.1 Benefit is not attracted under this item when an anaesthetist examines the larynx during the course of administration of a general anaesthetic.

T8.46 Microlaryngoscopy (Item 41858)

T8.46.1 This item covers the removal of "juvenile papillomata" by mechanical means, e.g. cup forceps. Item 41861 refers to the removal by laser surgery.

T8.47 Refractive Keratoplasty (Item 42671)

T8.47.1 The description of this item refers to two sets of calculations, one performed some time prior to the operation, the other during the course of the operation. Both of these measurements are included in the Schedule fee and benefit for Item 42671.

T8.48 Capsulectomy or Lensectomy (Items 42731)

T8.48.1 The following items would be regarded as intraocular operations, and should not be itemised with Item 42731:

42551	42554	42557	42560	42563	42566
42569	42698	42701	42702	42703	42704

42707 42716 42734 42743 42746 42761
42764 42767 42857

T8.48.2 This list of exclusions was developed following consultation with the Royal Australian College of Ophthalmologists.

T8.49 Laser Trabeculoplasty (Items 42782, 42783)

T8.49.1 Item 42782 is restricted to a maximum of 4 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42783 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

T8.50 Laser Iridotomy (Items 42785, 42786)

T8.50 Item 42785 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42786 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

T8.51 Laser Capsulotomy (Items 42788, 42789)

T8.51 Item 42788 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42789 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

T8.52 Laser Vitreolysis or Corticolysis of lens material or Fibrinolysis (Items 42791, 42792)

T8.52 Item 42791 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42792 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

T8.53 Division of Suture by Laser (Item 42794)

T8.53.1 Benefits under this item are restricted to a maximum of 2 treatments in a 2 year period. There is no provision for additional treatments in that period.

T8.54 Laser Coagulation of Corneal or Scleral Blood Vessels (Item 42797)

T8.54.1 Benefits under this item are restricted to 4 treatments in a 2 year period. There is no provision for additional treatments in that period.

T8.54.2 Benefits are not payable under Item 42797 for procedures undertaken for cosmetic purposes (see paragraph 13.1.2 of the General Explanatory Notes).

T8.55 Readjustment of Adjustable Sutures (Item 42845)

T8.55.1 This item refers to the occasion when readjustment has to be made to the sutures to vary the angle of deviation of the eye. It does not cover the mere tightening of the loosely tied sutures without repositioning.

T8.56 Full Face Chemical Peel (Items 45019, 45020)

T8.56.1 These items relate to full face chemical peel in the circumstances outlined in the item descriptors. Claims for benefits should be accompanied by full clinical details, including pre-operative colour photographs, to confirm that the conditions for payment of benefits have been met. Where digitial photographs are supplied, they must be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

T8.57 Abrasive therapy/Resurfacing (Items 45021 - 45026)

T8.57.1 For the purposes of the above items, one aesthetic area is any of the following of the whole face (considered to be divided into six segments):- forehead; right cheek; left cheek; nose; upper lip; and chin.

T8.57.2 Items 45021 and 45024 cover abrasive therapy only. Services performed using a laser are not eligible for benefits under these items.

T8.58 Foreign Implant (Item 45051)

T8.58.1 For Medicare benefits to be payable for this item the intention of the implantation must be either to reconstruct facial or body contours which have been damaged by trauma or disease or to correct a deformity which has been pathologically caused.

T8.59 Escharotomy (Item 45054)

T8.59.1 Benefits are payable once only under Item 45054 for each limb (or chest) regardless of the number of incisions to each of these areas.

T8.60 Local Skin Flap - Definition

T8.60.1 A local skin flap is an area of skin and subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by its pedicle and is moved into the defect by rotation, advancement or transposition, or a combination of these manoeuvres. A benefit is only payable when the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This later procedure will also attract benefit if closed by graft or flap repair but not when closed by direct suture.

T8.60.2 By definition, direct wound closure (e.g. by suture) does not constitute skin flap repair. Similarly, angled, curved or trapdoor incisions which are used for exposure and which are sutured back in the same position relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of a wound prior to suturing is considered a normal part of wound closure and is not considered a skin flap repair.

T8.60.3 A "Z" plasty is a particular type of transposition flap repair. Although 2 flaps are created, benefit will be paid on the basis of Items 45200, 45203 or 45206 once only.

T8.60.4 Items where benefit for local skin flap repair (if indicated as above) is payable, include:

30023, 30180, 30186, 30269, 31200-31340, 45030, 45033, 45036-45045, 45506, 45512, 45626.

Note: This list is not all-inclusive and there are circumstances where other services might involve flap repair.

T8.60.5 The following items are examples of where local flap repair would usually not be payable. If further advice is required the Health Insurance Commission should be contacted.

30026-30052, 30099-30114, 30165-30177, 45521, 45524, 45563, 45587, 45632-45644, 45659, 45662, 45677-45713.

T8.61 Free grafting to burns (Items 45406 - 45418)

T8.61.1 Items 45406 to 45418 cover split skin grafting using autografts, homografts or xenografts.

T8.62 Augmentation Mammaplasty (Items 45524, 45527, 45528)

T8.62.1 Medicare benefit is generally not attracted under Item 45524 unless the asymmetry in breast size is greater than 10%. Augmentation of a second breast some time after an initial augmentation of one side would not attract benefits. Benefits are not payable for augmentation mammaplasty in association with correction of breast ptosis (Items 45543 and 45544).

T8.62.2 Item 45528 applies where bilateral mammaplasty is indicated because of disease, trauma or congenital malformation (other than covered under Item 45524 or 45527). Claims for benefits should be accompanied by full clinical details, including pre-operative colour photographs. Where digital photographs are supplied, they must also be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

T8.63 Breast Reconstruction, Myocutaneous Flap (Item 45530)

T8.63.1 When a prosthesis is inserted in conjunction with this operation, benefit would be attracted under Item 45527, the multiple operation rule applying. Benefits would also be payable for nipple reconstruction (Item 45545) when performed.

T8.63.2 When a rectus abdominus flap is used, secondary repair of the muscle defect by an external oblique muscle flap would be covered under Item 45012. However, where the repair is by Teflon or similar mesh, Item 30405 should be itemised.

T8.64 Breast Ptosis (Items 45543, 45544)

T8.64.1 For the purposes of Item 45543, Medicare benefit is only payable for the correction of breast ptosis when performed unilaterally, to match the position of the contralateral breast. Additional benefit is not payable if this procedure is also performed on the contralateral breast.

T8.64.2 Bilateral correction of breast ptosis under Item 45544 attracts Medicare benefits subject to the multiple operation rule.

T8.64.3 Item 45544 applies where correction of breast ptosis is indicated because the nipple is inferior to the infra-mammary groove. Claims for benefits should be accompanied by full clinical details including colour photographs. Where digital photographs are supplied they must also be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

T8.65 Nipple and/or Areola Reconstruction (Item 45545, 45546)
T8.65.1 Item 45545 involves the taking of tissue from, for example, the other breast, the ear lobe and the inside of the upper thigh with or without local flap.
T8.65.2 Item 45546 covers the non-surgical creation of nipple or areola by intradermal colouration.

T8.66 Liposuction (Items 45584, 45585)
T8.66.1 Medicare benefits for liposuction are generally attracted under Item 45584, that is, for the treatment of post traumatic pseudolipoma. Such trauma must be significant and result in large haematoma and localised swelling. Only on very rare occasions would benefits be payable for bilateral liposuction.
T8.66.2 Where liposuction is indicated for the treatment of conditions such as pathological lipodystrophy of hips, buttocks, thighs and lower legs (including knees), gynaecomastia and lymphoedema, Item 45585 applies. Claims for benefits under this item should be accompanied by full clinical details, including full body pre-operative photographs. Where digital photographs are supplied, they must also be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

T8.67 Meloplasty for Correction of Facial Asymmetry (Items 45587, 45588)
T8.67.1 Benefits are payable under Item 45587 for unilateral face-lift operations performed to correct soft tissue abnormalities of the face due to causes other than the ageing process.
T8.67.2 Where bilateral meloplasty is indicated because of disease, trauma or congenital malformation for conditions such as drooling from the angles of the mouth and deep pitting of the skin due to acne scars Item 45588 applies. Claims for benefits under this item should be accompanied by full clinical details, including pre-operative colour photographs. Where digital photographs are supplied, they must be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

T8.68 Reduction of Eyelids (Items 45617, 45620)
T8.68.1 Where a reduction is performed for a medical condition of one eyelid, it may be necessary to undertake a similar compensating procedure on the other eyelid to restore symmetry. The latter operation would also attract benefits. Where there is doubt as to whether benefits would be payable, advice should be sought from a medical adviser of the Health Insurance Commission.

T8.69 Rhinoplasty (45638, 45639)
T8.69.1 Benefits are payable for septoplasty (Item 41671) where performed in conjunction with rhinoplasty.
T8.69.2 Item 45639 applies where surgery is indicated for the correction of significant developmental deformity. Developmental deformity includes cleft nose, bifid tip and twisted nose. Claims for benefits under this item should be accompanied by full clinical details and pre-operative photographs, including front, base (i.e. inferior view) and two laterals of the nose. Where digital photographs are supplied, they must also be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

T8.70 Vermilionectomy (Item 45669)
T8.70.1 Item 45669 covers treatment of the entire lip.

T8.71 Osteotomy of Jaw (Items 45720 - 45752)
T8.71.1 The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, e.g. iliac crest, would attract additional benefit under Item 47726 or 47729 for the harvesting, plus Item 48239 or 48242 for the grafting.
T8.71.2 For the purposes of these items, a reference to maxilla includes the zygoma.

T8.72 Genioplasty (Items 45761)
T8.72.1 Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

T8.73 Reduction of Dislocation or Fracture
T8.73.1 Closed reduction means treatment of a dislocation or fracture by non-operative reduction, and includes the use of percutaneous fixation or external splintage by cast or splints.
T8.73.2 Open reduction means treatment of a dislocation or fracture by either operative exposure including the use of any internal or external fixation; or non-operative (closed reduction) where intra-medullary or external fixation is used.
T8.73.3 Where the treatment of a fracture requires reduction on more than one occasion to achieve an adequate alignment, benefits are payable for each separate occasion at which reduction is performed under the appropriate item covering the fracture being treated.

T8.73.4 The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts benefits on an attendance basis.

T8.74 Internal Fixation (Items 48678-48690)

T8.74.1 Benefits under these items are only attracted where internal fixation is carried out in association with spinal fusion covered by Items 48642 to 48675. The multiple rule would apply in each instance.

T8.75 Wrist Surgery (Items 49200-49227)

T8.75.1 For the purposes of these items, the wrist includes both the radiocarpal joint and the midcarpal joint.

T8.76 Joint or other Synovial Cavity, Aspiration of, or Injection into (Items 50124, 50125)

T8.76.1 Item 50124 is restricted to a maximum of 25 treatments in a 12 month period. Where additional treatments are necessary Item 50125 applies. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. Where digitial photographs are supplied, they must be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

ASSISTANCE AT OPERATIONS (Group T9)

T9.1 General

T9.1.1 Items covering operations which are eligible for benefits for surgical assistance have been identified by the inclusion of the word "Assist." in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

T9.1.2 The assistance must be rendered by a medical practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

T9.1.3 Where more than one practitioner provides assistance to a surgeon no additional benefits are payable. The assistance benefit payable is the same irrespective of the number of practitioners providing surgical assistance.

T9.2 Benefits payable under Item 51300

T9.2.1 Medicare benefits are payable under item 51300 for assistance rendered at any operation identified by the word "Assist." for which the fee does not exceed the fee threshold specified in the item descriptor, or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee threshold specified in the item descriptor has not been exceeded.

T9.3 Benefits payable under item 51303

T9.3.1 Medicare benefits are payable under item 51303 for assistance rendered at any operation identified by the word "Assist." for which the fee exceeds the fee threshold specified in the item descriptor or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee exceeds the threshold specified in the item descriptor.

T9.4 Benefits Payable Under Item 51309

T9.4.1 Medicare benefits are payable under item 51309 for assistance rendered at any operation identified by the word "Assist." or a series or combination of operations identified by the word "Assist." and assistance at a delivery involving Caesarean section.

T9.4.2 Where assistance is provided at a Caesarean section delivery and at a procedure or procedures which have not been identified by the word "Assist.", benefits are payable under item 51306.

T9.5 Assistance at Multiple Operations

T9.5.1 Where surgical assistance is provided at two or more operations performed on a patient on the one occasion the multiple operation formula is applied to all the operations to determine the surgeon's fee for Medicare benefits purposes. The multiple-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for surgical assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Item 51300 or 51303).

Example.

Multiple Operation Rule - Surgeon	**Multiple Operation Rule - Assistant**
Item A - $300@100%	Item A(Assist.) - $300@100%
Item B - $250@50%	Item B(No Assist.) -
Item C - $200@25%	Item C(Assist.) - $200@50%
Item D - $150@25%	Item D(Assist.) - $150@25%

T9.5.2 The derived fee applicable to Item 51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery which attracts an assistance rebate.

T9.6 Surgeons Operating Independently

T9.6.1 Where two surgeons operate independently (ie neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a surgical assistant is engaged by each, or one of the surgeons, benefits for surgical assistance are payable in the same manner as if the surgeons were operating separately.

T9.7 Assistance at Cataract and Intraocular Lens Surgery

T9.7.1 The reference to "previous significant surgical complication" covers vitreous loss, rupture of posterior capsule, loss of nuclear material into the vitreous, intraocular haemorrhage, intraocular infection (endophthalmitis), cystoid macular oedema, corneal decompensation or retinal detachment.

GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES

SUBGROUP 1 - HYPERBARIC OXYGEN THERAPY

13020	HYPERBARIC OXYGEN THERAPY performed in a comprehensive hyperbaric medicine facility for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance *(See para T1.1 of explanatory notes to this Category)* **Fee:** $201.50	**Benefit:** 75% = $151.15	85% = $171.30
13025	HYPERBARIC OXYGEN THERAPY performed in a comprehensive hyperbaric medicine facility for a period in the hyperbaric chamber greater than 3 hours, including any associated attendance - per hour (or part of an hour) *(See para T1.1 of explanatory notes to this Category)* **Fee:** $90.10	**Benefit:** 75% = $67.60	85% = $76.60
13030	HYPERBARIC OXYGEN THERAPY performed in a comprehensive hyperbaric medicine facility where the medical practitioner is pressurised in the hyperbaric chamber for the purpose of providing continuous life saving emergency treatment, including any associated attendance - per hour (or part of an hour) *(See para T1.1 of explanatory notes to this Category)* **Fee:** $127.25	**Benefit:** 75% = $95.45	85% = $108.20

SUBGROUP 2 - DIALYSIS

13100	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day *(See para T1.2 of explanatory notes to this Category)* **Fee:** $106.40	**Benefit:** 75% = $79.80	85% = $90.45
13103	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day *(See para T1.2 of explanatory notes to this Category)* **Fee:** $55.40	**Benefit:** 75% = $41.55	85% = $47.10
13106	DECLOTTING OF AN ARTERIOVENOUS SHUNT **Fee:** $94.55	**Benefit:** 75% = $70.95	85% = $80.40
13109	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes. 17710 = 6B + 4T) **Fee:** $177.30	**Benefit:** 75% = $133.00	85% = $150.75
13110	TENCKHOFF PERITONEAL DIALYSIS CATHETER, removal of (including catheter cuffs) (Anaes. 17708 = 6B + 2T) **Fee:** $177.85	**Benefit:** 75% = $133.40	85% = $151.20
13112	PERITONEAL DIALYSIS, establishment of, by abdominal puncture and insertion of temporary catheter (including associated consultation) (Anaes. 17708 = 6B + 2T) **Fee:** $106.40	**Benefit:** 75% = $79.80	85% = $90.45

SUBGROUP 3 - ASSISTED REPRODUCTIVE SERVICES

‡ 13200	ASSISTED REPRODUCTIVE SERVICES (such as in vitro fertilisation, gamete intrafallopian transfer or similar procedures) involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13203, 13206 or 13218 applies - being services rendered during 1 treatment cycle, if the duration of the treatment cycle is at least 9 days *(See para T1.3 of explanatory notes to this Category)* **Fee:** $1,556.50	**Benefit:** 75% = $1,167.40	85% = $1,505.60
13203	OVULATION MONITORING SERVICES, for superovulated treatment cycles of less than 9 days duration and artificial insemination - including quantitative estimation of hormones and ultrasound examinations, being services rendered during 1 treatment cycle but excluding a service to which item 13200, 13206, 13212, 13215 or 13218 applies *(See para T1.3 of explanatory notes to this Category)* **Fee:** $389.10	**Benefit:** 75% = $291.85	85% = $338.20

13206	ASSISTED REPRODUCTIVE SERVICES (such as in vitro fertilisation, gamete intrafallopian transfer or similar procedures), using unstimulated ovulation or ovulation stimulated only by clomiphene citrate, and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, frozen embryo transfer or donated embryos or ova or treatment involving the use of drugs to induce superovulation being services rendered during 1 treatment cycle but only if rendered in conjunction with a service to which item 13212 applies *(See para T1.3 of explanatory notes to this Category)*		
	Fee: $667.05	**Benefit:** 75% = $500.30	85% = $616.15
13209	PLANNING and MANAGEMENT of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies including in vitro fertilisation, gamete intrafallopian transfer and similar procedures, or for artificial insemination payable once only during 1 treatment cycle *(See para T1.3 of explanatory notes to this Category)*		
	Fee: $66.60	**Benefit:** 75% = $49.95	85% = $56.65
13212	OOCYTE RETRIEVAL by any means including laparoscopy or ultrasoundguided ova flushing, for the purposes of assisted reproductive technologies including in vitro fertilisation, gamete intra-fallopian transfer or similar procedures - only if rendered in conjunction with a service to which item 13200 or 13206 applies (Anaes. 17707 = 4B + 3T) *(See para T1.3 of explanatory notes to this Category)*		
	Fee: $283.50	**Benefit:** 75% = $212.65	85% = $241.00
13215	TRANSFER of EMBRYOS or both ova and sperm to the female reproductive system, by any means but excluding artificial insemination or the transfer of frozen or donated embryos - only if rendered in conjunction with a service to which item 13200 or 13206 applies, being services rendered in 1 treatment cycle (Anaes. 17709 = 6B + 3T) *(See para T1.3 of explanatory notes to this Category)*		
	Fee: $89.00	**Benefit:** 75% = $66.75	85% = $75.65
13218	PREPARATION AND TRANSFER of frozen or donated embryos or both ova and sperm, to the female reproductive system, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in 1 treatment cycle and excluding a service to which item 13200, 13203, 13206, 13212 or 13215 applies (Anaes. 17709 = 6B + 3T) *(See para T1.3 of explanatory notes to this Category)*		
	Fee: $667.05	**Benefit:** 75% = $500.30	85% = $616.15
13221	PREPARATION OF SEMEN for the purposes of assisted reproductive technologies or for artificial insemination *(See para T1.3 of explanatory notes to this Category)*		
	Fee: $40.60	**Benefit:** 75% = $30.45	85% = $34.55
13290	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required		
	Fee: $159.05	**Benefit:** 75% = $119.30	85% = $135.20
13292	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under general anaesthetic, in a hospital or approved day-hospital facility (Anaes. 17708 = 4B + 4T)		
	Fee: $318.10	**Benefit:** 75% = $238.60	85% = $270.40
	SUBGROUP 4 - PAEDIATRIC & NEONATAL		
13300	UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate		
	Fee: $44.35	**Benefit:** 75% = $33.30	85% = $37.70
13303	UMBILICAL ARTERY CATHETERISATION with or without infusion		
	Fee: $65.75	**Benefit:** 75% = $49.35	85% = $55.90
13306	BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor		
	Fee: $260.10	**Benefit:** 75% = $195.10	85% = $221.10
13309	BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already collected		
	Fee: $221.75	**Benefit:** 75% = $166.35	85% = $188.50
13312	BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS		
	Fee: $22.10	**Benefit:** 75% = $16.60	85% = $18.80

13318	CENTRAL VEIN CATHETERISATION (via jugular or subclavian vein) - by open exposure in a person under 12 years of age (Anaes. 17709 = 5B + 4T) **Fee:** $177.10	**Benefit:** 75% = $132.85	85% = $150.55
13319	CENTRAL VEIN CATHETERISATION in a neonate via peripheral vein (Anaes. 17709 = 5B + 4T) **Fee:** $177.10	**Benefit:** 75% = $132.85	85% = $150.55
	SUBGROUP 5 - CARDIOVASCULAR		
13400	RESTORATION OF CARDIAC RHYTHM by electrical stimulation (cardioversion), other than in the course of cardiac surgery (Anaes. 17706 = 5B + 1T) **Fee:** $75.40	**Benefit:** 75% = $56.55	85% = $64.10
	SUBGROUP 6 - GASTROENTEROLOGY		
13500	GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant IN THE ABSENCE OF GASTROINTESTINAL HAEMORRHAGE **Fee:** $140.40	**Benefit:** 75% = $105.30	85% = $119.35
13503	GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant FOR UPPER GASTROINTESTINAL HAEMORRHAGE **Fee:** $280.80	**Benefit:** 75% = $210.60	85% = $238.70
13506	GASTRO-OESOPHAGEAL balloon intubation, Minnesota, Sengstaken-Blakemore or similar, for control of bleeding from gastric oesophageal varices **Fee:** $143.60	**Benefit:** 75% = $107.70	85% = $122.10
	SUBGROUP 7 - PERFUSION		
13600	PERFUSION OF LIMB OR ORGAN using heart-lung machine or equivalent *(See para T1.4 of explanatory notes to this Category)* **Fee:** $345.50	**Benefit:** 75% = $259.15	85% = $294.60
13603	WHOLE BODY PERFUSION, CARDIAC BYPASS, using heartlung machine or equivalent *(See para T1.4 of explanatory notes to this Category)* **Fee:** $489.30	**Benefit:** 75% = $367.00	85% = $438.40
13604	PROLONGED WHOLE BODY PERFUSION, CARDIAC BY-PASS, using heart-lung machine or equivalent, where the time for the procedure exceeds 6 hours *(See para T1.4 of explanatory notes to this Category)* **Derived Fee:** An amount of $548.50 plus $14.80 for each additional 10 minutes (or part thereof) beyond 6 hours		
13606	INDUCED CONTROLLED HYPOTHERMIA total body *(See para T1.4 of explanatory notes to this Category)* **Fee:** $85.25	**Benefit:** 75% = $63.95	85% = $72.50
13609	CARDIOPLEGIA, blood or crystalloid, administration by any route *(See para T1.4 of explanatory notes to this Category)* **Fee:** $196.80	**Benefit:** 75% = $147.60	85% = $167.30
13612	DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed *(See para T1.4 of explanatory notes to this Category)* **Fee:** $308.15	**Benefit:** 75% = $231.15	85% = $261.95
	SUBGROUP 8 - HAEMATOLOGY		
13700	HARVESTING OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the purpose of transplantation (Anaes. 17712 = 5B + 7T) **Fee:** $259.50	**Benefit:** 75% = $194.65	85% = $220.60
13703	ADMINISTRATION OF BLOOD, including collection from donor **Fee:** $93.00	**Benefit:** 75% = $69.75	85% = $79.05
13706	ADMINISTRATION OF BLOOD or bone marrow already collected *(See para T1.5 of explanatory notes to this Category)* **Fee:** $64.95	**Benefit:** 75% = $48.75	85% = $55.25

13709	COLLECTION OF BLOOD for autologous transfusion or when homologous blood is required for immediate transfusion in emergency situation *(See para T1.6 of explanatory notes to this Category)* **Fee:** $37.70	**Benefit:** 75% = $28.30	85% = $32.05
13750	THERAPEUTIC HAEMAPHERESIS for the removal of plasma or cellular (or both) elements of blood, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies, if performed; continuous monitoring of vital signs, fluid balance, blood volume and other parameters with continuous registered nurse attendance under the supervision of a consultant physician, not being a service associated with a service to which item 13755 applies -payable once per day **Fee:** $106.40	**Benefit:** 75% = $79.80	85% = $90.45
13755	DONOR HAEMAPHERESIS for the collection of blood products for transfusion, utilising continuous or intermitten flow techniques; including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuous registered nurse attendance under the supervision of a consultant physician; not being a service associated with a service to which item 13750 applies - payable once per day **Fee:** $106.40	**Benefit:** 75% = $79.80	85% = $90.45
13757	THERAPEUTIC VENESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda **Fee:** $56.80	**Benefit:** 75% = $42.60	85% = $48.30
13760	IN VITRO PROCESSING (and cryopreservation) of bone marrow or peripheral blood for autologous stem cell transplantation as an adjunct to high dose chemotherapy for: . chemosensitive intermediate or high grade non-Hodgkin's lymphoma at high risk of relapse following first line chemotherapy; or . Hodgkin's disease which has relapsed following, or is refractory to, chemotherapy; or . acute myelogenous leukaemia in first remission, where suitable genotypically matched sibling donor is not available for allogenic bone marrow transplant; or . multiple myeloma in remission (complete or partial) following standard dose chemotherapy; or . small round cell sarcomas; or . primitive neuroectodermal tumour; or .germ cell tumours which have relapsed following, or are refractory to, chemotherapy; . germ cell tumours which have had an incomplete response to first line therapy. - performed under the supervision of a consultant physician - each day. **Fee:** $593.75	**Benefit:** 75% = $445.35	85% = $542.85
	SUBGROUP 9 - PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT		
13815	CENTRAL VEIN CATHETERISATION (via jugular, subclavian or femoral vein) by percutaneous or open exposure not being a service to which item 13318 applies (Anaes. 17705 = 3B + 2T) **Fee:** $66.35	**Benefit:** 75% = $49.80	85% = $56.40
13818	RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes. 17705 = 3B + 2T) *(See para T1.8 of explanatory notes to this Category)* **Fee:** $88.55	**Benefit:** 75% = $66.45	85% = $75.30
13830	INTRACRANIAL PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician - each day **Fee:** $58.65	**Benefit:** 75% = $44.00	85% = $49.90
13839	ARTERIAL PUNCTURE and collection of blood for diagnostic purposes **Fee:** $17.90	**Benefit:** 75% = $13.45	85% = $15.25
13842	INTRAARTERIAL CANNULISATION for the purpose of taking multiple arterial blood samples for blood gas analysis *(See para T1.8 of explanatory notes to this Category)* **Fee:** $53.95	**Benefit:** 75% = $40.50	85% = $45.90
13845	COUNTERPULSATION BY INTRAAORTIC BALLOON management on the first day, including percutaneous insertion, initial and subsequent consultations and monitoring of parameters (Anaes. 17710 = 8B + 2T) **Fee:** $421.15	**Benefit:** 75% = $315.90	85% = $370.25
13848	COUNTERPULSATION BY INTRAAORTIC BALLOON management on each day subsequent to the first, including associated consultations and monitoring of parameters **Fee:** $102.00	**Benefit:** 75% = $76.50	85% = $86.70
13851	CIRCULATORY SUPPORT DEVICE, management of, on first day **Fee:** $384.35	**Benefit:** 75% = $288.30	85% = $333.45

13854	CIRCULATORY SUPPORT DEVICE, management of, on each day subsequent to the first **Fee:** $89.35	**Benefit:** 75% = $67.05	85% = $75.95
13857	MECHANICAL VENTILATION, initiation of (other than initiation of ventilation in the context of an anaesthetic for surgery), outside of an Intensive Care Unit, where subsequent management of ventilatory support is undertaken in an Intensive Care Unit *(See para T1.8 of explanatory notes to this Category)* **Fee:** $114.00	**Benefit:** 75% = $85.50	85% = $96.90

SUBGROUP 10 - MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT

(Note: See para T1.7 of Explanatory Notes to this Category for definition of an Intensive Care Unit)

13870	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician - including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling, bladder catheterisation and blood sampling - management on the first day *(See para T1.9 of explanatory notes to this Category)* **Fee:** $237.50	**Benefit:** 75% = $178.15	85% = $201.90
13873	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician - including all attendances, electrocardiographic monitoring, arterial sampling, bladder catheterisation and blood sampling - management on each day subsequent to the first day *(See para T1.9 of explanatory notes to this Category)* **Fee:** $176.85	**Benefit:** 75% = $132.65	85% = $150.35
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 type of pressure up to a maximum of 4 pressures *(See para T1.9 of explanatory notes to this Category)* **Fee:** $53.95	**Benefit:** 75% = $40.50	85% = $45.90
13879	MECHANICAL VENTILATION, initiation of, by a specialist or consultant physician, in an Intensive Care Unit, including subsequent management of ventilatory support on the first day **Fee:** $172.35	**Benefit:** 75% = $129.30	85% = $146.50
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 **Fee:** $58.65	**Benefit:** 75% = $44.00	85% = $49.90
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:** $106.10	**Benefit:** 75% = $79.60	85% = $90.20
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:** $55.25	**Benefit:** 75% = $41.45	85% = $47.00

SUBGROUP 11 - CHEMOTHERAPEUTIC PROCEDURES

13915	CYTOTOXIC CHEMOTHERAPY, administration of, either by intravenous push technique (directly into a vein, or a butterfly needle, or the side-arm of an infusion) or by intravenous infusion of not more than 1 hours duration - payable once only on the same day **Fee:** $50.65	**Benefit:** 75% = $38.00	85% = $43.10
13918	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day **Fee:** $76.20	**Benefit:** 75% = $57.15	85% = $64.80
13921	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - for the first day of treatment **Fee:** $86.20	**Benefit:** 75% = $64.65	85% = $73.30
13924	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode **Fee:** $50.85	**Benefit:** 75% = $38.15	85% = $43.25

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:** $65.75	**Benefit:** 75% = $49.35	85% = $55.90
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:** $91.70	**Benefit:** 75% = $68.80	85% = $77.95
13933	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment **Fee:** $101.70	**Benefit:** 75% = $76.30	85% = $86.45
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:** $66.25	**Benefit:** 75% = $49.70	85% = $56.35
13939	IMPLANTED PUMP OR RESERVOIR, loading of, with a cytotoxic agent or agents, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies *(See para T1.10 of explanatory notes to this Category)* **Fee:** $76.20	**Benefit:** 75% = $57.15	85% = $64.80
13942	AMBULATORY DRUG DELIVERY DEVICE, loading of, with a cytotoxic agent or agents for the infusion of the agent or agents via the intravenous, intra-arterial or spinal routes, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies *(See para T1.10 of explanatory notes to this Category)* **Fee:** $50.85	**Benefit:** 75% = $38.15	85% = $43.25
13945	LONG-TERM IMPLANTED DRUG DELIVERY DEVICE FOR CYTOTOXIC CHEMOTHERAPY, accessing of **Fee:** $40.90	**Benefit:** 75% = $30.70	85% = $34.80
13948	CYTOTOXIC AGENT, instillation of, into a body cavity **Fee:** $50.85	**Benefit:** 75% = $38.15	85% = $43.25
	SUBGROUP 12 - DERMATOLOGY		
14050	PUVA THERAPY or UVB THERAPY administered in whole body cabinet, not being a service associated with a service to which item 14053 applies including associated consultations other than an initial consultation *(See para T1.11 of explanatory notes to this Category)* **Fee:** $41.10	**Benefit:** 75% = $30.85	85% = $34.95
14053	PUVA THERAPY or UVB THERAPY administered to localised body areas in hand and foot cabinet not being a service associated with a service to which item 14050 applies including associated consultations other than an initial consultation *(See para T1.11 of explanatory notes to this Category)* **Fee:** $41.10	**Benefit:** 75% = $30.85	85% = $34.95
14100	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600nm in the treatment of severely disfiguring vascular lesions of the head or neck where abnormality is visible from 4 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - session of at least 30 minutes duration (Anaes. 17708 = 5B + 3T) **Fee:** $118.75	**Benefit:** 75% = $89.10	85% = $100.95
14103	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600nm in the treatment of severely disfiguring vascular lesions of the head or neck where abnormality is visible from 4 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - session of at least 60 minutes duration (Anaes. 17710 = 5B + 5T) **Fee:** $145.80	**Benefit:** 75% = $109.35	85% = $123.95
14106	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment up to $50cm^2$ (Anaes. 17707 = 5B + 2T) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $118.75	**Benefit:** 75% = $89.10	85% = $100.95

14109	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than $50cm^2$ and up to $100cm^2$ (Anaes. 17708 = 5B + 3T) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $145.80 **Benefit:** 75% = $109.35 85% = $123.95
14112	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than $100cm^2$ and up to $150cm^2$ (Anaes. 17709 = 5B + 4T) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $172.70 **Benefit:** 75% = $129.55 85% = $146.80
14115	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than $150cm^2$ and up to $250cm^2$ (Anaes. 17710 = 5B + 5T) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $199.65 **Benefit:** 75% = $149.75 85% = $169.75
14118	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 apply) in any 12 month period - area of treatment more than $250cm^2$ (Anaes. 17711 = 5B + 6T) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $253.65 **Benefit:** 75% = $190.25 85% = $215.65
14120	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600nm in the treatment of severely disfiguring vascular lesions of the head or neck where abnormality is visible from 4 metres, including any associated consultation - session of at least 30 minutes duration - ***where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period*** (Anaes. 17708 = 5B + 3T) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $118.75 **Benefit:** 75% = $89.10 85% = $100.95
14122	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600nm in the treatment of severely disfiguring vascular lesions of the head or neck where abnormality is visible from 4 metres, including any associated consultation, session of at least 60 minutes duration - ***where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period*** (Anaes. 17710 = 5B + 5T) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $145.80 **Benefit:** 75% = $109.35 85% = $123.95
14124	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation - area of treatment up to $50cm^2$ - ***where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period*** (Anaes. 17707 = 5B + 2T) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $118.75 **Benefit:** 75% = $89.10 85% = $100.95
14126	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation - area of treatment more than $50cm^2$ and up to $100cm^2$ - ***where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period*** (Anaes. 17708 = 5B + 3T) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $145.80 **Benefit:** 75% = $109.35 85% = $123.95
14128	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation - area of treatment more than $100cm^2$ and up to $150cm^2$ - ***where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period*** (Anaes. 17709 = 5B + 4T) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $172.70 **Benefit:** 75% = $129.55 85% = $146.80

14130	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation - area of treatment more than 150cm^2 and up to 250cm^2 - ***where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period*** (Anaes. 17710 = 5B + 5T) *(See para T1.12 of explanatory notes to this Category)* **Fee:** $199.65 **Benefit:** 75% = $149.75 85% = $169.75
14132	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation - area of treatment more than 250cm^2 - ***where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period*** *(Anaes. 17711 = 5B + 6T)* *(See para T1.12 of explanatory notes to this Category)* **Fee:** $253.65 **Benefit:** 75% = $190.25 85% = $215.65
	SUBGROUP 13 - OTHER THERAPEUTIC PROCEDURES
14200	GASTRIC LAVAGE in the treatment of ingested poison **Fee:** $46.60 **Benefit:** 75% = $34.95 85% = $39.65
14203	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes. 17706 = 4B + 2T) **Fee:** $39.80 **Benefit:** 75% = $29.85 85% = $33.85
14206	HORMONE OR LIVING TISSUE IMPLANTATION by cannula **Fee:** $27.75 **Benefit:** 75% = $20.85 85% = $23.60
14209	INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent **Fee:** $69.10 **Benefit:** 75% = $51.85 85% = $58.75
14212	INTUSSUSCEPTION, management of fluid or gas reduction for (Anaes. 17705 = 3B + 2T) **Fee:** $144.30 **Benefit:** 75% = $108.25 85% = $122.70
14215	LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, accessing of to add or remove fluid **Fee:** $76.20 **Benefit:** 75% = $57.15 85% = $64.80
14218	IMPLANTED PUMP OR RESERVOIR, LOADING OF, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space **Fee:** $76.20 **Benefit:** 75% = $57.15 85% = $64.80
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:** $40.90 **Benefit:** 75% = $30.70 85% = $34.80
14224	ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes. 17705 = 4B + 1T) **Fee:** $54.70 **Benefit:** 75% = $41.05 85% = $46.50

GROUP T2 - RADIATION ONCOLOGY

SUBGROUP 1 - SUPERFICIAL

(Benefits for administration of general anaesthetic for radiotherapy are payable under item 17965)

15000	RADIOTHERAPY, SUPERFICIAL (including treatment with xrays, radium rays or other radioactive substances), not being a service to which another item in this Group applies each attendance at which fractionated treatment is given - 1 field **Fee:** $33.15 **Benefit:** 75% = $24.90 85% = $28.20
15003	- 2 or more fields up to a maximum of 5 additional fields **Derived Fee:** The fee for item 15000 plus for each field in excess of 1, an amount of $13.30
15006	RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied - 1 field **Fee:** $73.50 **Benefit:** 75% = $55.15 85% = $62.50
15009	- 2 or more fields up to a maximum of 5 additional fields **Derived Fee:** The fee for item 15006 plus for each field in excess of 1, an amount of $14.45
15012	RADIOTHERAPY, SUPERFICIAL each attendance at which treatment is given to an eye **Fee:** $41.60 **Benefit:** 75% = $31.20 85% = $35.40

SUBGROUP 2 - ORTHOVOLTAGE

15100	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 3 or more treatments per week - 1 field **Fee:** $37.15 **Benefit:** 75% = $27.90 85% = $31.60
15103	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15100 plus for each field in excess of 1, an amount of $14.65
15106	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 1 field **Fee:** $43.85 **Benefit:** 75% = $32.90 85% = $37.30
15109	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15106 plus for each field in excess of 1, an amount of $17.65
15112	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field **Fee:** $93.55 **Benefit:** 75% = $70.20 85% = $79.55
15115	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15112 plus for each field in excess of 1, an amount of $36.80

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:** $46.45 **Benefit:** 75% = $34.85 85% = $39.50
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 $29.55
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:** $46.45 **Benefit:** 75% = $34.85 85% = $39.50
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 $29.55

15211	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given - 1 field **Fee:** $42.55 **Benefit:** 75% = $31.95 85% = $36.20
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 $24.80
	SUBGROUP 4 - BRACHYTHERAPY
15303	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a halflife greater than 115 days using manual afterloading techniques (Anaes. 17705 = 3B + 2T) **Fee:** $277.95 **Benefit:** 75% = $208.50 85% = $236.30
15304	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half life greater than 115 days using automatic afterloading techniques (Anaes. 17705 = 3B + 2T) **Fee:** $277.95 **Benefit:** 75% = $208.50 85% = $236.30
15307	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a halflife of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes. 17705 = 3B + 2T) **Fee:** $526.95 **Benefit:** 75% = $395.25 85% = $476.05
15308	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes. 17705 = 3B + 2T) **Fee:** $526.95 **Benefit:** 75% = $395.25 85% = $476.05
15311	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a halflife greater than 115 days using manual afterloading techniques (Anaes. 17705 = 3B + 2T) **Fee:** $259.45 **Benefit:** 75% = $194.60 85% = $220.55
15312	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a halflife greater than 115 days using automatic afterloading techniques (Anaes. 17705 = 3B + 2T) **Fee:** $257.60 **Benefit:** 75% = $193.20 85% = $219.00
15315	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a halflife of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes. 17705 = 3B + 2T) **Fee:** $509.35 **Benefit:** 75% = $382.05 85% = $458.45
15316	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a halflife of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes. 17706 = 3B + 3T) **Fee:** $509.35 **Benefit:** 75% = $382.05 85% = $458.45
15319	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a halflife greater than 115 days using manual afterloading techniques (Anaes. 17706 = 3B + 3T) **Fee:** $316.05 **Benefit:** 75% = $237.05 85% = $268.65
15320	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a halflife greater than 115 days using automatic afterloading techniques (Anaes. 17706 = 3B + 3T) **Fee:** $316.05 **Benefit:** 75% = $237.05 85% = $268.65
15323	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a halflife of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes. 17706 = 3B + 3T) **Fee:** $562.05 **Benefit:** 75% = $421.55 85% = $511.15
15324	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a halflife of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes. 17706 = 3B + 3T) **Fee:** $562.05 **Benefit:** 75% = $421.55 85% = $511.15
15327	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a halflife of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using manual afterloading techniques (Anaes. 17707 = 4B + 3T) **Fee:** $611.50 **Benefit:** 75% = $458.65 85% = $560.60
15328	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a halflife of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using automatic afterloading techniques (Anaes. 17708 = 5B + 3T) **Fee:** $611.50 **Benefit:** 75% = $458.65 85% = $560.60

15331	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a halflife of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using manual afterloading techniques (Anaes. 17708 = 5B + 3T) **Fee:** $580.65	**Benefit:** 75% = $435.50	85% = $529.75
15332	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a halflife of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using automatic afterloading techniques (Anaes. 17708 = 5B + 3T) **Fee:** $580.65	**Benefit:** 75% = $435.50	85% = $529.75
15335	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a halflife of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using manual afterloading techniques (Anaes. 17705 = 3B + 2T) **Fee:** $526.95	**Benefit:** 75% = $395.25	85% = $476.05
15336	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a halflife of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using automatic afterloading techniques (Anaes. 17705 = 3B + 2T) **Fee:** $526.95	**Benefit:** 75% = $395.25	85% = $476.05
15339	REMOVAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural or spinal nerve block (Anaes. 17705 = 3B + 2T) **Fee:** $59.30	**Benefit:** 75% = $44.50	85% = $50.45
15342	CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a halflife of greater than 115 days, to treat intracavity, intraoral or intranasal site **Fee:** $148.20	**Benefit:** 75% = $111.15	85% = $126.00
15345	CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a halflife of less than 115 days including iodine, gold, iridium or tantalum to treat intracavity, intraoral or intranasal sites **Fee:** $395.35	**Benefit:** 75% = $296.55	85% = $344.45
15348	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345 each attendance **Fee:** $45.45	**Benefit:** 75% = $34.10	85% = $38.65
15351	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD not exceeding 5 cm. diameter to an external surface **Fee:** $90.80	**Benefit:** 75% = $68.10	85% = $77.20
15354	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface **Fee:** $110.25	**Benefit:** 75% = $82.70	85% = $93.75
15357	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15351 or 15354 each attendance **Fee:** $31.10	**Benefit:** 75% = $23.35	85% = $26.45

SUBGROUP 5 - COMPUTERISED PLANNING

RADIOTHERAPY PLANNING

15500	RADIATION FIELD SETTING using a simulator or isocentric xray 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) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $189.00	**Benefit:** 75% = $141.75	85% = $160.65
15503	RADIATION FIELD SETTING using a simulator or isocentric xray 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) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $242.60	**Benefit:** 75% = $181.95	85% = $206.25
15506	RADIATION FIELD SETTING using a simulator or isocentric xray 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 offaxis fields or several joined fields (not being a service associated with a service to which item 15515 applies) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $362.25	**Benefit:** 75% = $271.70	85% = $311.35

15509	RADIATION FIELD SETTING using a diagnostic xray unit of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15500 applies) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $163.85	**Benefit:** 75% = $122.90	85% = $139.30
15512	RADIATION FIELD SETTING using a diagnostic xray unit of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15503 applies) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $211.05	**Benefit:** 75% = $158.30	85% = $179.40
15515	RADIATION FIELD SETTING using a diagnostic xray unit of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15506 applies) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $305.55	**Benefit:** 75% = $229.20	85% = $259.75
15518	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks *(See para T2.2 of explanatory notes to this Category)* **Fee:** $59.95	**Benefit:** 75% = $45.00	85% = $51.00
15521	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used *(See para T2.2 of explanatory notes to this Category)* **Fee:** $264.60	**Benefit:** 75% = $198.45	85% = $224.95
15524	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields *(See para T2.2 of explanatory notes to this Category)* **Fee:** $496.20	**Benefit:** 75% = $372.15	85% = $445.30
15527	RADIATION DOSIMETRY by a nonCT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks *(See para T2.2 of explanatory notes to this Category)* **Fee:** $61.40	**Benefit:** 75% = $46.05	85% = $52.20
15530	RADIATION DOSIMETRY by a nonCT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used *(See para T2.2 of explanatory notes to this Category)* **Fee:** $274.10	**Benefit:** 75% = $205.60	85% = $233.00
15533	RADIATION DOSIMETRY by a nonCT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields, or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields *(See para T2.2 of explanatory notes to this Category)* **Fee:** $519.80	**Benefit:** 75% = $389.85	85% = $468.90
15536	BRACHYTHERAPY PLANNING, computerised radiation dosimetry *(See para T2.2 of explanatory notes to this Category)* **Fee:** $207.75	**Benefit:** 75% = $155.85	85% = $176.60
	SUBGROUP 6 - STEREOTACTIC RADIOSURGERY		
15600	STEREOTACTIC RADIOSURGERY, including all radiation oncology consultations, planning, simulation, dosimetry and treatment **Fee:** $1,325.35	**Benefit:** 75% = $994.05	85% = $1,274.45

	GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE
16003	INTRACAVITARY ADMINISTRATION OF A THERAPEUTIC DOSE OF YTTRIUM 90 (not including preliminary paracentesis) (Anaes. 17705 = 3B + 2T) **Fee:** $506.50 **Benefit:** 75% = $379.90 85% = $455.60
16006	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique **Fee:** $389.15 **Benefit:** 75% = $291.90 85% = $338.25
16009	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique **Fee:** $265.60 **Benefit:** 75% = $199.20 85% = $225.80
16012	INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32 **Fee:** $229.75 **Benefit:** 75% = $172.35 85% = $195.30
16015	ADMINISTRATION OF STRONTIUM 89 for painful bony metastases from carcinoma of the prostate where hormone therapy has failed and either: (i) the disease is poorly controlled by conventional radiotherapy; or (ii) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain **Fee:** $3,180.90 **Benefit:** 75% = $2,385.70 85% = $3,130.00
16018	ADMINISTRATION OF ^{153} SM-LEXIDRONAM for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan) from either:- (i) carcinoma of the prostate, where hormonal therapy has failed; or (ii) carcinoma of the breast, where both hormonal therapy and chemotherapy have failed; and either:- (a) the disease is poorly controlled by conventional radiotherapy; or (b) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain **Fee:** $1,901.55 **Benefit:** 75% = $1,426.20 85% = $1,850.65

GROUP T4 - OBSTETRICS

ANTENATAL CARE

16500 ANTENATAL ATTENDANCE
(See para T4.1 of explanatory notes to this Category)
Fee: $27.00 **Benefit:** 75% = $20.25 85% = $22.95

† 16501 EXTERNAL CEPHALIC VERSION for breech presentation, after 36 weeks where no contraindication exists, in a Unit with facilities for Caesarean Section, including pre- and post version CTG, with or without tocolysis, not being a service to which items 55718 to 55728 and 55768 to 55774 apply - chargeable whether or not the version is successful and limited to a maximum of 2 ECV's per pregnancy
(See para T4.2 of explanatory notes to this Category)
Fee: $109.40 **Benefit:** 75% = $82.05 85% = $93.00

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: $27.00 **Benefit:** 75% = $20.25 85% = $22.95

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: $27.00 **Benefit:** 75% = $20.25 85% = $22.95

16505 THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance
Fee: $27.00 **Benefit:** 75% = $20.25 85% = $22.95

16508 PREGNANCY COMPLICATED BY acute intercurrent infection, intrauterine growth retardation, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day
Fee: $27.00 **Benefit:** 75% = $20.25 85% = $22.95

16509 PREECLAMPSIA, ECLAMPSIA OR ANTEPARTUM HAEMORRHAGE, treatment of each attendance that is not a routine antenatal attendance
Fee: $27.00 **Benefit:** 75% = $20.25 85% = $22.95

16511 CERVIX, purse string ligation of (Anaes. 17706 = 4B + 2T)
Fee: $171.20 **Benefit:** 75% = $128.40 85% = $145.55

16512 CERVIX, removal of purse string ligature of (Anaes. 17706 = 4B + 2T)
Fee: $49.40 **Benefit:** 75% = $37.05 85% = $42.00

16514 ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement)
Fee: $28.55 **Benefit:** 75% = $21.45 85% = $24.30

MANAGEMENT OF LABOUR AND DELIVERY

16515 MANAGEMENT OF VAGINAL DELIVERY as an independent procedure where the patient's care has been transferred by another medical practitioner for management of the delivery and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the delivery
(See para T4.3 of explanatory notes to this Category)
Fee: $269.85 **Benefit:** 75% = $202.40 85% = $229.40

16518 MANAGEMENT OF LABOUR, incomplete, where the patient's care has been transferred to another medical practitioner for completion of the delivery
(See para T4.3 of explanatory notes to this Category)
Fee: $123.55 **Benefit:** 75% = $92.70 85% = $105.05

16519 MANAGEMENT OF LABOUR and delivery by any means (including Caesarean section) including post-partum care for 5 days
(See para T4.3 of explanatory notes to this Category)
Fee: $415.60 **Benefit:** 75% = $311.70 85% = $364.70

16520 CAESAREAN SECTION and post-operative care for 7 days where the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care
(See para T4.4 of explanatory notes to this Category)
Fee: $485.65 **Benefit:** 75% = $364.25 85% = $434.75

	MANAGEMENT OF LABOUR AND DELIVERY, or delivery alone, (including Caesarean section), where in the course of antenatal supervision or intrapartum management 1 or more of the following conditions is present, including postnatal care for 7 days: . multiple pregnancy; . recurrent antepartum haemorrhage from 20 weeks gestation; . grades 2, 3 or 4 placenta praevia; . baby with a birth weight less than or equal to 2500gm; . preexisting diabetes mellitus dependent on medication, or gestational diabetes requiring at least daily blood glucose monitoring; . trial of vaginal delivery in a patient with uterine scar, or trial of vaginal breech delivery; . preexisting hypertension requiring antihypertensive medication, or pregnancy induced hypertension of at least 140/90mmHg associated with at least 1+ proteinuria on urinalysis; . prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress; . fetal distress defined by significant cardiotocograph or scalp pH abnormalities requiring immediate delivery; OR . conditions that pose a significant risk of maternal death. *(See para T4.5 of explanatory notes to this Category)*		
16522	**Fee:** $975.80	**Benefit:** 75% = $731.85	85% = $924.90
	MANAGEMENT OF SECOND TRIMESTER LABOUR, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease, not being a service to which item 35643 applies *(See para T4.3 of explanatory notes to this Category)*		
16525	**Fee:** $230.20	**Benefit:** 75% = $172.65	85% = $195.70
	POST-PARTUM CARE		
	EVACUATION OF RETAINED PRODUCTS OF CONCEPTION (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure *(See para T4.6 of explanatory notes to this Category)*		
16564	**Fee:** $169.75	**Benefit:** 75% = $127.35	85% = $144.30
	MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure *(See para T4.6 of explanatory notes to this Category)*		
16567	**Fee:** $248.30	**Benefit:** 75% = $186.25	85% = $211.10
	ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure *(See para T4.6 of explanatory notes to this Category)*		
16570	**Fee:** $323.85	**Benefit:** 75% = $242.90	85% = $275.30
	CERVIX, repair of extensive laceration or lacerations *(See para T4.6 of explanatory notes to this Category)*		
16571	**Fee:** $248.30	**Benefit:** 75% = $186.25	85% = $211.10
	THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure *(See para T4.6 of explanatory notes to this Category)*		
16573	**Fee:** $202.30	**Benefit:** 75% = $151.75	85% = $172.00
	INTERVENTIONAL TECHNIQUES		
	AMNIOCENTESIS, diagnostic *(See para T4.7 of explanatory notes to this Category)*		
16600	**Fee:** $49.40	**Benefit:** 75% = $37.05	85% = $42.00
	CHORIONIC VILLUS SAMPLING, by any route *(See para T4.7 of explanatory notes to this Category)*		
16603	**Fee:** $94.95	**Benefit:** 75% = $71.25	85% = $80.75
	FETAL BLOOD SAMPLING, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes. 17707 = 4B + 3T) *(See para T4.7 of explanatory notes to this Category)*		
16606	**Fee:** $189.30	**Benefit:** 75% = $142.00	85% = $160.95
	FETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling (Anaes. 17712 = 4B + 8T) *(See para T4.7 of explanatory notes to this Category)*		
16609	**Fee:** $386.15	**Benefit:** 75% = $289.65	85% = $335.25

16612	FETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling - not performed in conjunction with a service described in item 16609 (Anaes. 17711 = 4B + 7T) *(See para T4.7 of explanatory notes to this Category)* **Fee:** $303.85 **Benefit:** 75% = $227.90 85% = $258.30
16615	FETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes. 17710 = 4B + 6T) *(See para T4.7 of explanatory notes to this Category)* **Fee:** $161.75 **Benefit:** 75% = $121.35 85% = $137.50
16618	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated *(See para T4.7 of explanatory notes to this Category)* **Fee:** $161.75 **Benefit:** 75% = $121.35 85% = $137.50
16621	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios *(See para T4.7 of explanatory notes to this Category)* **Fee:** $161.75 **Benefit:** 75% = $121.35 85% = $137.50
16624	FETAL FLUID FILLED CAVITY, drainage of *(See para T4.7 of explanatory notes to this Category)* **Fee:** $232.85 **Benefit:** 75% = $174.65 85% = $197.95
16627	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis *(See para T4.7 of explanatory notes to this Category)* **Fee:** $474.05 **Benefit:** 75% = $355.55 85% = $423.15
16633	PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16606, 16609, 16612, 16615 and 16627 *(See para T4.7 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee for the first foetus for any additional foetus tested
16636	PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16600, 16603, 16618, 16621 and 16624 *(See para T4.7 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee for the first foetus for any additional foetus tested

	GROUP T5 - ASSISTANCE IN THE ADMINISTRATION OF AN ANAESTHETIC
17503	Assistance in the administration of an anaesthetic requiring continuous anaesthesia on a patient in imminent danger of death requiring continuous life saving emergency treatment, to the exclusion of all other patients *(See para T5.1 of explanatory notes to this Category)* **Derived Fee:** 30% of the fee for the administration of the anaesthetic
17506	Assistance in the administration of an elective anaesthetic, where: (i) the patient has complex airway problems; or (ii) the patient is a neonate or a complex paediatric case; or (iii) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or (iv) the patient is critically ill, with multiple organ failure; and where the anaesthesia time is expected to exceed 6 hours and the assistance is provided to the exclusion of all other patients *(See para T5.2 of explanatory notes to this Category)* **Derived Fee:** 30% of the fee for the administration of the anaesthetic

GROUP T6 - ANAESTHETICS

SUBGROUP 1 - EXAMINATION BY AN ANAESTHETIST

(Note: See paragraph T6.1.1 and T6.1.5 for explanatory note relating to this item)

	17603	EXAMINATION OF A PATIENT IN PREPARATION FOR THE ADMINISTRATION OF AN ANAESTHETIC RELATING TO A CLINICALLY RELEVANT SERVICE, being an examination carried out at a place other than an operating theatre or an anaesthetic induction room **Fee:** $33.40	**Benefit:** 75% = $25.05	85% = $28.40

SUBGROUP 2 - ADMINISTRATION OF AN ANAESTHETIC IN CONNECTION WITH A MEDICAL SERVICE

		ADMINISTRATION OF AN ANAESTHETIC - In connection with a medical service which has been assigned an anaesthetic unit value of		
	17701	- ONE UNIT **Fee:** $14.80	**Benefit:** 75% = $11.10	85% = $12.60
	17702	- TWO UNITS **Fee:** $29.60	**Benefit:** 75% = $22.20	85% = $25.20
	17703	- THREE UNITS **Fee:** $44.40	**Benefit:** 75% = $33.30	85% = $37.75
	17704	- FOUR UNITS **Fee:** $59.20	**Benefit:** 75% = $44.40	85% = $50.35
	17705	- FIVE UNITS **Fee:** $74.00	**Benefit:** 75% = $55.50	85% = $62.90
	17706	- SIX UNITS **Fee:** $88.80	**Benefit:** 75% = $66.60	85% = $75.50
	17707	- SEVEN UNITS **Fee:** $103.60	**Benefit:** 75% = $77.70	85% = $88.10
	17708	- EIGHT UNITS **Fee:** $118.40	**Benefit:** 75% = $88.80	85% = $100.65
	17709	- NINE UNITS **Fee:** $133.20	**Benefit:** 75% = $99.90	85% = $113.25
	17710	- TEN UNITS **Fee:** $148.00	**Benefit:** 75% = $111.00	85% = $125.80
	17711	- ELEVEN UNITS **Fee:** $162.80	**Benefit:** 75% = $122.10	85% = $138.40
	17712	- TWELVE UNITS **Fee:** $177.60	**Benefit:** 75% = $133.20	85% = $151.00
	17713	- THIRTEEN UNITS **Fee:** $192.40	**Benefit:** 75% = $144.30	85% = $163.55
	17714	- FOURTEEN UNITS **Fee:** $207.20	**Benefit:** 75% = $155.40	85% = $176.15
	17715	- FIFTEEN UNITS **Fee:** $222.00	**Benefit:** 75% = $166.50	85% = $188.70
	17716	- SIXTEEN UNITS **Fee:** $236.80	**Benefit:** 75% = $177.60	85% = $201.30
	17717	- SEVENTEEN UNITS **Fee:** $251.60	**Benefit:** 75% = $188.70	85% = $213.90

17718	- EIGHTEEN UNITS **Fee:** $266.40	**Benefit:** 75% = $199.80	85% = $226.45
17719	- NINETEEN UNITS **Fee:** $281.20	**Benefit:** 75% = $210.90	85% = $239.05
17720	- TWENTY UNITS **Fee:** $296.00	**Benefit:** 75% = $222.00	85% = $251.60
17721	- TWENTY-ONE UNITS **Fee:** $310.80	**Benefit:** 75% = $233.10	85% = $264.20
17722	- TWENTY-TWO UNITS **Fee:** $325.60	**Benefit:** 75% = $244.20	85% = $276.80
17723	- TWENTY-THREE UNITS **Fee:** $340.40	**Benefit:** 75% = $255.30	85% = $289.50
17724	- TWENTY-FOUR UNITS **Fee:** $355.20	**Benefit:** 75% = $266.40	85% = $304.30
17725	- TWENTY-FIVE UNITS **Fee:** $370.00	**Benefit:** 75% = $277.50	85% = $319.10
17726	- TWENTY-SIX UNITS **Fee:** $384.80	**Benefit:** 75% = $288.60	85% = $333.90
17727	- TWENTY-SEVEN UNITS **Fee:** $399.60	**Benefit:** 75% = $299.70	85% = $348.70
17728	- TWENTY-EIGHT UNITS **Fee:** $414.40	**Benefit:** 75% = $310.80	85% = $363.50
17729	- TWENTY-NINE UNITS **Fee:** $429.20	**Benefit:** 75% = $321.90	85% = $378.30
17730	- THIRTY UNITS **Fee:** $444.00	**Benefit:** 75% = $333.00	85% = $393.10
17731	- THIRTY-ONE UNITS **Fee:** $458.80	**Benefit:** 75% = $344.10	85% = $407.90
17732	- THIRTY-TWO UNITS **Fee:** $473.60	**Benefit:** 75% = $355.20	85% = $422.70
17733	- THIRTY-THREE UNITS **Fee:** $488.40	**Benefit:** 75% = $366.30	85% = $437.50
17734	- THIRTY-FOUR UNITS **Fee:** $503.20	**Benefit:** 75% = $377.40	85% = $452.30
17735	- THIRTY-FIVE UNITS **Fee:** $518.00	**Benefit:** 75% = $388.50	85% = $467.10
17736	- THIRTY-SIX UNITS **Fee:** $532.80	**Benefit:** 75% = $399.60	85% = $481.90
17737	- THIRTY-SEVEN UNITS **Fee:** $547.60	**Benefit:** 75% = $410.70	85% = $496.70
17738	- THIRTY-EIGHT UNITS **Fee:** $562.40	**Benefit:** 75% = $421.80	85% = $511.50
17739	- THIRTY-NINE UNITS **Fee:** $577.20	**Benefit:** 75% = $432.90	85% = $526.30

ANAESTHETICS			MEDICAL SERVICE
17740	- FORTY UNITS **Fee:** $592.00	**Benefit:** 75% = $444.00	85% = $541.10
17741	- FORTY-ONE UNITS **Fee:** $606.80	**Benefit:** 75% = $455.10	85% = $555.90
17742	- FORTY-TWO UNITS **Fee:** $621.60	**Benefit:** 75% = $466.20	85% = $570.70
17743	- FORTY-THREE UNITS **Fee:** $636.40	**Benefit:** 75% = $477.30	85% = $585.50
17744	- FORTY-FOUR UNITS **Fee:** $651.20	**Benefit:** 75% = $488.40	85% = $600.30
17745	- FORTY-FIVE UNITS **Fee:** $666.00	**Benefit:** 75% = $499.50	85% = $615.10
17746	- FORTY-SIX UNITS **Fee:** $680.80	**Benefit:** 75% = $510.60	85% = $629.90
17747	- FORTY-SEVEN UNITS **Fee:** $695.60	**Benefit:** 75% = $521.70	85% = $644.70
17748	- FORTY-EIGHT UNITS **Fee:** $710.40	**Benefit:** 75% = $532.80	85% = $659.50
17749	- FORTY-NINE UNITS **Fee:** $725.20	**Benefit:** 75% = $543.90	85% = $674.30
17750	- FIFTY UNITS **Fee:** $740.00	**Benefit:** 75% = $555.00	85% = $689.10
17751	- FIFTY-ONE UNITS **Fee:** $754.80	**Benefit:** 75% = $566.10	85% = $703.90
17752	- FIFTY-TWO UNITS **Fee:** $769.60	**Benefit:** 75% = $577.20	85% = $718.70
17753	- FIFTY-THREE UNITS **Fee:** $784.40	**Benefit:** 75% = $588.30	85% = $733.50
17754	- FIFTY-FOUR UNITS **Fee:** $799.20	**Benefit:** 75% = $599.40	85% = $748.30
17755	- FIFTY-FIVE UNITS **Fee:** $814.00	**Benefit:** 75% = $610.50	85% = $763.10
17756	- FIFTY-SIX UNITS **Fee:** $828.80	**Benefit:** 75% = $621.60	85% = $777.90
17757	- FIFTY-SEVEN UNITS **Fee:** $843.60	**Benefit:** 75% = $632.70	85% = $792.70
17758	- FIFTY-EIGHT UNITS **Fee:** $858.40	**Benefit:** 75% = $643.80	85% = $807.50
17759	- FIFTY-NINE UNITS **Fee:** $873.20	**Benefit:** 75% = $654.90	85% = $822.30
17760	- SIXTY UNITS **Fee:** $888.00	**Benefit:** 75% = $666.00	85% = $837.10
17761	- SIXTY-ONE UNITS **Fee:** $902.80	**Benefit:** 75% = $677.10	85% = $851.90

17762	- SIXTY-TWO UNITS **Fee:** $917.60	**Benefit:** 75% = $688.20	85% = $866.70
17763	- SIXTY-THREE UNITS **Fee:** $932.40	**Benefit:** 75% = $699.30	85% = $881.50
17764	- SIXTY-FOUR UNITS **Fee:** $947.20	**Benefit:** 75% = $710.40	85% = $896.30
17765	- SIXTY-FIVE UNITS **Fee:** $962.00	**Benefit:** 75% = $721.50	85% = $911.10
17766	- SIXTY-SIX UNITS **Fee:** $976.80	**Benefit:** 75% = $732.60	85% = $925.90
17767	- SIXTY-SEVEN UNITS **Fee:** $991.60	**Benefit:** 75% = $743.70	85% = $940.70
17768	- SIXTY-EIGHT UNITS **Fee:** $1,006.40	**Benefit:** 75% = $754.80	85% = $955.50
17769	- SIXTY-NINE UNITS **Fee:** $1,021.20	**Benefit:** 75% = $765.90	85% = $970.30
17770	- SEVENTY UNITS **Fee:** $1,036.00	**Benefit:** 75% = $777.00	85% = $985.10
17771	- SEVENTY-ONE UNITS **Fee:** $1,050.80	**Benefit:** 75% = $788.10	85% = $999.90
17772	- SEVENTY-TWO UNITS **Fee:** $1,065.60	**Benefit:** 75% = $799.20	85% = $1,014.70
17773	- SEVENTY-THREE UNITS **Fee:** $1,080.40	**Benefit:** 75% = $810.30	85% = $1,029.50
17774	- SEVENTY-FOUR UNITS **Fee:** $1,095.20	**Benefit:** 75% = $821.40	85% = $1,044.30
17775	- SEVENTY-FIVE UNITS **Fee:** $1,110.00	**Benefit:** 75% = $832.50	85% = $1,059.10
17776	- SEVENTY-SIX UNITS **Fee:** $1,124.80	**Benefit:** 75% = $843.60	85% = $1,073.90
17777	- SEVENTY-SEVEN UNITS **Fee:** $1,139.60	**Benefit:** 75% = $854.70	85% = $1,088.70
17778	- SEVENTY-EIGHT UNITS **Fee:** $1,154.40	**Benefit:** 75% = $865.80	85% = $1,103.50
17779	- SEVENTY-NINE UNITS **Fee:** $1,169.20	**Benefit:** 75% = $876.90	85% = $1,118.30
17780	- EIGHTY UNITS **Fee:** $1,184.00	**Benefit:** 75% = $888.00	85% = $1,133.10
17781	- EIGHTY-ONE UNITS **Fee:** $1,198.80	**Benefit:** 75% = $899.10	85% = $1,147.90
17782	- EIGHTY-TWO UNITS **Fee:** $1,213.60	**Benefit:** 75% = $910.20	85% = $1,162.70
17783	- EIGHTY-THREE UNITS **Fee:** $1,228.40	**Benefit:** 75% = $921.30	85% = $1,177.50

17784	- EIGHTY-FOUR UNITS **Fee:** $1,243.20	**Benefit:** 75% = $932.40	85% = $1,192.30
17785	- EIGHTY-FIVE UNITS **Fee:** $1,258.00	**Benefit:** 75% = $943.50	85% = $1,207.10
17786	- EIGHTY-SIX UNITS **Fee:** $1,272.80	**Benefit:** 75% = $954.60	85% = $1,221.90
17787	- EIGHTY-SEVEN UNITS **Fee:** $1,287.60	**Benefit:** 75% = $965.70	85% = $1,236.70
17788	- EIGHTY-EIGHT **Fee:** $1,302.40	**Benefit:** 75% = $976.80	85% = $1,251.50
17789	- EIGHTY-NINE UNITS **Fee:** $1,317.20	**Benefit:** 75% = $987.90	85% = $1,266.30
17790	- NINETY UNITS **Fee:** $1,332.00	**Benefit:** 75% = $999.00	85% = $1,281.10
17791	- NINETY-ONE UNITS **Fee:** $1,346.80	**Benefit:** 75% = $1,010.10	85% = $1,295.90
17792	- NINETY-TWO UNITS **Fee:** $1,361.60	**Benefit:** 75% = $1,021.20	85% = $1,310.70
17793	- NINETY-THREE UNITS **Fee:** $1,376.40	**Benefit:** 75% = $1,032.30	85% = $1,325.50
17794	- NINETY-FOUR UNITS **Fee:** $1,391.20	**Benefit:** 75% = $1,043.40	85% = $1,340.30
17795	- NINETY-FIVE UNITS **Fee:** $1,406.00	**Benefit:** 75% = $1,054.50	85% = $1,355.10
17796	- NINETY-SIX UNITS **Fee:** $1,420.80	**Benefit:** 75% = $1,065.60	85% = $1,369.90
17797	- NINETY-SEVEN UNITS **Fee:** $1,435.60	**Benefit:** 75% = $1,076.70	85% = $1,384.70
17798	- NINETY-EIGHT UNITS **Fee:** $1,450.40	**Benefit:** 75% = $1,087.80	85% = $1,399.50
17799	- NINETY-NINE UNITS **Fee:** $1,465.20	**Benefit:** 75% = $1,098.90	85% = $1,414.30
17800	Where the anaesthetic time exceeds the normal anaesthetic time for the procedure by more than 1 hour - applicable to anaesthesia assigned up to 12 anaesthetic time units *(See para T6.3 of explanatory notes to this Category)* **Derived Fee:** $14.80 for each additional anaesthetic time unit beyond the assigned number of anaesthetic time units		
17805	Where the anaesthetic time exceeds the normal anaesthetic time for the procedure by more than 1 hour and 30 minutes - applicable to anaesthesia assigned 13 to 24 anaesthetic time units *(See para T6.3 of explanatory notes to this Category)* **Derived Fee:** $14.80 for each additional anaesthetic time unit beyond the assigned number of anaesthetic time units		
17810	- Where the anaesthetic time exceeds the normal anaesthetic time for the procedure by more than 2 hours - applicable to anaesthesia assigned more than 24 anaesthetic time units *(See para T6.3 of explanatory notes to this Category)* **Derived Fee:** $14.80 for each additional anaesthetic time unit beyond the assigned number of anaesthetic time units		
17965	- In connection with radiotherapy (Anaes. = 7B + 4T) **Fee:** $162.80	**Benefit:** 75% = $122.10	85% = $138.40

17968	- In connection with forceps delivery, vacuum extraction delivery, breech delivery by manipulation or rotation of head followed by delivery (Anaes. = 5B + 3T) **Fee:** $118.40 **Benefit:** 75% = $88.80 85% = $100.65
17970	- In connection with an operative procedure to which Item 30001 applies *(See para T6.5 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee for the administration of the anaesthetic had the procedure not been discontinued
17974	- Where the anaesthetic is administered as a therapeutic procedure (Anaes. = 5B + 5T) **Fee:** $148.00 **Benefit:** 75% = $111.00 85% = $125.80
17977	- In connection with reamputation of amputation stump referred to in item 44376 **Derived Fee:** 85% of the fee specified for the anaesthetic for the amputation
17980	- In connection with computerised tomography brain scan with or without contrast medium study (Anaes. = 7B + 4T) **Fee:** $162.80 **Benefit:** 75% = $122.10 85% = $138.40
17983	- In connection with computerised tomography body scan with or without contrast medium study (Anaes. = 7B + 4T) **Fee:** $162.80 **Benefit:** 75% = $122.10 85% = $138.40
17986	- In connection with the removal of phaeochromocytoma (Anaes. = 10B + 15T) **Fee:** $370.00 **Benefit:** 75% = $277.50 85% = $319.10
17989	- In connection with peripheral venous cannulation (Anaes. = 3B + 2T) **Fee:** $74.00 **Benefit:** 75% = $55.50 85% = $62.90
17992	- In connection with peripheral venous cannulation by open exposure (Anaes. = 3B + 2T) **Fee:** $74.00 **Benefit:** 75% = $55.50 85% = $62.90
17995	- In connection with percutaneous central venous cannulation (Anaes. = 5B + 2T) **Fee:** $103.60 **Benefit:** 75% = $77.70 85% = $88.10
17998	- In connection with electrocochleography (insertion of electrodes and brain stem evoked response audiometry) (Anaes. = 5B + 7T) **Fee:** $177.60 **Benefit:** 75% = $133.20 85% = $151.00
18001	- In connection with manual removal of products of conception, treatment of postpartum haemorrhage or repair of third degree tear (Anaes. = 4B + 3T) **Fee:** $103.60 **Benefit:** 75% = $77.70 85% = $88.10
18004	- In connection with repair of extensive laceration or lacerations of cervix or manipulative correction of acute inversion of uterus by vaginal approach (Anaes. = 4B + 4T) **Fee:** $118.40 **Benefit:** 75% = $88.80 85% = $100.65
18007	- In connection with Caesarean section (Anaes. = 10B + 5T) **Fee:** $222.00 **Benefit:** 75% = $166.50 85% = $188.70
18010	- In connection with repair of episiotomy (Anaes. = 3B + 2T) **Fee:** $74.00 **Benefit:** 75% = $55.50 85% = $62.90
18013	- In connection with magnetic resonance imaging services covered by Items 63000 to 63946 (Anaes. = 7B + 7T) **Fee:** $207.20 **Benefit:** 75% = $155.40 85% = $176.15
18016	- In connection with a regional or field nerve block covered by item 18216, 18219, 18230, 18232, 18233, 18234, 18236, 18242, 18262, 18280, 18284, 18286, 18288, 18290, 18292, 18294, 18296 or 18298, not being an anaesthetic administered in conjunction with an operative procedure (Anaes. = 4B + 4T) **Fee:** $118.40 **Benefit:** 75% = $88.80 85% = $100.65
18019	- For incision and drainage of large haematoma, large abscess, cellulitis or similar lesion causing life threatening airway obstruction, or for the relief of life threatening airway obstruction due to epiglottitus (Anaes. = 15B + 4T) **Fee:** $281.20 **Benefit:** 75% = $210.90 85% = $239.05
18021	- In connection with muscle biopsy for malignant hyperpyrexia (Anaes. = 10B + 3T) **Fee:** $192.40 **Benefit:** 75% = $144.30 85% = $163.55
18022	- In connection with digital subtraction angiography (Anaes. = 7B + 3T) **Fee:** $148.00 **Benefit:** 75% = $111.00 85% = $125.80

18026	- During hyperbaric therapy where the medical practitioner is not confined in the chamber (including the administration of oxygen) (Anaes. = 8B + 6T) **Fee:** $207.20 **Benefit:** 75% = $155.40 85% = $176.15
18027	- During hyperbaric therapy where the medical practitioner is confined in the chamber (including the administration of oxygen) (Anaes. = 15B + 11T) **Fee:** $384.80 **Benefit:** 75% = $288.60 85% = $333.90
18030	- Performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been allocated anaesthetic units where the anaesthesia time is up to and including 30 minutes (Anaes. = 4B + 2T) **Fee:** $88.80 **Benefit:** 75% = $66.60 85% = $75.50
18031	- Performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been allocated anaesthetic units where the anaesthesia time exceeds 30 minutes and is up to and including 60 minutes (Anaes. = 4B + 4T) **Fee:** $118.40 **Benefit:** 75% = $88.80 85% = $100.65
18032	- Performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been allocated anaesthetic units where the anaesthesia time exceeds 60 minutes (Anaes. = 4B + 5T) **Fee:** $133.20 **Benefit:** 75% = $99.90 85% = $113.25
18033	- In connection with a procedure covered by an item which has not been allocated anaesthetic units, not being a service to which item 18030, 18031 or 18032 applies, where it can be demonstrated that there is a clinical need for anaesthesia *(See para T6.6 of explanatory notes to this Category)* **Derived Fee:** $59.20 (4 basic units) plus $14.80 for each 15 minutes of anaesthesia time
18035	- In connection with a change of dressing or change of plaster undertaken in a hospital or approved day-hospital facility (Anaes. = 3B + 2T) **Fee:** $74.00 **Benefit:** 75% = $55.50 85% = $62.90
	SUBGROUP 3 - ADMINISTRATION OF AN ANAESTHETIC IN CONNECTION WITH A DENTAL SERVICE
18102	ADMINISTRATION by a medical practitioner OF AN ANAESTHETIC in connection with a dental operation other than for the extraction of teeth or restorative dental work where the procedure is less than 15 minutes duration (Anaes. = 5B + 1T) **Fee:** $88.80 **Benefit:** 75% = $66.60 85% = $75.50
18103	ADMINISTRATION by a medical practitioner OF AN ANAESTHETIC in connection with a dental operation other than for the extraction of teeth or restorative dental work where the procedure is more than 15 minutes duration (Anaes. = 5B + 3T) **Fee:** $118.40 **Benefit:** 75% = $88.80 85% = $100.65
18105	ADMINISTRATION by a medical practitioner OF AN ANAESTHETIC for extraction of a tooth or teeth, not being a service to which item 18109 applies (Anaes. = 5B + 2T) **Fee:** $103.60 **Benefit:** 75% = $77.70 85% = $88.10
18109	ADMINISTRATION by a medical practitioner of an ANAESTHETIC for removal of a tooth or teeth requiring incision of soft tissue and removal of bone (Anaes. = 5B + 4T) **Fee:** $133.20 **Benefit:** 75% = $99.90 85% = $113.25
18113	ADMINISTRATION by a medical practitioner of an ANAESTHETIC for restorative dental work where the procedure is of not more than 30 minutes duration (Anaes. = 5B + 2T) **Fee:** $103.60 **Benefit:** 75% = $77.70 85% = $88.10
18118	ADMINISTRATION by a medical practitioner of an ANAESTHETIC for restorative dental work where the procedure is of more than 30 minutes duration (Anaes. = 5B + 6T) **Fee:** $162.80 **Benefit:** 75% = $122.10 85% = $138.40
18119	ADMINISTRATION by a medical practitioner of an ANAESTHETIC in connection with a dental operation where the procedure is of more than 3 hours duration (Anaes. = 5B + 12T) *(See para T6.4 of explanatory notes to this Category)* **Fee:** $251.60 **Benefit:** 75% = $188.70 85% = $213.90

GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS

86.C

(Note: Where an anaesthetic combines a regional nerve block with a general anaesthetic for an operative procedure, benefits will be paid only under the anaesthetic item relevant to the operation. The only instance where additional benefits are payable under an item in this Group is in relation to item 18206 or 18209, or for item 18210 to 18212 which apply to post-operative pain management)

18206	INTRODUCTION OF A NARCOTIC, for the control of postoperative pain, into the epidural or intrathecal space in conjunction with an operation *(See para T7.3 of explanatory notes to this Category)* **Fee:** $39.05	**Benefit:** 75% = $29.30	85% = $33.20
18209	INTRODUCTION OF LOCAL ANAESTHETIC, for control of postoperative pain, into the epidural or intrathecal space, in conjunction with an operation *(See para T7.4 of explanatory notes to this Category)* **Fee:** $39.05	**Benefit:** 75% = $29.30	85% = $33.20
18210	INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the femoral **OR** sciatic nerves, in conjunction with knee, ankle or foot surgery *(See para T7.5 of explanatory notes to this Category)* **Fee:** $34.55	**Benefit:** 75% = $25.95	85% = $29.40
18211	INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the femoral **AND** sciatic nerves, in conjunction with knee, ankle or foot surgery *(See para T7.5 of explanatory notes to this Category)* **Fee:** $41.45	**Benefit:** 75% = $31.10	85% = $35.25
18212	INTRODUCTION OF A REGIONAL OR FIELD NERVE block peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the brachial plexus in conjunction with shoulder surgery *(See para T7.5 of explanatory notes to this Category)* **Fee:** $34.55	**Benefit:** 75% = $25.95	85% = $29.40
18213	INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion **Fee:** $69.05	**Benefit:** 75% = $51.80	85% = $58.70
18216	INTRATHECAL OR EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner **Fee:** $147.85	**Benefit:** 75% = $110.90	85% = $125.70
18219	INTRATHECAL or EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, where continuous attendance by the medical practitioner extends beyond the first hour **Derived Fee:** The fee for item 18216 plus $14.80 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner		
18222	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is 15 minutes or less *(See para T7.6 of explanatory notes to this Category)* **Fee:** $29.30	**Benefit:** 75% = $22.00	85% = $24.95
18225	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is more than 15 minutes *(See para T7.6 of explanatory notes to this Category)* **Fee:** $39.05	**Benefit:** 75% = $29.30	85% = $33.20
18228	INTERPLEURAL BLOCK, initial injection or commencement of infusion of a therapeutic substance **Fee:** $48.65	**Benefit:** 75% = $36.50	85% = $41.40
18230	INTRATHECAL or EPIDURAL INJECTION of neurolytic substance **Fee:** $185.65	**Benefit:** 75% = $139.25	85% = $157.85
18232	INTRATHECAL or EPIDURAL INJECTION of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies *(See para T7.7 of explanatory notes to this Category)* **Fee:** $147.85	**Benefit:** 75% = $110.90	85% = $125.70

18233	EPIDURAL INJECTION of blood for blood patch **Fee:** $147.85	**Benefit:** 75% = $110.90	85% = $125.70
18234	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent **Fee:** $97.20	**Benefit:** 75% = $72.90	85% = $82.65
18236	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent **Fee:** $48.65	**Benefit:** 75% = $36.50	85% = $41.40
18238	FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies **Fee:** $29.30	**Benefit:** 75% = $22.00	85% = $24.95
18240	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent **Fee:** $72.85	**Benefit:** 75% = $54.65	85% = $61.95
18242	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent **Fee:** $29.30	**Benefit:** 75% = $22.00	85% = $24.95
18244	VAGUS NERVE, injection of an anaesthetic agent **Fee:** $78.45	**Benefit:** 75% = $58.85	85% = $66.70
18246	GLOSSOPHARYNGEAL NERVE, injection of an anaesthetic agent **Fee:** $78.45	**Benefit:** 75% = $58.85	85% = $66.70
18248	PHRENIC NERVE, injection of an anaesthetic agent **Fee:** $69.05	**Benefit:** 75% = $51.80	85% = $58.70
18250	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent **Fee:** $48.65	**Benefit:** 75% = $36.50	85% = $41.40
18252	CERVICAL PLEXUS, injection of an anaesthetic agent **Fee:** $78.45	**Benefit:** 75% = $58.85	85% = $66.70
18254	BRACHIAL PLEXUS, injection of an anaesthetic agent **Fee:** $78.45	**Benefit:** 75% = $58.85	85% = $66.70
18256	SUPRASCAPULAR NERVE, injection of an anaesthetic agent **Fee:** $48.65	**Benefit:** 75% = $36.50	85% = $41.40
18258	INTERCOSTAL NERVE (single), injection of an anaesthetic agent **Fee:** $48.65	**Benefit:** 75% = $36.50	85% = $41.40
18260	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent **Fee:** $69.05	**Benefit:** 75% = $51.80	85% = $58.70
18262	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent **Fee:** $48.65	**Benefit:** 75% = $36.50	85% = $41.40
18264	PUDENDAL NERVE, injection of an anaesthetic agent **Fee:** $78.45	**Benefit:** 75% = $58.85	85% = $66.70
18266	ULNAR, RADIAL OR MEDIAN NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent, not being associated with a brachial plexus block **Fee:** $48.65	**Benefit:** 75% = $36.50	85% = $41.40
18268	OBTURATOR NERVE, injection of an anaesthetic agent **Fee:** $69.05	**Benefit:** 75% = $51.80	85% = $58.70
18270	FEMORAL NERVE, injection of an anaesthetic agent **Fee:** $69.05	**Benefit:** 75% = $51.80	85% = $58.70
18272	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent **Fee:** $48.65	**Benefit:** 75% = $36.50	85% = $41.40

REGIONAL OR FIELD NERVE BLOCKS				REGIONAL OR FIELD NERVE BLOCKS
18274	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level) **Fee:** $69.05	**Benefit:** 75% = $51.80	85% = $58.70	
18276	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels) **Fee:** $97.20	**Benefit:** 75% = $72.90	85% = $82.65	
18278	SCIATIC NERVE, injection of an anaesthetic agent **Fee:** $69.05	**Benefit:** 75% = $51.80	85% = $58.70	
18280	SPHENOPALATINE GANGLION, injection of an anaesthetic agent **Fee:** $97.20	**Benefit:** 75% = $72.90	85% = $82.65	
18282	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure **Fee:** $78.45	**Benefit:** 75% = $58.85	85% = $66.70	
18284	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) **Fee:** $114.95	**Benefit:** 75% = $86.25	85% = $97.75	
18286	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) **Fee:** $114.95	**Benefit:** 75% = $86.25	85% = $97.75	
18288	COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent **Fee:** $114.95	**Benefit:** 75% = $86.25	85% = $97.75	
18290	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent **Fee:** $194.45	**Benefit:** 75% = $145.85	85% = $165.30	
18292	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies *(See para T7.8 of explanatory notes to this Category)* **Fee:** $97.20	**Benefit:** 75% = $72.90	85% = $82.65	
18294	COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent **Fee:** $137.00	**Benefit:** 75% = $102.75	85% = $116.45	
18296	LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent **Fee:** $117.15	**Benefit:** 75% = $87.90	85% = $99.60	
18298	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent **Fee:** $137.00	**Benefit:** 75% = $102.75	85% = $116.45	

GROUP T8 - SURGICAL OPERATIONS

29.7%

SUBGROUP 1 - GENERAL

30001	OPERATIVE PROCEDURE, not being a service to which any other item in this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds *(See para T8.8 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee which would have applied had the procedure not been discontinued		
30003	LOCALISED BURNS, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation **Fee:** $27.00	**Benefit:** 75% = $20.25	85% = $22.95
30006	EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation **Fee:** $36.20	**Benefit:** 75% = $27.15	85% = $30.80
30009 G 30010 S	LOCALISED BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes. 17708 = 4B + 4T) **Fee:** $47.25 **Fee:** $57.55	**Benefit:** 75% = $35.45 **Benefit:** 75% = $43.20	85% = $40.20 85% = $48.95
30013 G 30014 S	EXTENSIVE BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes. 17710 = 4B + 6T) **Fee:** $101.85 **Fee:** $121.00	**Benefit:** 75% = $76.40 **Benefit:** 75% = $90.75	85% = $86.60 85% = $102.85
30017	BURNS, excision of, under general anaesthesia, involving not more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $253.80	**Benefit:** 75% = $190.35	85% = $215.75
30020	BURNS, excision of, under general anaesthesia, involving more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes. 17715 = 4B + 11T) (Assist.) **Fee:** $494.35	**Benefit:** 75% = $370.80	85% = $443.45
30023	WOUND OF SOFT TISSUE, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes. 17707 = 4B + 3T) (Assist.) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $253.80	**Benefit:** 75% = $190.35	85% = $215.75
30026	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes. 17706 = 4B + 2T) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $40.65	**Benefit:** 75% = $30.50	85% = $34.60
30029	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes. 17706 = 4B + 2T) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $70.05	**Benefit:** 75% = $52.55	85% = $59.55
30032	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes. 17709 = 4B + 5T) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $64.20	**Benefit:** 75% = $48.15	85% = $54.60
30035	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes. 17709 = 4B + 5T) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $91.50	**Benefit:** 75% = $68.65	85% = $77.80
30038	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes. 17709 = 4B + 5T) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $70.05	**Benefit:** 75% = $52.55	85% = $59.55

	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes. 17709 = 4B + 5T) *(See para T8.9 of explanatory notes to this Category)*		
30041 G	**Fee:** $112.15	**Benefit:** 75% = $84.15	85% = $95.35
30042 S	**Fee:** $144.60	**Benefit:** 75% = $108.45	85% = $122.95
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes. 17709 = 4B + 5T) *(See para T8.9 of explanatory notes to this Category)*		
30045	**Fee:** $91.50	**Benefit:** 75% = $68.65	85% = $77.80
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes. 17709 = 4B + 5T) *(See para T8.9 of explanatory notes to this Category)*		
30048 G	**Fee:** $116.60	**Benefit:** 75% = $87.45	85% = $99.15
30049 S	**Fee:** $144.60	**Benefit:** 75% = $108.45	85% = $122.95
	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes. 17711 = 5B + 6T) (Assist.)		
30052	**Fee:** $197.75	**Benefit:** 75% = $148.35	85% = $168.10
	WOUNDS, DRESSING OF, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in this Group applies (Anaes. 17706 = 4B + 2T)		
30055	**Fee:** $57.55	**Benefit:** 75% = $43.20	85% = $48.95
	POSTOPERATIVE HAEMORRHAGE, control of, under general anaesthesia, as an independent procedure (Anaes. 17705 = 3B + 2T)		
30058	**Fee:** $112.15	**Benefit:** 75% = $84.15	85% = $95.35
	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (Anaes. 17706 = 4B + 2T)		
30061	**Fee:** $18.25	**Benefit:** 75% = $13.70	85% = $15.55
	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes. 17707 = 4B + 3T)		
30064	**Fee:** $85.60	**Benefit:** 75% = $64.20	85% = $72.80
	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes. 17707 = 4B + 3T) (Assist.)		
30067 G	**Fee:** $174.10	**Benefit:** 75% = $130.60	85% = $148.00
30068 S	**Fee:** $215.45	**Benefit:** 75% = $161.60	85% = $183.15
	BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure (Anaes. 17706 = 4B + 2T)		
30071	**Fee:** $40.65	**Benefit:** 75% = $30.50	85% = $34.60
	BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure (Anaes. 17706 = 4B + 2T)		
30074 G	**Fee:** $91.50	**Benefit:** 75% = $68.65	85% = $77.80
30075 S	**Fee:** $116.60	**Benefit:** 75% = $87.45	85% = $99.15
	DRILL BIOPSY OF LYMPH GLAND, DEEP TISSUE OR ORGAN, as an independent procedure (Anaes. 17706 = 4B + 2T) *(See para T8.10 of explanatory notes to this Category)*		
30078	**Fee:** $37.70	**Benefit:** 75% = $28.30	85% = $32.05
	BIOPSY OF BONE MARROW by trephine using open approach (Anaes. 17706 = 4B + 2T)		
30081	**Fee:** $85.60	**Benefit:** 75% = $64.20	85% = $72.80
	BIOPSY OF BONE MARROW by trephine using percutaneous approach with a Jamshidi needle or similar device (Anaes. 17706 = 4B + 2T)		
30084	**Fee:** $45.75	**Benefit:** 75% = $34.35	85% = $38.90
	BIOPSY OF BONE MARROW by aspiration or PUNCH BIOPSY OF SYNOVIAL MEMBRANE (Anaes. 17706 = 4B + 2T)		
30087	**Fee:** $22.95	**Benefit:** 75% = $17.25	85% = $19.55
	BIOPSY OF PLEURA, PERCUTANEOUS 1 or more biopsies on any 1 occasion (Anaes. 17706 = 4B + 2T)		
30090	**Fee:** $100.05	**Benefit:** 75% = $75.05	85% = $85.05

	NEEDLE BIOPSY OF VERTEBRA (Anaes. 17708 = 4B + 4T)		
30093	**Fee:** $133.55	**Benefit:** 75% = $100.20	85% = $113.55
	PERCUTANEOUS ASPIRATION BIOPSY of deep organ using interventional imaging techniques - but not including imaging (Anaes. 17706 = 4B + 2T)		
30094	**Fee:** $147.45	**Benefit:** 75% = $110.60	85% = $125.35
	SCALENE NODE BIOPSY (Anaes. 17707 = 5B + 2T)		
30096	**Fee:** $143.15	**Benefit:** 75% = $107.40	85% = $121.70
	SINUS, excision of, involving superficial tissue only (Anaes. 17706 = 4B + 2T)		
30099	**Fee:** $70.05	**Benefit:** 75% = $52.55	85% = $59.55
	SINUS, excision of, involving muscle and deep tissue (Anaes. 17706 = 4B + 2T)		
30102 G	**Fee:** $116.60	**Benefit:** 75% = $87.45	85% = $99.15
30103 S	**Fee:** $143.15	**Benefit:** 75% = $107.40	85% = $121.70
	PRE-AURICULAR SINUS, excision of (Anaes. 17706 = 4B + 2T)		
30104	**Fee:** $98.85	**Benefit:** 75% = $74.15	85% = $84.05
	GANGLION OR SMALL BURSA, excision of, not being a service associated with a service to which another item in this Group applies (Anaes. 17706 = 4B + 2T)		
30106 G	**Fee:** $121.00	**Benefit:** 75% = $90.75	85% = $102.85
30107 S	**Fee:** $171.20	**Benefit:** 75% = $128.40	85% = $145.55
	BURSA (LARGE), INCLUDING OLECRANON, CALCANEUM OR PATELLA, excision of (Anaes. 17707 = 4B + 3T) (Assist.)		
30110 G	**Fee:** $221.40	**Benefit:** 75% = $166.05	85% = $188.20
30111 S	**Fee:** $289.20	**Benefit:** 75% = $216.90	85% = $245.85
	BURSA, SEMIMEMBRANOSUS (Baker's cyst), excision of (Anaes. 17707 = 3B + 4T) (Assist.)		
30114	**Fee:** $289.20	**Benefit:** 75% = $216.90	85% = $245.85
	LIPECTOMY transverse wedge excision of abdominal apron (Anaes. 17710 = 5B + 5T) (Assist.)		
30165	**Fee:** $354.15	**Benefit:** 75% = $265.65	85% = $303.25
	LIPECTOMY wedge excision of skin or fat not being a service to which item 30165 applies 1 EXCISION (Anaes. 17710 = 4B + 6T) (Assist.)		
30168	**Fee:** $354.15	**Benefit:** 75% = $265.65	85% = $303.25
	LIPECTOMY wedge excision of skin or fat not being a service to which item 30165 applies 2 OR MORE EXCISIONS (Anaes. 17712 = 4B + 8T) (Assist.) *(See para T8.11 of explanatory notes to this Category)*		
30171	**Fee:** $538.65	**Benefit:** 75% = $404.00	85% = $487.75
	LIPECTOMY subumbilical excision with undermining of skin edges and strengthening of musculoaponeurotic wall (Anaes. 17712 = 5B + 7T) (Assist.)		
30174	**Fee:** $538.65	**Benefit:** 75% = $404.00	85% = $487.75
	LIPECTOMY radical abdominoplasty (Pitanguy type or similar) with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus (Anaes. 17715 = 5B + 10T) (Assist.)		
30177	**Fee:** $767.40	**Benefit:** 75% = $575.55	85% = $716.50
	AXILLARY HYPERHIDROSIS, wedge excision for (Anaes. 17706 = 3B + 3T)		
30180	**Fee:** $106.25	**Benefit:** 75% = $79.70	85% = $90.35
	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes. 17709 = 3B + 6T)		
30183	**Fee:** $191.90	**Benefit:** 75% = $143.95	85% = $163.15
	PALMAR OR PLANTAR WART, removal of, not being a service to which item 30187 applies (Anaes. 17705 = 3B + 2T) *(See para T8.12 of explanatory notes to this Category)*		
30186	**Fee:** $36.95	**Benefit:** 75% = $27.75	85% = $31.45

30187	PALMAR OR PLANTAR WARTS, removal of, by carbon dioxide laser, requiring admission to a hospital or day-hospital facility, or when performed by a specialist in the practice of his/her specialty, where the time taken is greater than 45 minutes (5 or more warts) (Anaes. 17707 = 3B + 4T) *(See para T8.12 of explanatory notes to this Category)* **Fee:** $200.05	**Benefit:** 75% = $150.05	85% = $170.05
30189	WARTS or MOLLUSCUM CONTAGIOSUM, removal of, by any method (other than by chemical means), where undertaken in the operating theatre of a hospital or approved day-hospital facility, not being a service associated with a service to which another item in this Group applies (Anaes. 17705 = 4B + 1T) *(See para T8.12 of explanatory notes to this Category)* **Fee:** $114.65	**Benefit:** 75% = $86.00	85% = $97.50
30190	ANGIOFIBROMAS, TRICHOEPITHELIOMAS or other severely disfiguring tumours suitable for laser excision as confirmed by specialist opinion, of the face or neck, removal of, by carbon dioxide laser excision-ablation including associated resurfacing (10 or more tumours) (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $309.70	**Benefit:** 75% = $232.30	85% = $263.25
30192	PREMALIGNANT SKIN LESIONS, treatment of, by galvanocautery or electrodesiccation or cryocautery (10 or more lesions) (Anaes. 17706 = 4B + 2T) *(See para T8.12 of explanatory notes to this Category)* **Fee:** $30.85	**Benefit:** 75% = $23.15	85% = $26.25
30195	NEOPLASTIC SKIN LESIONS, other than viral verrucae (common warts) and seborrheic keratoses, treatment by electrosurgical destruction, simple curettage or shave excision, or laser photocoagulation, not being a service to which items 30196, 30197, 30202, 30203 or 30205 apply (1 or more lesions) (Anaes. 17706 = 4B + 2T) **Fee:** $49.40	**Benefit:** 75% = $37.05	85% = $42.00
30196	CANCER OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser excision-ablation, including any associated cryotherapy or diathermy, not being a service to which item 30197 applies (Anaes. 17706 = 4B + 2T) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $98.35	**Benefit:** 75% = $73.80	85% = $83.60
30197	CANCER OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser excision-ablation, including any associated cryotherapy or diathermy, (10 or more lesions) (Anaes. 17708 = 4B + 4T) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $342.60	**Benefit:** 75% = $256.95	85% = $291.70
30202	CANCER OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles, not being a service to which item 30203 applies *(See para T8.13 of explanatory notes to this Category)* **Fee:** $37.60	**Benefit:** 75% = $28.20	85% = $32.00
30203	CANCER OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles (10 OR MORE LESIONS) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $132.60	**Benefit:** 75% = $99.45	85% = $112.75
30205	CANCER OF SKIN proven by histopathology, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles WHERE CANCER EXTENDS INTO CARTILAGE (Anaes. 17706 = 4B + 2T) **Fee:** $98.35	**Benefit:** 75% = $73.80	85% = $83.60
30207	SKIN LESIONS, multiple injections with hydrocortisone or similar preparations (Anaes. 17706 = 4B + 2T) **Fee:** $34.70	**Benefit:** 75% = $26.05	85% = $29.50
30210	KELOID and other SKIN LESIONS, EXTENSIVE, MULTIPLE INJECTIONS OF HYDROCORTISONE or similar preparations where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17706 = 4B + 2T) **Fee:** $126.90	**Benefit:** 75% = $95.20	85% = $107.90
30213	TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - limited to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - for a session of at least 20 minutes duration (Anaes. 17707 = 5B + 2T) *(See para T8.14 of explanatory notes to this Category)* **Fee:** $85.50	**Benefit:** 75% = $64.15	85% = $72.70

30214	TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - session of at least 20 minutes duration - ***where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period*** *(See para T8.14 of explanatory notes to this Category)* **Fee:** $85.50 **Benefit:** 75% = $64.15 85% = $72.70
30216	HAEMATOMA, aspiration of (Anaes. 17705 = 4B + 1T) **Fee:** $21.25 **Benefit:** 75% = $15.95 85% = $18.10
30219	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital or day-hospital facilit - INCISION WITH DRAINAGE OF (excluding aftercare) **Fee:** $21.25 **Benefit:** 75% = $15.95 85% = $18.10
30223	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital or day-hospital facility, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes. 17706 = 4B + 2T) **Fee:** $126.90 **Benefit:** 75% = $95.20 85% = $107.90
30224	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imaging techniques - but not including imaging (Anaes. 17707 = 4B + 3T) **Fee:** $185.00 **Benefit:** 75% = $138.75 85% = $157.25
30225	ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes. 17706 = 4B + 2T) **Fee:** $208.35 **Benefit:** 75% = $156.30 85% = $177.10
30226	MUSCLE, excision of (LIMITED), or fasciotomy (Anaes. 17706 = 4B + 2T) **Fee:** $116.60 **Benefit:** 75% = $87.45 85% = $99.15
30229	MUSCLE, excision of (EXTENSIVE) (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $212.50 **Benefit:** 75% = $159.40 85% = $180.65
30232	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes. 17707 = 4B + 3T) **Fee:** $174.10 **Benefit:** 75% = $130.60 85% = $148.00
30235	MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $230.20 **Benefit:** 75% = $172.65 85% = $195.70
30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE (Anaes. 17707 = 4B + 3T) **Fee:** $116.60 **Benefit:** 75% = $87.45 85% = $99.15
30241	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in this Group applies (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $277.45 **Benefit:** 75% = $208.10 85% = $235.85
30244	STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes. 17708 = 5B + 3T) (Assist.) **Fee:** $277.45 **Benefit:** 75% = $208.10 85% = $235.85
30246	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $537.00 **Benefit:** 75% = $402.75 85% = $486.10
30247	PAROTID GLAND, total extirpation of (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $575.60 **Benefit:** 75% = $431.70 85% = $524.70
30250	PAROTID GLAND, total extirpation of, with preservation of facial nerve (Anaes. 17718 = 5B + 13T) (Assist.) **Fee:** $973.95 **Benefit:** 75% = $730.50 85% = $923.05
30251	RECURRENT PAROTID TUMOUR, excision of, with preservation of facial nerve (Anaes. 17723 = 5B + 18T) (Assist.) **Fee:** $1,496.10 **Benefit:** 75% = $1,122.10 85% = $1,445.20
30253	PAROTID GLAND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $649.40 **Benefit:** 75% = $487.05 85% = $598.50
30255	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $864.70 **Benefit:** 75% = $648.55 85% = $813.80

30256	SUBMANDIBULAR GLAND, extirpation of (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $346.80	**Benefit:** 75% = $260.10	85% = $295.90
30259	SUBLINGUAL GLAND, extirpation of (Anaes. 17707 = 5B + 2T) **Fee:** $153.45	**Benefit:** 75% = $115.10	85% = $130.45
30262	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes. 17706 = 5B + 1T) **Fee:** $45.75	**Benefit:** 75% = $34.35	85% = $38.90
30265 G 30266 S	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes. 17707 = 5B + 2T) **Fee:** $91.50 **Fee:** $116.60	**Benefit:** 75% = $68.65 **Benefit:** 75% = $87.45	85% = $77.80 85% = $99.15
30269	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes. 17707 = 5B + 2T) **Fee:** $116.60	**Benefit:** 75% = $87.45	85% = $99.15
30272	TONGUE, partial excision of (Anaes. 17707 = 5B + 2T) (Assist.) **Fee:** $230.20	**Benefit:** 75% = $172.65	85% = $195.70
30275	RADICAL EXCISION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE AND LYMPH GLANDS OF NECK (commandotype operation) (Anaes. 17718 = 7B + 11T) (Assist.) **Fee:** $1,372.45	**Benefit:** 75% = $1,029.35	85% = $1,321.55
30278	TONGUE TIE, repair of, not being a service to which another item in this Group applies (Anaes. 17707 = 5B + 2T) **Fee:** $36.20	**Benefit:** 75% = $27.15	85% = $30.80
30281	TONGUE TIE, MANDIBULAR FRENULUM or MAXILLARY FRENULUM, repair of, in a person aged 2 years and over, under general anaesthesia (Anaes. 17707 = 5B + 2T) **Fee:** $93.00	**Benefit:** 75% = $69.75	85% = $79.05
30282 G 30283 S	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes. 17709 = 5B + 4T) **Fee:** $121.00 **Fee:** $159.40	**Benefit:** 75% = $90.75 **Benefit:** 75% = $119.55	85% = $102.85 85% = $135.50
30286	BRANCHIAL CYST, removal of (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $309.80	**Benefit:** 75% = $232.35	85% = $263.35
30289	BRANCHIAL FISTULA, removal of (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $391.05	**Benefit:** 75% = $293.30	85% = $340.15
30293	CERVICAL OESOPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or without plastic repair (Anaes. 17715 = 6B + 9T) (Assist.) **Fee:** $346.80	**Benefit:** 75% = $260.10	85% = $295.90
30294	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes. 17723 = 6B + 17T) (Assist.) **Fee:** $1,372.45	**Benefit:** 75% = $1,029.35	85% = $1,321.55
30296	THYROIDECTOMY, total (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $797.05	**Benefit:** 75% = $597.80	85% = $746.15
30297	THYROIDECTOMY following previous thyroid surgery (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $797.05	**Benefit:** 75% = $597.80	85% = $746.15
30306	TOTAL HEMITHYROIDECTOMY (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $621.75	**Benefit:** 75% = $466.35	85% = $570.85
30308	BILATERAL SUBTOTAL THYROIDECTOMY (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $621.75	**Benefit:** 75% = $466.35	85% = $570.85
30309	THYROIDECTOMY, SUBTOTAL for THYROTOXICOSIS (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $797.05	**Benefit:** 75% = $597.80	85% = $746.15
30310	THYROID, unilateral subtotal thyroidectomy or equivalent partial thyroidectomy (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $356.10	**Benefit:** 75% = $267.10	85% = $305.20

30313	THYROGLOSSAL CYST, removal of (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $212.50 **Benefit:** 75% = $159.40 85% = $180.65
30314	THYROGLOSSAL CYST or FISTULA or both, radical removal of, including thyroglossal duct and portion of hyoid bone (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $356.10 **Benefit:** 75% = $267.10 85% = $305.20
30315	PARATHYROID operation for hyperparathyroidism (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $887.45 **Benefit:** 75% = $665.60 85% = $836.55
30317	CERVICAL REEXPLORATION for recurrent or persistent hyperparathyroidism (Anaes. 17720 = 6B + 14T) (Assist.) **Fee:** $1,062.70 **Benefit:** 75% = $797.05 85% = $1,011.80
30318	MEDIASTINUM, exploration of, via the cervical route, for hyperparathyroidism (including thymectomy) (Anaes. 17715 = 6B + 9T) (Assist.) **Fee:** $706.60 **Benefit:** 75% = $529.95 85% = $655.70
30320	MEDIASTINUM, exploration of, via mediastinotomy, for hyperparathyroidism (including thymectomy) (Anaes. 17717 = 6B + 11T) (Assist.) **Fee:** $1,062.70 **Benefit:** 75% = $797.05 85% = $1,011.80
30321	RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of (Anaes. 17722 = 10B + 12T) (Assist.) **Fee:** $706.60 **Benefit:** 75% = $529.95 85% = $655.70
30323	RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of, requiring complex and extensive dissection (Anaes. 17730 = 10B + 20T) (Assist.) **Fee:** $1,062.70 **Benefit:** 75% = $797.05 85% = $1,011.80
30324	ADRENAL GLAND TUMOUR, excision of (Anaes. 17725 = 10B + 15T) (Assist.) **Fee:** $1,062.70 **Benefit:** 75% = $797.05 85% = $1,011.80
30329	LYMPH GLANDS of GROIN, limited excision of (Anaes. 17709 = 3B + 6T) **Fee:** $192.20 **Benefit:** 75% = $144.15 85% = $163.40
30330	LYMPH GLANDS of GROIN, radical excision of (Anaes. 17713 = 3B + 10T) (Assist.) **Fee:** $559.60 **Benefit:** 75% = $419.70 85% = $508.70
30332	LYMPH NODES of AXILLA, limited excision of (sampling) (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $270.00 **Benefit:** 75% = $202.50 85% = $229.50
30335	LYMPH NODES of AXILLA, complete excision of, to level I (Anaes. 17713 = 5B + 8T) (Assist.) *(See para T8.15 of explanatory notes to this Category)* **Fee:** $674.90 **Benefit:** 75% = $506.20 85% = $624.00
30336	LYMPH NODES of AXILLA, complete excision of, to level II or level III (Anaes. 17715 = 5B + 10T) (Assist.) *(See para T8.15 of explanatory notes to this Category)* **Fee:** $809.95 **Benefit:** 75% = $607.50 85% = $759.05
30339	BREAST, BENIGN LESION up to and including 50mm in diameter, including simple cyst, fibroadenoma or fibrocystic disease, open surgical biopsy or excision of, with or without frozen section histology (Anaes. 17708 = 5B + 3T) **Fee:** $202.45 **Benefit:** 75% = $151.85 85% = $172.10
30340	BREAST, BENIGN LESION more than 50mm in diameter, excision of (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $270.00 **Benefit:** 75% = $202.50 85% = $229.50
30343	BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $303.75 **Benefit:** 75% = $227.85 85% = $258.20
30344	BREAST, MALIGNANT TUMOUR, open surgical biopsy of, with or without frozen section histology (Anaes. 17710 = 5B + 5T) **Fee:** $270.00 **Benefit:** 75% = $202.50 85% = $229.50
30347	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $506.20 **Benefit:** 75% = $379.65 85% = $455.30

30348	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $339.55 **Benefit:** 75% = $254.70 85% = $288.65
30351	BREAST (female), total mastectomy (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $573.25 **Benefit:** 75% = $429.95 85% = $522.35
30352	BREAST (male), total mastectomy (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $337.50 **Benefit:** 75% = $253.15 85% = $286.90
30354	BREAST (female), subcutaneous mastectomy (Anaes. 17713 = 5B + 8T) (Assist.) *(See para T8.16 of explanatory notes to this Category)* **Fee:** $809.95 **Benefit:** 75% = $607.50 85% = $759.05
30355	BREAST (male), subcutaneous mastectomy (Anaes. 17711 = 5B + 6T) (Assist.) *(See para T8.16 of explanatory notes to this Category)* **Fee:** $404.95 **Benefit:** 75% = $303.75 85% = $354.05
† 30358	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, where imaging has demonstrated: (a) microcalcification of lesion; or (b) impalpable lesion less than 1cm in diameter - including pre-operative localisation of lesion where performed, not being a service to which item 30363 applies **Fee:** $463.75 **Benefit:** 75% = $347.85 85% = $412.85
30360	FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes. 17705 = 3B + 2T) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $107.35 **Benefit:** 75% = $80.55 85% = $91.25
30361	BREAST, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques - but not including imaging (Anaes. 17705 = 3B + 2T) **Fee:** $147.45 **Benefit:** 75% = $110.60 85% = $125.35
‡ 30363	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using mechanical biopsy device, for histological examination, not being a service to which item 30358 applies (Anaes. 17705 = 3B + 2T) **Fee:** $107.35 **Benefit:** 75% = $80.55 85% = $91.25
30364	BREAST, HAEMATOMA, SEROMA OR INFLAMMATORY CONDITION including abscess, granulomatous mastitis or similar, exploration and drainage of when undertaken in the operating theatre of a hospital or day-hospital facility, excluding aftercare (Anaes. 17707 = 3B + 4T) **Fee:** $168.70 **Benefit:** 75% = $126.55 85% = $143.40
30366	BREAST, microdochotomy of, for benign or malignant condition (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $337.50 **Benefit:** 75% = $253.15 85% = $286.90
30367	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $270.00 **Benefit:** 75% = $202.50 85% = $229.50
30369	ACCESSORY BREAST TISSUE, excision of (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $270.00 **Benefit:** 75% = $202.50 85% = $229.50
30370	INVERTED NIPPLE, surgical eversion of (Anaes. 17707 = 3B + 4T) **Fee:** $202.25 **Benefit:** 75% = $151.70 85% = $171.95
30372	ACCESSORY NIPPLE, excision of (Anaes. 17707 = 3B + 4T) **Fee:** $101.25 **Benefit:** 75% = $75.95 85% = $86.10
30373	LAPAROTOMY (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes. 17711 = 7B + 4T) (Assist.) **Fee:** $376.25 **Benefit:** 75% = $282.20 85% = $325.35
30375	LAPAROTOMY involving Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, Gastrotomy, Reduction of intussusception, Removal of Meckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas (Anaes. 17713 = 7B + 6T) (Assist.) *(See para T8.18 of explanatory notes to this Category)* **Fee:** $405.80 **Benefit:** 75% = $304.35 85% = $354.90

30376	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intraabdominal procedure is performed) (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $405.80	**Benefit:** 75% = $304.35	85% = $354.90
30378	LAPAROTOMY involving division of adhesions in conjunction with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $407.70	**Benefit:** 75% = $305.80	85% = $356.80
30379	LAPAROTOMY WITH DIVISION OF EXTENSIVE ADHESIONS (duration greater than 2 hours) with or without insertion of long intestinal tube (Anaes. 17720 = 7B + 13T) (Assist.) **Fee:** $722.65	**Benefit:** 75% = $542.00	85% = $671.75
30382	ENTEROCUTANEOUS FISTULA, radical repair of, involving extensive dissection and resection of bowel (Anaes. 17716 = 7B + 9T) (Assist.) **Fee:** $1,017.45	**Benefit:** 75% = $763.10	85% = $966.55
30384	LAPAROTOMY FOR GRADING OF LYMPHOMA, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $855.90	**Benefit:** 75% = $641.95	85% = $805.00
30385	LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where no other procedure is performed (Anaes. 17712 = 7B + 5T) (Assist.) **Fee:** $438.55	**Benefit:** 75% = $328.95	85% = $387.65
30387	LAPAROTOMY INVOLVING OPERATION ON ABDOMINAL VISCERA (including pelvic viscera), not being a service to which another item in this Group applies (Anaes. 17712 = 7B + 5T) (Assist.) **Fee:** $494.35	**Benefit:** 75% = $370.80	85% = $443.45
30388	LAPAROTOMY for trauma involving 3 or more organs (Anaes. 17721 = 7B + 14T) (Assist.) **Fee:** $1,243.65	**Benefit:** 75% = $932.75	85% = $1,192.75
30390	LAPAROSCOPY, diagnostic (Anaes. 17709 = 6B + 3T) **Fee:** $171.20	**Benefit:** 75% = $128.40	85% = $145.55
30391	LAPAROSCOPY with biopsy (Anaes. 17709 = 6B + 3T) (Assist.) **Fee:** $221.40	**Benefit:** 75% = $166.05	85% = $188.20
30392	RADICAL OR DEBULKING OPERATION for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Anaes. 17721 = 10B + 11T) (Assist.) **Fee:** $525.15	**Benefit:** 75% = $393.90	85% = $474.25
30393	LAPAROSCOPIC DIVISION OF ADHESIONS in association with another intra-abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $407.70	**Benefit:** 75% = $305.80	85% = $356.80
30394	LAPAROTOMY for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess, ruptured appendix or for peritonitis from any cause, with or without appendicectomy (Anaes. 17711 = 7B + 4T) (Assist.) **Fee:** $383.65	**Benefit:** 75% = $287.75	85% = $332.75
30396	LAPAROTOMY for gross intra peritoneal sepsis requiring debridement of fibrin, with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity via a major abdominal incision, with or without closure of abdomen and with or without mesh or zipper insertion (Anaes. 17720 = 7B + 13T) (Assist.) **Fee:** $791.45	**Benefit:** 75% = $593.60	85% = $740.55
30397	LAPAROSTOMY, via wound previously made and left open or closed with zipper, involving change of dressings or packs, and with or without drainage of loculated collections (Anaes. 17713 = 7B + 6T) **Fee:** $180.90	**Benefit:** 75% = $135.70	85% = $153.80
30399	LAPAROSTOMY, final closure of wound made at previous operation, after removal of dressings or packs and removal of mesh or zipper if previously inserted (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $248.80	**Benefit:** 75% = $186.60	85% = $211.50
30400	LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic therapy including placement of reservoir (Anaes. 17712 = 7B + 5T) (Assist.) **Fee:** $492.40	**Benefit:** 75% = $369.30	85% = $441.50

30402	RETROPERITONEAL ABSCESS, drainage of, not involving laparotomy (Anaes. 17709 = 6B + 3T) (Assist.) **Fee:** $361.70 **Benefit:** 75% = $271.30 85% = $310.80
30403	VENTRAL, INCISIONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repair of (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $405.80 **Benefit:** 75% = $304.35 85% = $354.90
30405	VENTRAL OR INCISIONAL HERNIA, repair of, requiring muscle transposition, mesh hernioplasty or resection of strangulated bowel (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $712.30 **Benefit:** 75% = $534.25 85% = $661.40
30406	PARACENTESIS ABDOMINIS (Anaes. 17708 = 6B + 2T) **Fee:** $40.65 **Benefit:** 75% = $30.50 85% = $34.60
30408	PERITONEO venous (Leveen) shunt, insertion of (Anaes. 17711 = 7B + 4T) (Assist.) **Fee:** $305.25 **Benefit:** 75% = $228.95 85% = $259.50
30409	LIVER BIOPSY, percutaneous (Anaes. 17706 = 4B + 2T) **Fee:** $135.90 **Benefit:** 75% = $101.95 85% = $115.55
30411	LIVER BIOPSY by wedge excision when performed in conjunction with another intraabdominal procedure (Anaes. 17711 = 7B + 4T) **Fee:** $69.15 **Benefit:** 75% = $51.90 85% = $58.80
30412	LIVER BIOPSY by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes. 17711 = 7B + 4T) **Fee:** $40.75 **Benefit:** 75% = $30.60 85% = $34.65
30414	LIVER, subsegmental resection of, (local excision), other than for trauma (Anaes. 17716 = 7B + 9T) (Assist.) **Fee:** $537.00 **Benefit:** 75% = $402.75 85% = $486.10
30415	LIVER, segmental resection of, other than for trauma (Anaes. 17722 = 13B + 9T) (Assist.) **Fee:** $1,074.05 **Benefit:** 75% = $805.55 85% = $1,023.15
30416	LIVER CYST, laparoscopic marsupialisation of, where the size of the cyst is greater than 5cm in diameter (Anaes. 17716 = 7B + 9T) (Assist.) **Fee:** $583.15 **Benefit:** 75% = $437.40 85% = $532.25
30417	LIVER CYSTS, laparoscopic marsupialisation of 5 or more, including any cyst greater than 5cm in diameter (Anaes. 17720 = 7B + 13T) (Assist.) **Fee:** $874.70 **Benefit:** 75% = $656.05 85% = $823.80
30418	LIVER, lobectomy of, other than for trauma (Anaes. 17724 = 13B + 11T) (Assist.) **Fee:** $1,243.65 **Benefit:** 75% = $932.75 85% = $1,192.75
30419	LIVER TUMOURS, destruction of, by hepatic cryotherapy (Anaes. 17720 = 7B + 13T) (Assist.) **Fee:** $636.20 **Benefit:** 75% = $477.15 85% = $585.30
30421	LIVER, TRI-SEGMENTAL RESECTION (extended lobectomy) of, other than for trauma (Anaes. 17726 = 13B + 13T) (Assist.) **Fee:** $1,554.45 **Benefit:** 75% = $1,165.85 85% = $1,503.55
30422	LIVER, repair of superficial laceration of, for trauma (Anaes. 17712 = 7B + 5T) (Assist.) **Fee:** $525.75 **Benefit:** 75% = $394.35 85% = $474.85
30425	LIVER, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes. 17718 = 7B + 11T) (Assist.) **Fee:** $1,017.45 **Benefit:** 75% = $763.10 85% = $966.55
30427	LIVER, segmental resection of, for trauma (Anaes. 17724 = 13B + 11T) (Assist.) **Fee:** $1,215.30 **Benefit:** 75% = $911.50 85% = $1,164.40
30428	LIVER, lobectomy of, for trauma (Anaes. 17726 = 13B + 13T) (Assist.) **Fee:** $1,300.15 **Benefit:** 75% = $975.15 85% = $1,249.25
30430	LIVER, extended lobectomy (tri-segmental resection) of, for trauma (Anaes. 17728 = 13B + 15T) (Assist.) **Fee:** $1,808.80 **Benefit:** 75% = $1,356.60 85% = $1,757.90
30431	LIVER ABSCESS, open abdominal drainage of (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $405.80 **Benefit:** 75% = $304.35 85% = $354.90

30433	LIVER ABSCESS (multiple), open abdominal drainage of (Anaes. 17716 = 7B + 9T) (Assist.) **Fee:** $565.30 **Benefit:** 75% = $424.00 85% = $514.40
30434	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $457.90 **Benefit:** 75% = $343.45 85% = $407.00
30436	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles, with omentoplasty or myeloplasty (Anaes. 17716 = 7B + 9T) (Assist.) **Fee:** $508.75 **Benefit:** 75% = $381.60 85% = $457.85
30437	HYDATID CYST OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall) (Anaes. 17718 = 7B + 11T) (Assist.) **Fee:** $633.10 **Benefit:** 75% = $474.85 85% = $582.20
30438	HYDATID CYST OF LIVER, excision of, with drainage and excision of liver tissue (Anaes. 17718 = 7B + 11T) (Assist.) **Fee:** $895.95 **Benefit:** 75% = $672.00 85% = $845.05
30439	OPERATIVE CHOLANGIOGRAPHY OR OPERATIVE PANCREATOGRAPHY OR INTRA OPERATIVE ULTRASOUND of the biliary tract (including 1 or more examinations performed during the 1 operation) (Anaes. 17711 = 7B + 4T) **Fee:** $144.60 **Benefit:** 75% = $108.45 85% = $122.95
30440	CHOLANGIOGRAM, percutaneous transhepatic, and biliary drainage, using interventional imaging techniques - but not including imaging (Anaes. 17712 = 7B + 5T) (Assist.) **Fee:** $409.80 **Benefit:** 75% = $307.35 85% = $358.90
30441	INTRA OPERATIVE ULTRASOUND for staging of intra abdominal tumours (Anaes. 17711 = 7B + 4T) **Fee:** $106.05 **Benefit:** 75% = $79.55 85% = $90.15
30442	CHOLEDOCHOSCOPY in conjunction with another procedure (Anaes. 17709 = 7B + 2T) **Fee:** $144.60 **Benefit:** 75% = $108.45 85% = $122.95
30443	CHOLECYSTECTOMY (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $575.60 **Benefit:** 75% = $431.70 85% = $524.70
30445	LAPAROSCOPIC CHOLECYSTECTOMY (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $575.60 **Benefit:** 75% = $431.70 85% = $524.70
30446	LAPAROSCOPIC CHOLECYSTECTOMY when procedure is completed by laparotomy (Anaes. 17717 = 7B + 10T) (Assist.) **Fee:** $575.60 **Benefit:** 75% = $431.70 85% = $524.70
30448	LAPAROSCOPIC CHOLECYSTECTOMY, involving removal of common duct calculi via the cystic duct (Anaes. 17718 = 7B + 11T) (Assist.) **Fee:** $757.50 **Benefit:** 75% = $568.15 85% = $706.60
30449	LAPAROSCOPIC CHOLECYSTECTOMY with removal of common duct calculi via laparoscopic choledochotomy (Anaes. 17720 = 7B + 13T) (Assist.) **Fee:** $842.25 **Benefit:** 75% = $631.70 85% = $791.35
30450	CALCULUS OF BILIARY OR RENAL TRACT, extraction of, using interventional imaging techniques - not being a service associated with a service to which items 36627, 36630, 36645 or 36648 applies (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $408.20 **Benefit:** 75% = $306.15 85% = $357.30
30451	BILIARY DRAINAGE TUBE, exchange of, using interventional imaging techniques - but not including imaging (Anaes. 17710 = 7B + 3T) (Assist.) **Fee:** $208.35 **Benefit:** 75% = $156.30 85% = $177.10
30452	CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Anaes. 17716 = 7B + 9T) (Assist.) **Fee:** $293.95 **Benefit:** 75% = $220.50 85% = $249.90
30454	CHOLEDOCHOTOMY (with or without cholecystectomy), with or without removal of calculi (Anaes. 17716 = 7B + 9T) (Assist.) **Fee:** $671.45 **Benefit:** 75% = $503.60 85% = $620.55

30455	CHOLEDOCHOTOMY (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (Anaes. 17718 = 7B + 11T) (Assist.) **Fee:** $789.50 **Benefit:** 75% = $592.15 85% = $738.60
30457	CHOLEDOCHOTOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes. 17716 = 7B + 9T) (Assist.) **Fee:** $1,074.05 **Benefit:** 75% = $805.55 85% = $1,023.15
30458	TRANSDUODENAL OPERATION ON SPHINCTER OF ODDI, involving 1 or more of, removal of calculi, sphincterotomy, sphincteroplasty, biopsy, local excision of peri-ampullary or duodenal tumour, sphincteroplasty of the pancreatic duct, pancreatic duct septoplasty, with or without choledochotomy (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $789.50 **Benefit:** 75% = $592.15 85% = $738.60
30460	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $671.45 **Benefit:** 75% = $503.60 85% = $620.55
‡ 30461	RADICAL RESECTION of porta hepatis with biliary-enteric anastomoses, not being a service associated with a service to which item 30443, 30454, 30455, 30458 or 30460 applies (Anaes. 17719 = 7B + 12T) (Assist.) **Fee:** $1,151.05 **Benefit:** 75% = $863.30 85% = $1,100.15
‡ 30463	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses (Anaes. 17724 = 7B + 17T) (Assist.) **Fee:** $1,413.15 **Benefit:** 75% = $1,059.90 85% = $1,362.25
‡ 30464	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, involving more than 2 anastomoses or resection of segment or major portion of segment of liver (Anaes. 17730 = 7B + 23T) (Assist.) **Fee:** $1,695.85 **Benefit:** 75% = $1,271.90 85% = $1,644.95
30466	INTRAHEPATIC biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes. 17722 = 7B + 15T) (Assist.) **Fee:** $977.95 **Benefit:** 75% = $733.50 85% = $927.05
30467	INTRAHEPATIC BYPASS of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes. 17722 = 7B + 15T) (Assist.) **Fee:** $1,209.65 **Benefit:** 75% = $907.25 85% = $1,158.75
30469	BILIARY STRICTURE, repair of, after 1 or more operations on the biliary tree (Anaes. 17724 = 7B + 17T) (Assist.) **Fee:** $1,339.70 **Benefit:** 75% = $1,004.80 85% = $1,288.80
‡ 30472	HEPATIC OR COMMON BILE DUCT, repair of, as the primary procedure subsequent to partial or total transection of bile duct or ducts (Anaes. 17722 = 7B + 15T) (Assist.) **Fee:** $723.50 **Benefit:** 75% = $542.65 85% = $672.60
30473	OESOPHAGOSCOPY (not being a service to which item 41816 or 41822 applies), GASTROSCOPY, DUODENOSCOPY or PANENDOSCOPY (1 or more such procedures), with or without biopsy, not being a service associated with a service to which item 30476 or 30478 applies (Anaes. 17706 = 5B + 1T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $137.90 **Benefit:** 75% = $103.45 85% = $117.25
30475	ENDOSCOPY with balloon dilatation of gastric or gastroduodenal stricture (Anaes. 17708 = 5B + 3T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $249.30 **Benefit:** 75% = $187.00 85% = $211.95
30476	OESOPHAGOSCOPY (not being a service to which item 41816 or 41822 applies), GASTROSCOPY, DUODENOSCOPY or PANENDOSCOPY (1 or more such procedures), with endoscopic sclerosing injection or banding of oesophageal or gastric varices, not being a service associated with a service to which item 30473 or 30478 applies (Anaes. 17708 = 6B + 2T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $191.20 **Benefit:** 75% = $143.40 85% = $162.55
30478	OESOPHAGOSCOPY (not being a service to which item 41816, 41822 or 41825 applies), gastroscopy, duodenoscopy or panendoscopy (1 or more such procedures), with 1 or more of the following endoscopic procedures - polypectomy, removal of foreign body, diathermy, heater probe or laser coagulation, or sclerosing injection of bleeding upper gastrointestinal lesions, not being a service associated with a service to which item 30473 or 30476 applies (Anaes. 17708 = 6B + 2T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $191.20 **Benefit:** 75% = $143.40 85% = $162.55

30479	ENDOSCOPIC LASER THERAPY for neoplasia and benign vascular lesions or strictures of the gastrointestinal tract (Anaes. 17711 = 5B + 6T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $370.65	**Benefit:** 75% = $278.00	85% = $319.75
30481	PERCUTANEOUS GASTROSTOMY (initial procedure), including any associated imaging services (Anaes. 17711 = 5B + 6T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $277.95	**Benefit:** 75% = $208.50	85% = $236.30
30482	PERCUTANEOUS GASTROSTOMY (repeat procedure), including any associated imaging services (Anaes. 17711 = 5B + 6T) **Fee:** $197.65	**Benefit:** 75% = $148.25	85% = $168.05
30483	GASTROSTOMY BUTTON, non-endoscopic insertion of, or non-endoscopic replacement of (Anaes. 17707 = 3B + 4T) **Fee:** $137.85	**Benefit:** 75% = $103.40	85% = $117.20
30484	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes. 17708 = 5B + 3T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $284.10	**Benefit:** 75% = $213.10	85% = $241.50
30485	ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from common bile duct (Anaes. 17708 = 5B + 3T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $438.55	**Benefit:** 75% = $328.95	85% = $387.65
30487	SMALL BOWEL INTUBATION with biopsy (Anaes. 17707 = 5B + 2T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $140.85	**Benefit:** 75% = $105.65	85% = $119.75
30488	SMALL BOWEL INTUBATION as an independent procedure (Anaes. 17707 = 5B + 2T) **Fee:** $70.05	**Benefit:** 75% = $52.55	85% = $59.55
30490	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Anaes. 17710 = 6B + 4T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $409.80	**Benefit:** 75% = $307.35	85% = $358.90
30491	BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dilatation) (Anaes. 17711 = 5B + 6T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $432.35	**Benefit:** 75% = $324.30	85% = $381.45
30493	BILIARY MANOMETRY (Anaes. 17709 = 5B + 4T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $259.45	**Benefit:** 75% = $194.60	85% = $220.55
30494	ENDOSCOPIC BILIARY DILATATION (Anaes. 17711 = 5B + 6T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $327.35	**Benefit:** 75% = $245.55	85% = $278.25
30496	VAGOTOMY, truncal or selective, with or without pyloroplasty or gastroenterostomy (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $457.90	**Benefit:** 75% = $343.45	85% = $407.00
30497	VAGOTOMY and ANTRECTOMY (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $545.95	**Benefit:** 75% = $409.50	85% = $495.05
30499	VAGOTOMY, highly selective (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $649.40	**Benefit:** 75% = $487.05	85% = $598.50
30500	VAGOTOMY, highly selective with duodenoplasty for peptic stricture (Anaes. 17717 = 7B + 10T) (Assist.) **Fee:** $695.30	**Benefit:** 75% = $521.50	85% = $644.40
30502	VAGOTOMY, highly selective, with dilatation of pylorus (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $767.40	**Benefit:** 75% = $575.55	85% = $716.50
30503	VAGOTOMY or ANTRECTOMY, or both, for peptic ulcer following previous operation for peptic ulcer (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $859.30	**Benefit:** 75% = $644.50	85% = $808.40

OPERATIONS		GENERAL
30505	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $429.60 **Benefit:** 75% = $322.20 85% = $378.70	
30506	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $751.85 **Benefit:** 75% = $563.90 85% = $700.95	
30508	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $791.45 **Benefit:** 75% = $593.60 85% = $740.55	
30509	BLEEDING PEPTIC ULCER, control of, involving gastric resection (other than wedge resection) (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $791.45 **Benefit:** 75% = $593.60 85% = $740.55	
30511	(*see Item 31441 for repair, revision or replacement of implanted reservoir associated with adjustable gastric band*) MORBID OBESITY, gastric reduction or gastroplasty for, by any method (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $661.40 **Benefit:** 75% = $496.05 85% = $610.50	
30512	MORBID OBESITY, gastric bypass for, by any method including anastomosis (Anaes. 17723 = 7B + 16T) (Assist.) **Fee:** $813.95 **Benefit:** 75% = $610.50 85% = $763.05	
30514	MORBID OBESITY, surgical reversal of procedure to which item 30511 or 30512 applies (Anaes. 17724 = 7B + 17T) (Assist.) **Fee:** $1,198.35 **Benefit:** 75% = $898.80 85% = $1,147.45	
30515	GASTROENTEROSTOMY (INCLUDING GASTRODUODENOSTOMY) OR ENTEROCOLOSTOMY OR ENTEROENTEROSTOMY (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $548.30 **Benefit:** 75% = $411.25 85% = $497.40	
30517	GASTROENTEROSTOMY, PYLOROPLASTY or GASTRODUODENOSTOMY, reconstruction of (Anaes. 17716 = 7B + 9T) (Assist.) **Fee:** $717.90 **Benefit:** 75% = $538.45 85% = $667.00	
30518	PARTIAL GASTRECTOMY (Anaes. 17717 = 7B + 10T) (Assist.) **Fee:** $768.80 **Benefit:** 75% = $576.60 85% = $717.90	

30520	GASTRIC TUMOUR, removal of, by local excision, not being a service to which item 30518 applies (Anaes. 17717 = 7B + 10T) (Assist.) **Fee:** $525.75 **Benefit:** 75% = $394.35 85% = $474.85
30521	GASTRECTOMY, TOTAL, for benign disease (Anaes. 17721 = 7B + 14T) (Assist.) **Fee:** $1,124.95 **Benefit:** 75% = $843.75 85% = $1,074.05
30523	GASTRECTOMY, SUBTOTAL RADICAL, for carcinoma, (including splenectomy when performed) (Anaes. 17721 = 7B + 14T) (Assist.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $1,175.70 **Benefit:** 75% = $881.80 85% = $1,124.80
30524	GASTRECTOMY, TOTAL RADICAL, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (Anaes. 17723 = 7B + 16T) (Assist.) **Fee:** $1,294.45 **Benefit:** 75% = $970.85 85% = $1,243.55
30526	GASTRECTOMY, TOTAL, and including lower oesophagus, performed by left thoraco-abdominal incision or opening of diaphragmatic hiatus, (including splenectomy when performed) (Anaes. 17735 = 15B + 20T) (Assist.) **Fee:** $1,678.80 **Benefit:** 75% = $1,259.10 85% = $1,627.90
30527	ANTIREFLUX OPERATION by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus not being a service to which item 30601 applies (Anaes. 17722 = 9B + 13T) (Assist.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $678.35 **Benefit:** 75% = $508.80 85% = $627.45
30529	ANTIREFLUX operation by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophagus (Anaes. 17730 = 15B + 15T) (Assist.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $1,017.45 **Benefit:** 75% = $763.10 85% = $966.55
30530	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes. 17730 = 15B + 15T) (Assist.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $610.55 **Benefit:** 75% = $457.95 85% = $559.65
‡ 30532	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes. 17727 = 15B + 12T) (Assist.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $701.05 **Benefit:** 75% = $525.80 85% = $650.15
‡ 30533	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, WITH FUNDOPLASTY, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes. 17728 = 15B + 13T) (Assist.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $833.85 **Benefit:** 75% = $625.40 85% = $782.95
30535	OESOPHAGECTOMY with gastric reconstruction by abdominal mobilisation and thoracotomy (Anaes. 17735 = 15B + 20T) (Assist.) **Fee:** $1,320.85 **Benefit:** 75% = $990.65 85% = $1,269.95
‡ 30536	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - 1 surgeon (Anaes. 17739 = 15B + 24T) (Assist.) **Fee:** $1,339.70 **Benefit:** 75% = $1,004.80 85% = $1,288.80
‡ 30538	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest- conjoint surgery, principal surgeon (including aftercare) (Anaes. 17739 = 15B + 24T) (Assist.) **Fee:** $927.05 **Benefit:** 75% = $695.30 85% = $876.15
‡ 30539	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - conjoint surgery, co-surgeon (Assist.) **Fee:** $678.35 **Benefit:** 75% = $508.80 85% = $627.45
30541	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - 1 surgeon (Anaes. 17739 = 15B + 24T) (Assist.) **Fee:** $1,181.45 **Benefit:** 75% = $886.10 85% = $1,130.55

30542	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, principal surgeon (including aftercare) (Anaes. 17739 = 15B + 24T) (Assist.) **Fee:** $802.65 **Benefit:** 75% = $602.00 85% = $751.75
30544	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, co-surgeon (Assist.) **Fee:** $587.90 **Benefit:** 75% = $440.95 85% = $537.00
30545	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - 1 surgeon (Anaes. 17739 = 15B + 24T) (Assist.) **Fee:** $1,430.20 **Benefit:** 75% = $1,072.65 85% = $1,379.30
30547	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, principal surgeon (including aftercare) (Anaes. 17739 = 15B + 24T) (Assist.) **Fee:** $983.55 **Benefit:** 75% = $737.70 85% = $932.65
30548	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, co-surgeon (Assist.) **Fee:** $734.85 **Benefit:** 75% = $551.15 85% = $683.95
30550	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - 1 surgeon (Anaes. 17739 = 15B + 24T) (Assist.) **Fee:** $1,605.40 **Benefit:** 75% = $1,204.05 85% = $1,554.50
30551	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, principal surgeon (including aftercare) (Anaes. 17739 = 15B + 24T) (Assist.) **Fee:** $1,107.95 **Benefit:** 75% = $831.00 85% = $1,057.05
30553	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, co-surgeon (Assist.) **Fee:** $819.60 **Benefit:** 75% = $614.70 85% = $768.70
30554	OESOPHAGECTOMY with reconstruction by free jejunal graft - 1 surgeon (Anaes. 17739 = 15B + 24T) (Assist.) **Fee:** $1,786.30 **Benefit:** 75% = $1,339.75 85% = $1,735.40
30556	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, principal surgeon (including aftercare) (Anaes. 17739 = 15B + 24T) (Assist.) **Fee:** $1,232.30 **Benefit:** 75% = $924.25 85% = $1,181.40
30557	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, co-surgeon (Assist.) **Fee:** $910.10 **Benefit:** 75% = $682.60 85% = $859.20
30559	OESOPHAGUS, local excision for tumour of (Anaes. 17730 = 15B + 15T) (Assist.) **Fee:** $661.40 **Benefit:** 75% = $496.05 85% = $610.50
30560	OESOPHAGEAL PERFORATION, repair of, by thoracotomy (Anaes. 17735 = 15B + 20T) (Assist.) **Fee:** $734.85 **Benefit:** 75% = $551.15 85% = $683.95
30562	ENTEROSTOMY or COLOSTOMY, closure of not involving resection of bowel (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $463.30 **Benefit:** 75% = $347.50 85% = $412.40
30563	COLOSTOMY OR ILEOSTOMY, refashioning of (Anaes. 17712 = 7B + 5T) (Assist.) **Fee:** $463.30 **Benefit:** 75% = $347.50 85% = $412.40
30564	SMALL BOWEL STRICTUREPLASTY for chronic inflammatory bowel disease (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $601.30 **Benefit:** 75% = $451.00 85% = $550.40
30565	SMALL INTESTINE, resection of, without anastomosis (including formation of stoma) (Anaes. 17719 = 7B + 12T) (Assist.) **Fee:** $678.35 **Benefit:** 75% = $508.80 85% = $627.45
30566	SMALL INTESTINE, resection of, with anastomosis (Anaes. 17720 = 7B + 13T) (Assist.) **Fee:** $753.55 **Benefit:** 75% = $565.20 85% = $702.65
30568	INTRAOPERATIVE ENTEROTOMY for visualisation of the small intestine by endoscopy (Anaes. 17710 = 7B + 3T) (Assist.) **Fee:** $565.30 **Benefit:** 75% = $424.00 85% = $514.40

30569	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy, with or without biopsies (Anaes. 17710 = 7B + 3T) (Assist.) **Fee:** $288.25 **Benefit:** 75% = $216.20 85% = $245.05
30571	APPENDICECTOMY, not being a service to which item 30574 applies (Anaes. 17710 = 6B + 4T) (Assist.) **Fee:** $346.80 **Benefit:** 75% = $260.10 85% = $295.90
30572	LAPAROSCOPIC APPENDICECTOMY (Anaes. 17711 = 7B + 4T) (Assist.) **Fee:** $346.80 **Benefit:** 75% = $260.10 85% = $295.90
30574	**NOTE:** *Multiple Operation and Multiple Anaesthetic rules apply to this item* APPENDICECTOMY, when performed in conjunction with any other intraabdominal procedure through the same incision (Anaes. 17707 = 6B + 1T) **Fee:** $95.95 **Benefit:** 75% = $72.00 85% = $81.60
30575	PANCREATIC ABSCESS, laparotomy and external drainage of, not requiring retro-pancreatic dissection (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $399.20 **Benefit:** 75% = $299.40 85% = $348.30
30577	PANCREATIC NECROSECTOMY for PANCREATIC NECROSIS or ABSCESS FORMATION requiring major pancreatic or retro-pancreatic dissection, excluding aftercare (Anaes. 17726 = 7B + 19T) (Assist.) **Fee:** $847.95 **Benefit:** 75% = $636.00 85% = $797.05
30578	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of pancreatic tumour (Anaes. 17725 = 8B + 17T) (Assist.) **Fee:** $893.15 **Benefit:** 75% = $669.90 85% = $842.25
30580	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of duodenal tumour (Anaes. 17724 = 7B + 17T) (Assist.) **Fee:** $813.95 **Benefit:** 75% = $610.50 85% = $763.05
30581	ENDOCRINE TUMOUR, exploration of pancreas or duodenum for, but no tumour found (Anaes. 17722 = 7B + 15T) (Assist.) **Fee:** $593.55 **Benefit:** 75% = $445.20 85% = $542.65
30583	DISTAL PANCREATECTOMY (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $929.80 **Benefit:** 75% = $697.35 85% = $878.90
30584	PANCREATICO-DUODENECTOMY, WHIPPLE'S OPERATION, with or without preservation of pylorus (Anaes. 17730 = 10B + 20T) (Assist.) **Fee:** $1,372.45 **Benefit:** 75% = $1,029.35 85% = $1,321.55
30586	PANCREATIC CYST ANASTOMOSIS TO STOMACH OR DUODENUM - by open or endoscopic means (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $545.95 **Benefit:** 75% = $409.50 85% = $495.05
30587	PANCREATIC CYST, anastomosis to Roux loop of jejunum (Anaes. 17716 = 7B + 9T) (Assist.) **Fee:** $565.30 **Benefit:** 75% = $424.00 85% = $514.40
30589	PANCREATICO-JEJUNOSTOMY for pancreatitis or trauma (Anaes. 17720 = 7B + 13T) (Assist.) **Fee:** $973.95 **Benefit:** 75% = $730.50 85% = $923.05
30590	PANCREATICO-JEJUNOSTOMY following previous pancreatic surgery (Anaes. 17722 = 7B + 15T) (Assist.) **Fee:** $1,074.05 **Benefit:** 75% = $805.55 85% = $1,023.15
30593	PANCREATECTOMY, near total or total (including duodenum), with or without splenectomy (Anaes. 17730 = 10B + 20T) (Assist.) **Fee:** $1,469.75 **Benefit:** 75% = $1,102.35 85% = $1,418.85
30594	PANCREATECTOMY for pancreatitis following previously attempted drainage procedure or partial resection (Anaes. 17725 = 10B + 15T) (Assist.) **Fee:** $1,695.85 **Benefit:** 75% = $1,271.90 85% = $1,644.95
‡ 30596	SPLENORRHAPHY OR PARTIAL SPLENECTOMY (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $698.55 **Benefit:** 75% = $523.95 85% = $647.65
30597	SPLENECTOMY (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $560.75 **Benefit:** 75% = $420.60 85% = $509.85

	SPLENECTOMY, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal incision (Anaes. 17721 = 7B + 14T) (Assist.)		
30599	**Fee:** $1,017.45	**Benefit:** 75% = $763.10	85% = $966.55
	DIAPHRAGMATIC HERNIA, TRAUMATIC, repair of (Anaes. 17720 = 9B + 11T) (Assist.)		
30600	**Fee:** $605.05	**Benefit:** 75% = $453.80	85% = $554.15
	DIAPHRAGMATIC HERNIA, CONGENITAL repair of, by thoracic or abdominal approach (Anaes. 17717 = 9B + 8T) (Assist.)		
30601	**Fee:** $745.30	**Benefit:** 75% = $559.00	85% = $694.40
	PORTAL HYPERTENSION, porto-caval shunt for (Anaes. 17734 = 15B + 19T) (Assist.)		
30602	**Fee:** $1,209.65	**Benefit:** 75% = $907.25	85% = $1,158.75
	PORTAL HYPERTENSION, meso-caval shunt for (Anaes. 17726 = 7B + 19T) (Assist.)		
30603	**Fee:** $1,277.55	**Benefit:** 75% = $958.20	85% = $1,226.65
	PORTAL HYPERTENSION, selective spleno-renal shunt for (Anaes. 17734 = 15B + 19T) (Assist.)		
30605	**Fee:** $1,452.80	**Benefit:** 75% = $1,089.60	85% = $1,401.90
	PORTAL HYPERTENSION, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Anaes. 17720 = 7B + 13T) (Assist.)		
30606	**Fee:** $864.85	**Benefit:** 75% = $648.65	85% = $813.95
	FEMORAL OR INGUINAL HERNIA, laparoscopic repair of, not being a service associated with a service to which item 30612 or 30614 applies (Anaes. 17711 = 7B + 4T) (Assist.)		
30609	**Fee:** $361.60	**Benefit:** 75% = $271.20	85% = $310.70
	FEMORAL OR INGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to which item 30403 or 30615 applies (Anaes. 17708 = 4B + 4T) (Assist.)		
30612 G	**Fee:** $277.45	**Benefit:** 75% = $208.10	85% = $235.85
30614 S	**Fee:** $361.60	**Benefit:** 75% = $271.20	85% = $310.70
	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel resection (Anaes. 17710 = 4B + 6T) (Assist.)		
30615	**Fee:** $405.80	**Benefit:** 75% = $304.35	85% = $354.90
	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, in a person under 10 years of age (Anaes. 17707 = 4B + 3T)		
30616 G	**Fee:** $206.55	**Benefit:** 75% = $154.95	85% = $175.60
30617 S	**Fee:** $277.45	**Benefit:** 75% = $208.10	85% = $235.85
	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, in a person 10 years of age or over (Anaes. 17707 = 4B + 3T) (Assist.)		
30620 G	**Fee:** $233.15	**Benefit:** 75% = $174.90	85% = $198.20
30621 S	**Fee:** $317.30	**Benefit:** 75% = $238.00	85% = $269.75
	HYDROCELE, tapping of		
30628	**Fee:** $27.75	**Benefit:** 75% = $20.85	85% = $23.60
	HYDROCELE, removal of, not being a service associated with a service to which items 30638, 30641 and 30644 apply (Anaes. 17705 = 3B + 2T)		
30631	**Fee:** $184.20	**Benefit:** 75% = $138.15	85% = $156.60
	VARICOCELE, surgical correction of, not being a service associated with a service to which items 30638, 30641 and 30644 apply, 1 procedure (Anaes. 17707 = 4B + 3T) (Assist.)		
30634 G	**Fee:** $183.00	**Benefit:** 75% = $137.25	85% = $155.55
30635 S	**Fee:** $227.25	**Benefit:** 75% = $170.45	85% = $193.20
	ORCHIDECTOMY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis (Anaes. 17706 = 3B + 3T) (Assist.)		
30638 G	**Fee:** $233.15	**Benefit:** 75% = $174.90	85% = $198.20
30641 S	**Fee:** $317.30	**Benefit:** 75% = $238.00	85% = $269.75
	EXPLORATION OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis (Anaes. 17707 = 4B + 3T) (Assist.)		
30644	**Fee:** $405.80	**Benefit:** 75% = $304.35	85% = $354.90

30653	CIRCUMCISION of a male UNDER 6 MONTHS of age (Anaes. 17705 = 3B + 2T) **Fee:** $36.20	**Benefit:** 75% = $27.15	85% = $30.80
30656	CIRCUMCISION of a male UNDER 10 YEARS of age but not less than 6 months of age (Anaes. 17706 = 3B + 3T) **Fee:** $84.15	**Benefit:** 75% = $63.15	85% = $71.55
30659 G 30660 S	CIRCUMCISION of a male 10 YEARS OF AGE OR OVER (Anaes. 17706 = 3B + 3T) **Fee:** $116.60 **Fee:** $144.60	**Benefit:** 75% = $87.45 **Benefit:** 75% = $108.45	85% = $99.15 85% = $122.95
30663	HAEMORRHAGE, arrest of, following circumcision requiring general anaesthesia (Anaes. 17705 = 3B + 2T) **Fee:** $112.40	**Benefit:** 75% = $84.30	85% = $95.55
30666	PARAPHIMOSIS, reduction of, under general anaesthesia, with or without dorsal incision, not being a service associated with a service to which another item in this Group applies (Anaes. 17705 = 3B + 2T) **Fee:** $36.95	**Benefit:** 75% = $27.75	85% = $31.45
30672	COCCYX, excision of (Anaes. 17710 = 6B + 4T) (Assist.) **Fee:** $346.80	**Benefit:** 75% = $260.10	85% = $295.90
30675 G 30676 S	PILONIDAL SINUS OR CYST, OR SACRAL SINUS OR CYST, excision of (Anaes. 17709 = 5B + 4T) **Fee:** $233.15 **Fee:** $295.15	**Benefit:** 75% = $174.90 **Benefit:** 75% = $221.40	85% = $198.20 85% = $250.90
30679	PILONIDAL SINUS, injection of sclerosant fluid under anaesthesia (Anaes. 17707 = 5B + 2T) **Fee:** $74.95	**Benefit:** 75% = $56.25	85% = $63.75
31000	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 6 or fewer sections (Anaes. 17707 = 4B + 3T) **Fee:** $452.20	**Benefit:** 75% = $339.15	85% = $401.30
31001	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 7 to 12 sections (inclusive) (Anaes. 17708 = 4B + 4T) **Fee:** $565.30	**Benefit:** 75% = $424.00	85% = $514.40
31002	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 13 or more sections (Anaes. 17712 = 4B + 8T) **Fee:** $678.35	**Benefit:** 75% = $508.80	85% = $627.45
31200	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach to an operation), **removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane,** not being a service to which another item in this Group applies *(See para T8.22 of explanatory notes to this Category)* **Fee:** $26.50	**Benefit:** 75% = $19.90	85% = $22.55
31205	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size up to 10mm in diameter, removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where specimen sent for histological examination*** (not being a service to which item 30195 applies) (Anaes. 17706 = 4B + 2T) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $74.25	**Benefit:** 75% = $55.70	85% = $63.15
31210	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size more than 10mm and up to 20mm in diameter, removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where specimen sent for histological examination*** (not being a service to which item 30195 applies) (Anaes. 17706 = 4B + 2T) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $95.80	**Benefit:** 75% = $71.85	85% = $81.45

31215	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size more than 20mm in diameter, removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where specimen sent for histological examination*** (not being a service to which item 30195 applies) (Anaes. 17706 = 4B + 2T) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $111.70 **Benefit:** 75% = $83.80 85% = $94.95
31220	TUMOURS (other than viral verrucae [common warts] and seborrheic keratoses), CYSTS, ULCERS OR SCARS (other than scars removed during the surgical approach at an operation), **lesion size up to 10mm in diameter, removal of 4 to 10 lesions by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where specimen sent for histological examination*** (not being a service to which item 30195 applies) (Anaes. 17707 = 4B + 3T) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $167.05 **Benefit:** 75% = $125.30 85% = $142.00
31225	TUMOURS (other than viral verrucae [common warts] and seborrheic keratoses), CYSTS, ULCERS OR SCARS (other than scars removed during the surgical approach at an operation), **lesion size up to 10mm in diameter, removal of more than 10 lesions by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where specimen sent for histological examination*** (not being a service to which item 30195 applies) (Anaes. 17713 = 4B + 9T) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $296.85 **Benefit:** 75% = $222.65 85% = $252.35
31230	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision and suture from nose, eyelid, lip, ear, digit or genitalia, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where specimen sent histological examination*** (not being a service to which item 30195 applies) (Anaes. 17708 = 5B + 3T) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $130.85 **Benefit:** 75% = $98.15 85% = $111.25
31235	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, **lesion size up to 10mm in diameter** - ***where specimen sent for histological examination*** (not being a service to which item 30195 applies) (Anaes. 17707 = 4B + 3T) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $111.70 **Benefit:** 75% = $83.80 85% = $94.95
31240	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, **lesion size more than 10mm in diameter** - ***where specimen sent for histological examination*** (not being a service to which item 30195 applies) (Anaes. 17707 = 4B + 3T) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $130.85 **Benefit:** 75% = $98.15 85% = $111.25
31245	SKIN AND SUBCUTANEOUS TISSUE, extensive excision of, in the treatment of SUPPURATIVE HYDRADENITIS (excision from axilla, groin or natal cleft) or SYCOSIS BARBAE or NUCHAE (excision from face or neck) (Anaes. 17710 = 4B + 6T) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $287.25 **Benefit:** 75% = $215.45 85% = $244.20
31250	GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of body surface ***where the specimen is sent for histological confirmation of diagnosis*** *(Anaes. 17710 = 4B + 6T)* *(See para T8.22 of explanatory notes to this Category)* **Fee:** $287.25 **Benefit:** 75% = $215.45 85% = $244.20
31255	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to 10mm in diameter** - where removal is by **surgical excision and suture *and histological confirmation of malignancy has been obtained*** *(Anaes. 17708 = 5B + 3T)* *(See para T8.22 of explanatory notes to this Category)* **Fee:** $172.35 **Benefit:** 75% = $129.30 85% = $146.50
31260	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter** - where removal is by **surgical excision and suture *and histological confirmation of malignancy has been obtained*** *(Anaes. 17708 = 5B + 3T)* *(See para T8.22 of explanatory notes to this Category)* **Fee:** $245.75 **Benefit:** 75% = $184.35 85% = $208.90

31265	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle), tumour size up to 10mm in diameter** - where removal is by **surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** *(Anaes. 17707 = 4B + 3T)* *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $143.60 **Benefit:** 75% = $107.70 85% = $122.10
31270	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 10mm and up to 20mm in diameter** - where removal is by **surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** *(Anaes. 17707 = 4B + 3T)* *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $201.10 **Benefit:** 75% = $150.85 85% = $170.95
31275	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 20mm in diameter** - where removal is by **surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** *(Anaes. 17708 = 4B + 4T)* *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $233.00 **Benefit:** 75% = $174.75 85% = $198.05
31280	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31255* and *31265*, tumour size up to 10mm in diameter** - where removal is by **surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** *(Anaes. 17707 = 4B + 3T)* *(See para T8.22 of explanatory notes to this Category)* **Fee:** $121.30 **Benefit:** 75% = $91.00 85% = $103.15
31285	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31270*, tumour size more than 10mm and up to 20mm in diameter** - where removal is by **surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** *(Anaes. 17707 = 4B + 3T)* *(See para T8.22 of explanatory notes to this Category)* **Fee:** $165.90 **Benefit:** 75% = $124.45 85% = $141.05
31290	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31275*, tumour size more than 20mm in diameter** - where removal is by **surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** *(Anaes. 17708 = 4B + 4T)* *(See para T8.22 of explanatory notes to this Category)* **Fee:** $191.45 **Benefit:** 75% = $143.60 85% = $162.75
31295	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, residual or recurrent (where lesion treated by previous surgery, serial cautery and curettage, radiotherapy or two prolonged freeze/thaw cycles of liquid nitrogen therapy), ***performed by a specialist in the practice of his or her specialty or by a practitioner other than the practitioner who provided the previous treatment***, **removal from the head or neck (anterior to the sternomastoid muscles)**, where removal is by **surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** *(Anaes. 17708 = 5B + 3T)* *(See para T8.22 of explanatory notes to this Category)* **Fee:** $228.00 **Benefit:** 75% = $171.00 85% = $193.80
31300	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to 10mm in diameter** - where removal is by **definitive surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** *(Anaes. 17708 = 5B + 3T)* *(See para T8.22 of explanatory notes to this Category)* **Fee:** $249.00 **Benefit:** 75% = $186.75 85% = $211.65
31305	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter** - where removal is by **definitive surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** *(Anaes. 17708 = 5B + 3T)* *(See para T8.22 of explanatory notes to this Category)* **Fee:** $306.35 **Benefit:** 75% = $229.80 85% = $260.40
31310	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size up to 10mm in diameter** - where removal is by **definitive surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** *(Anaes. 17707 = 4B + 3T)* *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $217.00 **Benefit:** 75% = $162.75 85% = $184.45

31315	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 10mm and up to 20mm in diameter** - where removal is by **definitive surgical excision and suture *and histological confirmation of malignancy has been obtained*** *(Anaes. 17707 = 4B + 3T)* *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $274.45 **Benefit:** 75% = $205.85 85% = $233.30
31320	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 20mm in diameter** - where removal is by **definitive surgical excision and suture *and histological confirmation of malignancy has been obtained*** *(Anaes. 17708 = 4B + 4T)* *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $306.35 **Benefit:** 75% = $229.80 85% = $260.40
31325	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31300* and *31310* - tumour size up to 10mm in diameter** - where removal is by **definitive surgical excision and suture *and histological confirmation of malignancy has been obtained*** *(Anaes. 17707 = 4B + 3T)* *(See para T8.22 of explanatory notes to this Category)* **Fee:** $210.70 **Benefit:** 75% = $158.05 85% = $179.10
31330	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31305* and *31310* - tumour size more than 10mm and up to 20mm in diameter** - where removal is by **definitive surgical excision and suture *and histological confirmation of malignancy has been obtained*** *(Anaes. 17707 = 4B + 3T)* *(See para T8.22 of explanatory notes to this Category)* **Fee:** $249.00 **Benefit:** 75% = $186.75 85% = $211.65
31335	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31305* and *31320* - tumour size more than 20mm in diameter** - where removal is by **definitive surgical excision and suture *and histological confirmation of malignancy has been obtained*** *(Anaes. 17708 = 4B + 4T)* *(See para T8.22 of explanatory notes to this Category)* **Fee:** $287.25 **Benefit:** 75% = $215.45 85% = $244.20
31340	**NOTE:** *Multiple Operation and Multiple Anaesthetic rules apply to this item.* MUSCLE, BONE OR CARTILAGE, excision of one or more of, where clinically indicated, performed in association with excision of malignant tumour of skin covered by item **31255, 31260, 31265, 31270, 31275, 31280, 31285, 31290, 31295, 31300, 31305, 31310, 31315, 31320, 31325, 31330 or 31335** (Anaes. 17710 = 4B + 6T) *(See para T8.22 of explanatory notes to this Category)* **Derived Fee:** 75% of the fee for excision of malignant tumour
31345	LIPOMA, removal of by surgical excision or liposuction, where lesion is subcutaneous and **greater than 50mm in diameter**, or is sub-fascial, ***where specimen is sent for histological confirmation of diagnosis*** *(Anaes. 17707 = 4B + 3T)* *(See para T8.22 of explanatory notes to this Category)* **Fee:** $164.15 **Benefit:** 75% = $123.15 85% = $139.55
31350	BENIGN TUMOUR of SOFT TISSUE, removal of by **surgical excision**, where ***specimen is sent for histological confirmation of diagnosis***, not being a service to which another item in this Group applies (Anaes. 17708 = 4B + 4T) (Assist.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $337.40 **Benefit:** 75% = $253.05 85% = $286.80
31355	MALIGNANT TUMOUR of SOFT TISSUE, removal of by **surgical excision**, where ***histological proof of malignancy has been obtained***, not being a service to which another item in this Group applies (Anaes. 17710 = 5B + 5T) (Assist.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $556.20 **Benefit:** 75% = $417.15 85% = $505.30
31400	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR up to 20mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $203.25 **Benefit:** 75% = $152.45 85% = $172.80
31403	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 20mm and up to 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $234.60 **Benefit:** 75% = $175.95 85% = $199.45

31406	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes. 17718 = 6B + 12T) (Assist.) **Fee:** $390.95	**Benefit:** 75% = $293.25	85% = $340.05
31409	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes. 17718 = 6B + 12T) (Assist.) **Fee:** $1,214.60	**Benefit:** 75% = $910.95	85% = $1,163.70
31412	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes. 17722 = 6B + 16T) (Assist.) **Fee:** $1,496.10	**Benefit:** 75% = $1,122.10	85% = $1,445.20
31420	LYMPH NODE OF NECK, biopsy of (Anaes. 17709 = 5B + 4T) **Fee:** $143.15	**Benefit:** 75% = $107.40	85% = $121.70
31423	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes. 17713 = 5B + 8T) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $312.75	**Benefit:** 75% = $234.60	85% = $265.85
31426	LYMPH NODES OF NECK, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes. 17715 = 5B + 10T) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $625.55	**Benefit:** 75% = $469.20	85% = $574.65
31429	LYMPH NODES OF NECK, selective dissection of 4 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes. 17719 = 5B + 14T) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $974.80	**Benefit:** 75% = $731.10	85% = $923.90
31432	LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections) (Anaes. 17723 = 5B + 18T) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $1,042.55	**Benefit:** 75% = $781.95	85% = $991.65
31435	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck (Anaes. 17719 = 5B + 14T) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $766.30	**Benefit:** 75% = $574.75	85% = $715.40
31438	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes. 17723 = 5B + 18T) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $1,214.60	**Benefit:** 75% = $910.95	85% = $1,163.70
31441	LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, repair, revision or replacement of (Anaes. 17710 = 6B + 4T) **Fee:** $195.90	**Benefit:** 75% = $146.95	85% = $166.55
31450	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken is 1 hour or less (Anaes. 17709 = 6B + 3T) (Assist.) **Fee:** $316.60	**Benefit:** 75% = $237.45	85% = $269.15
31452	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken in more than 1 hour (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $554.00	**Benefit:** 75% = $415.50	85% = $503.10
† 31454	LAPAROSCOPY with drainage of pus, bile or blood, as an independent procedure (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $438.55	**Benefit:** 75% = $328.95	85% = $387.65
† 31456	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition (Anaes. 17708 = 5B + 3T) **Fee:** $191.20	**Benefit:** 75% = $143.40	85% = $162.55
† 31458	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition, and where the use of imaging intensification is clinically indicated (Anaes. 17709 = 5B + 4T) **Fee:** $229.45	**Benefit:** 75% = $172.10	85% = $195.05

† 31460	PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $277.95 **Benefit:** 75% = $208.50 85% = $236.30
† 31462	OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestinal resection (Anaes. 17715 = 10B + 5T) (Assist.) **Fee:** $405.80 **Benefit:** 75% = $304.35 85% = $354.90
† 31464	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopic technique - not being a service to which item 30601 applies (Anaes. 17721 = 9B + 12T) (Assist.) *(See para T8.21 of explanatory notes to this Category* **Fee:** $678.35 **Benefit:** 75% = $508.80 85% = $627.45
† 31466	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, revision procedure, by laparoscopy or open operation (Anaes. 17725 = 9B + 16T) (Assist.) **Fee:** $1,017.50 **Benefit:** 75% = $763.15 85% = $966.60
† 31468	PARA-OESOPHAGEAL HIATUS HERNIA, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication (Anaes. 17727 = 9B + 18T) (Assist.) **Fee:** $1,117.90 **Benefit:** 75% = $838.45 85% = $1,067.00
† 31470	LAPAROSCOPIC SPLENECTOMY (Anaes. 17719 = 7B + 12T) (Assist.) **Fee:** $560.75 **Benefit:** 75% = $420.60 85% = $509.85
† 31472	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY OR ROUX-EN-Y as a bypass procedure where prior biliary surgery has been performed (Anaes. 17724 = 10B + 14T) (Assist.) **Fee:** $910.80 **Benefit:** 75% = $683.10 85% = $859.90
	SUBGROUP 2 - COLORECTAL
32000	LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes. 17717 = 7B + 10T) (Assist.) **Fee:** $802.95 **Benefit:** 75% = $602.25 85% = $752.05
32003	LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (Anaes. 17719 = 7B + 12T) (Assist.) **Fee:** $839.95 **Benefit:** 75% = $630.00 85% = $789.05
32004	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32005 or 32006 applies (Anaes. 17719 = 7B + 12T) (Assist.) **Fee:** $895.60 **Benefit:** 75% = $671.70 85% = $844.70
32005	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004 or 32006 applies (Anaes. 17721 = 7B + 14T) (Assist.) **Fee:** $1,011.75 **Benefit:** 75% = $758.85 85% = $960.85
32006	LEFT HEMICOLECTOMY, including the descending and sigmoid colon (including formation of stoma) (Anaes. 17719 = 7B + 12T) (Assist.) **Fee:** $895.60 **Benefit:** 75% = $671.70 85% = $844.70
32009	TOTAL COLECTOMY AND ILEOSTOMY (Anaes. 17720 = 8B + 12T) (Assist.) **Fee:** $1,062.40 **Benefit:** 75% = $796.80 85% = $1,011.50
32012	TOTAL COLECTOMY AND ILEORECTAL ANASTOMOSIS (Anaes. 17722 = 8B + 14T) (Assist.) **Fee:** $1,173.55 **Benefit:** 75% = $880.20 85% = $1,122.65
32015	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anaes. 17726 = 10B + 16T) (Assist.) **Fee:** $1,442.20 **Benefit:** 75% = $1,081.65 85% = $1,391.30
32018	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes. 17724 = 10B + 14T) (Assist.) **Fee:** $1,222.95 **Benefit:** 75% = $917.25 85% = $1,172.05
32021	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION (Assist.) **Fee:** $438.55 **Benefit:** 75% = $328.95 85% = $387.65

32024	RECTUM, HIGH RESTORATIVE ANTERIOR RESECTION WITH INTRAPERITONEAL ANASTOMOSIS (of the rectum) greater than 10 centimetres from the anal verge excluding resection of sigmoid colon alone (Anaes. 17722 = 10B + 12T) (Assist.) **Fee:** $1,062.40	**Benefit:** 75% = $796.80	85% = $1,011.50
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 (Anaes. 17724 = 10B + 14T) (Assist.) **Fee:** $1,421.05	**Benefit:** 75% = $1,065.80	85% = $1,370.15
32026	RECTUM, ULTRA LOW RESTORATIVE RESECTION, with or without covering stoma, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge (Anaes. 17728 = 10B + 18T) (Assist.) **Fee:** $1,530.35	**Benefit:** 75% = $1,147.80	85% = $1,479.45
32028	RECTUM, LOW OR ULTRA LOW RESTORATIVE RESECTION, with peranal sutured coloanal anastomosis, with or without covering stoma (Anaes. 17730 = 10B + 20T) (Assist.) **Fee:** $1,639.70	**Benefit:** 75% = $1,229.80	85% = $1,588.80
32029	COLONIC RESERVOIR, construction of, being a service associated with a service to which any other item in this Subgroup applies (Anaes. 17721 = 7B + 14T) (Assist.) **Fee:** $327.90	**Benefit:** 75% = $245.95	85% = $278.75
32030	RECTOSIGMOIDECTOMY (Hartmann's operation) (Anaes. 17718 = 8B + 10T) (Assist.) **Fee:** $802.95	**Benefit:** 75% = $602.25	85% = $752.05
32033	RESTORATION OF BOWEL following Hartmann's or similar operation, including dismantling of the stoma (Anaes. 17723 = 8B + 15T) (Assist.) **Fee:** $1,173.55	**Benefit:** 75% = $880.20	85% = $1,122.65
32036	SACROCOCCYGEAL AND PRESACRAL TUMOUR excision of (Anaes. 17720 = 8B + 12T) (Assist.) **Fee:** $1,488.50	**Benefit:** 75% = $1,116.40	85% = $1,437.60
32039	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF 1 surgeon (Anaes. 17726 = 10B + 16T) (Assist.) **Fee:** $1,195.15	**Benefit:** 75% = $896.40	85% = $1,144.25
32042	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes. 17724 = 10B + 14T) (Assist.) **Fee:** $1,006.80	**Benefit:** 75% = $755.10	85% = $955.90
32045	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.) **Fee:** $376.80	**Benefit:** 75% = $282.60	85% = $325.90
32046	RECTUM and ANUS, abdomino-perineal resection of, combined synchronous operation - perineal resection where the perineal surgeon also provides assistance to the abdominal surgeon (Assist.) **Fee:** $582.25	**Benefit:** 75% = $436.70	85% = $531.35
32047	PERINEAL PROCTECTOMY (Anaes. 17717 = 7B + 10T) (Assist.) **Fee:** $678.35	**Benefit:** 75% = $508.80	85% = $627.45
32051	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy 1 surgeon (Anaes. 17737 = 10B + 27T) (Assist.) **Fee:** $1,803.60	**Benefit:** 75% = $1,352.70	85% = $1,752.70
32054	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes. 17730 = 10B + 20T) (Assist.) **Fee:** $1,655.30	**Benefit:** 75% = $1,241.50	85% = $1,604.40
32057	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.) **Fee:** $438.55	**Benefit:** 75% = $328.95	85% = $387.65
32060	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy 1 surgeon (Anaes. 17730 = 10B + 20T) (Assist.) **Fee:** $1,803.60	**Benefit:** 75% = $1,352.70	85% = $1,752.70

32063	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes. 17726 = 10B + 16T) (Assist.) **Fee:** $1,655.30	**Benefit:** 75% = $1,241.50	85% = $1,604.40
32066	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, perineal surgeon (Assist.) **Fee:** $438.55	**Benefit:** 75% = $328.95	85% = $387.65
32069	ILEOSTOMY RESERVOIR, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes. 17727 = 7B + 20T) **Fee:** $1,334.15	**Benefit:** 75% = $1,000.65	85% = $1,283.25
32072	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), with or without biopsy **Fee:** $37.30	**Benefit:** 75% = $28.00	85% = $31.75
32075	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), UNDER GENERAL ANAESTHESIA, with or without biopsy, not being a service associated with a service to which another item in this Group applies (Anaes. 17705 = 4B + 1T) **Fee:** $58.45	**Benefit:** 75% = $43.85	85% = $49.70
32078	SIGMOIDOSCOPIC EXAMINATION with diathermy OR resection of 1 or more polyps where the time taken is less than or equal to 45 minutes (Anaes. 17707 = 4B + 3T) **Fee:** $131.20	**Benefit:** 75% = $98.40	85% = $111.55
32081	SIGMOIDOSCOPIC EXAMINATION with diathermy OR resection of 1 or more polyps where the time taken is greater than 45 minutes (Anaes. 17708 = 4B + 4T) **Fee:** $180.15	**Benefit:** 75% = $135.15	85% = $153.15
32084	FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY up to the hepatic flexure, WITH or WITHOUT BIOPSY (Anaes. 17706 = 4B + 2T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $86.70	**Benefit:** 75% = $65.05	85% = $73.70
32087	FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY up to the hepatic flexure WITH REMOVAL OF 1 OR MORE POLYPS not being a service to which item 32078 applies (Anaes. 17707 = 4B + 3T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $159.40	**Benefit:** 75% = $119.55	85% = $135.50
32090	FIBREOPTIC COLONOSCOPY examination of colon beyond the hepatic flexure WITH or WITHOUT BIOPSY (Anaes. 17707 = 4B + 3T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $260.25	**Benefit:** 75% = $195.20	85% = $221.25
32093	FIBREOPTIC COLONOSCOPY examination of colon beyond the hepatic flexure WITH REMOVAL OF 1 OR MORE POLYPS (Anaes. 17708 = 4B + 4T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $365.25	**Benefit:** 75% = $273.95	85% = $314.35
32094	ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES including colonoscopy (Anaes. 17708 = 4B + 4T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $429.60	**Benefit:** 75% = $322.20	85% = $378.70
32095	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed by stoma, with or without biopsies (Anaes. 17707 = 4B + 3T) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $99.50	**Benefit:** 75% = $74.65	85% = $84.60
32096	RECTAL BIOPSY, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital or approved day hospital facility (Anaes. 17706 = 4B + 2T) (Assist.) **Fee:** $200.05	**Benefit:** 75% = $150.05	85% = $170.05
32099	RECTAL TUMOUR of 5 centimetres or less in diameter, per anal submucosal excision of (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $259.45	**Benefit:** 75% = $194.60	85% = $220.55
32102	RECTAL TUMOUR of greater than 5 centimetres in diameter, indicated by pathological examination, per anal submucosal excision of (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $494.10	**Benefit:** 75% = $370.60	85% = $443.20

32105	ANORECTAL CARCINOMA per anal full thickness excision of (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $376.80 **Benefit:** 75% = $282.60 85% = $325.90
32108	RECTAL TUMOUR, transsphincteric excision of (Kraske or similar operation) (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $778.30 **Benefit:** 75% = $583.75 85% = $727.40
32111	RECTAL PROLAPSE Delorme procedure for (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $494.10 **Benefit:** 75% = $370.60 85% = $443.20
32112	RECTAL PROLAPSE, perineal recto-sigmoidectomy for (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $601.30 **Benefit:** 75% = $451.00 85% = $550.40
32114	RECTAL STRICTURE, per anal release of (Anaes. 17708 = 4B + 4T) **Fee:** $135.90 **Benefit:** 75% = $101.95 85% = $115.55
32115	RECTAL STRICTURE, dilatation of (Anaes. 17706 = 4B + 2T) **Fee:** $98.80 **Benefit:** 75% = $74.10 85% = $84.00
32117	RECTAL PROLAPSE, abdominal rectopexy of (Anaes. 17715 = 6B + 9T) (Assist.) **Fee:** $778.30 **Benefit:** 75% = $583.75 85% = $727.40
32120	RECTAL PROLAPSE, perineal repair of (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $200.05 **Benefit:** 75% = $150.05 85% = $170.05
32123	ANAL STRICTURE, anoplasty for (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $259.45 **Benefit:** 75% = $194.60 85% = $220.55
32126	ANAL INCONTINENCE, Parks' intersphincteric procedure for (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $376.80 **Benefit:** 75% = $282.60 85% = $325.90
32129	ANAL SPHINCTER, direct repair of (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $494.10 **Benefit:** 75% = $370.60 85% = $443.20
32131	RECTOCELE, perineal repair of (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $415.45 **Benefit:** 75% = $311.60 85% = $364.55
32132	HAEMORRHOIDS OR RECTAL PROLAPSE sclerotherapy for (Anaes. 17706 = 4B + 2T) **Fee:** $35.15 **Benefit:** 75% = $26.40 85% = $29.90
32135	HAEMORRHOIDS OR RECTAL PROLAPSE rubber band ligation of, with or without sclerotherapy, cryosurgery or infra red therapy for (Anaes. 17706 = 4B + 2T) **Fee:** $52.50 **Benefit:** 75% = $39.40 85% = $44.65
32138	HAEMORRHOIDECTOMY including excision of anal skin tags when performed (Anaes. 17707 = 4B + 3T) **Fee:** $286.30 **Benefit:** 75% = $214.75 85% = $243.40
32139	HAEMORRHOIDECTOMY involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $286.30 **Benefit:** 75% = $214.75 85% = $243.40
32142	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of (Anaes. 17706 = 4B + 2T) **Fee:** $52.50 **Benefit:** 75% = $39.40 85% = $44.65
32145	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17706 = 4B + 2T) **Fee:** $105.15 **Benefit:** 75% = $78.90 85% = $89.40
32147	PERIANAL THROMBOSIS, incision of (Anaes. 17705 = 3B + 2T) **Fee:** $35.15 **Benefit:** 75% = $26.40 85% = $29.90
32150	OPERATION FOR FISSUREINANO, including excision or sphincterotomy, but excluding dilatation only (Anaes. 17706 = 4B + 2T) (Assist.) **Fee:** $200.05 **Benefit:** 75% = $150.05 85% = $170.05
32153	ANUS, DILATATION OF, under general anaesthesia, with or without disimpaction of faeces, not being a service associated with a service to which another item in this Group applies (Anaes. 17706 = 4B + 2T) **Fee:** $54.65 **Benefit:** 75% = $41.00 85% = $46.50

32156	FISTULA-IN-ANO, SUBCUTANEOUS, excision of (Anaes. 17707 = 4B + 3T) **Fee:** $102.55	**Benefit:** 75% = $76.95	85% = $87.20
32159	ANAL FISTULA, excision of, involving lower half of the anal sphincter mechanism (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $259.45	**Benefit:** 75% = $194.60	85% = $220.55
32162	ANAL FISTULA, excision of, involving the upper half of the anal sphincter mechanism (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $376.80	**Benefit:** 75% = $282.60	85% = $325.90
32165	ANAL FISTULA, repair of, by mucosal flap advancement (Anaes. 17715 = 4B + 11T) (Assist.) **Fee:** $494.10	**Benefit:** 75% = $370.60	85% = $443.20
32166	ANAL FISTULA - readjustment of Seton (Anaes. 17707 = 4B + 3T) **Fee:** $160.50	**Benefit:** 75% = $120.40	85% = $136.45
32168	FISTULA WOUND, review of, under general or regional anaesthetic, as an independent procedure (Anaes. 17707 = 4B + 3T) **Fee:** $102.55	**Benefit:** 75% = $76.95	85% = $87.20
32171	ANORECTAL EXAMINATION, with or without biopsy, under general anaesthetic, not being a service associated with a service to which another item in this Group applies (Anaes. 17706 = 4B + 2T) **Fee:** $69.15	**Benefit:** 75% = $51.90	85% = $58.80
32174	INTRA-ANAL, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes. 17708 = 4B + 4T) **Fee:** $69.15	**Benefit:** 75% = $51.90	85% = $58.80
32175	INTRA-ANAL, PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating theatre of a hospital or approved day-hospital facility (excluding aftercare) (Anaes. 17708 = 4B + 4T) **Fee:** $126.60	**Benefit:** 75% = $94.95	85% = $107.65
32177	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital or approved dayhospital facility, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes. 17707 = 4B + 3T) **Fee:** $135.70	**Benefit:** 75% = $101.80	85% = $115.35
32180	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital or approved dayhospital facility, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes. 17708 = 4B + 4T) **Fee:** $200.05	**Benefit:** 75% = $150.05	85% = $170.05
32183	INTESTINAL SLING PROCEDURE prior to radiotherapy (Anaes. 17715 = 6B + 9T) (Assist.) **Fee:** $437.30	**Benefit:** 75% = $328.00	85% = $386.40
32186	COLONIC LAVAGE, total, intra operative (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $437.30	**Benefit:** 75% = $328.00	85% = $386.40
32200	DISTAL MUSCLE, devascularisation of (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $230.20	**Benefit:** 75% = $172.65	85% = $195.70
32203	ANAL OR PERINEAL GRACILOPLASTY (Anaes. 17717 = 4B + 13T) (Assist.) **Fee:** $494.35	**Benefit:** 75% = $370.80	85% = $443.45
32206	STIMULATOR AND ELECTRODES, insertion of, following previous graciloplasty (Anaes. 17715 = 4B + 11T) (Assist.) **Fee:** $446.60	**Benefit:** 75% = $334.95	85% = $395.70
32209	ANAL OR PERINEAL GRACILOPLASTY with insertion of stimulator and electrodes (Anaes. 17723 = 4B + 19T) (Assist.) **Fee:** $717.70	**Benefit:** 75% = $538.30	85% = $666.80
32210	GRACILIS NEOSPHINCTER PACEMAKER, replacement of (Anaes. 17710 = 6B + 4T) **Fee:** $198.85	**Benefit:** 75% = $149.15	85% = $169.05
32212	ANO-RECTAL APPLICATION OF FORMALIN in the treatment of radiation proctitis, where performed in the operating theatre of a hospital or approved day-hospital facility, excluding aftercare (Anaes. 17705 = 3B + 2T) **Fee:** $106.05	**Benefit:** 75% = $79.55	85% = $90.15

SUBGROUP 3 - VASCULAR

VARICOSE VEINS

32500	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg (excluding after-care) - to a maximum of 6 treatments in a 12 month period (Anaes. 17705 = 3B + 2T) *(See para T8.25 of explanatory notes to this Category)* **Fee:** $85.50 **Benefit:** 75% = $64.15 85% = $72.70
32501	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg, (excluding after-care) - ***where it can be demonstrated that a 7th or subsequent treatment (including any treatments to which item 32500 applies) is indicated in a 12 month period*** *(See para T8.25 of explanatory notes to this Category)* **Fee:** $85.50 **Benefit:** 75% = $64.15 85% = $72.70
32504	VARICOSE VEINS, multiple excision of tributaries, with or without division of 1 or more perforating veins - 1 leg - not being a service associated with a service to which item 32507, 32508, 32511, 32514 or 32517 applies (Anaes. 17707 = 3B + 4T) **Fee:** $208.35 **Benefit:** 75% = $156.30 85% = $177.10
32507	VARICOSE VEINS, sub-fascial surgical exploration of one or more incompetent perforating veins - 1 leg - not being a service associated with a service to which item 32508, 32511, 32514 or 32517 applies (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $415.45 **Benefit:** 75% = $311.60 85% = $364.55
32508	VARICOSE VEINS, complete dissection at the sapheno-femoral **OR** sapheno-popliteal junction, with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $415.45 **Benefit:** 75% = $311.60 85% = $364.55
32511	VARICOSE VEINS, complete dissection at the sapheno-femoral **AND** sapheno-popliteal junction, with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $617.60 **Benefit:** 75% = $463.20 85% = $566.70
32514	VARICOSE VEINS, ligation of the long or short saphenous vein, with or without stripping, by re-operation for recurrent veins in the same territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes. 17712 = 3B + 9T) (Assist.) **Fee:** $721.50 **Benefit:** 75% = $541.15 85% = $670.60
32517	VARICOSE VEINS, ligation of the long and short saphenous vein, with or without stripping, by re-operation for recurrent veins in either territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes. 17713 = 3B + 10T) (Assist.) **Fee:** $929.10 **Benefit:** 75% = $696.85 85% = $878.20

BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE

32700	ARTERY OF NECK, bypass using vein or synthetic material (Anaes. 17725 = 10B + 15T) (Assist.) **Fee:** $1,118.25 **Benefit:** 75% = $838.70 85% = $1,067.35
32703	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Anaes. 17724 = 10B + 14T) (Assist.) **Fee:** $925.05 **Benefit:** 75% = $693.80 85% = $874.15
32708	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes. 17731 = 15B + 16T) (Assist.) **Fee:** $1,106.60 **Benefit:** 75% = $829.95 85% = $1,055.70
32710	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Anaes. 17733 = 15B + 18T) (Assist.) **Fee:** $1,229.60 **Benefit:** 75% = $922.20 85% = $1,178.70
32711	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the common femoral or profunda femoris arteries (Anaes. 17735 = 15B + 20T) (Assist.) **Fee:** $1,352.55 **Benefit:** 75% = $1,014.45 85% = $1,301.65
32712	ILIO-FEMORAL BYPASS GRAFTING (Anaes. 17728 = 15B + 13T) (Assist.) **Fee:** $977.75 **Benefit:** 75% = $733.35 85% = $926.85

32715	AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (Anaes. 17728 = 15B + 13T) (Assist.) **Fee:** $977.75	**Benefit:** 75% = $733.35	85% = $926.85
32718	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes. 17729 = 15B + 14T) (Assist.) **Fee:** $925.05	**Benefit:** 75% = $693.80	85% = $874.15
32721	RENAL ARTERY, bypass grafting to (Anaes. 17732 = 15B + 17T) (Assist.) **Fee:** $1,469.40	**Benefit:** 75% = $1,102.05	85% = $1,418.50
32724	RENAL ARTERIES (both), bypass grafting to (Anaes. 17736 = 15B + 21T) (Assist.) **Fee:** $1,668.50	**Benefit:** 75% = $1,251.40	85% = $1,617.60
32730	MESENTERIC VESSEL (single), bypass grafting to (Anaes. 17728 = 15B + 13T) (Assist.) **Fee:** $1,264.60	**Benefit:** 75% = $948.45	85% = $1,213.70
32733	MESENTERIC VESSELS (multiple), bypass grafting to (Anaes. 17731 = 15B + 16T) (Assist.) **Fee:** $1,469.40	**Benefit:** 75% = $1,102.05	85% = $1,418.50
32736	INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intra-abdominal vascular operation (Anaes. 17727 = 15B + 12T) (Assist.) **Fee:** $321.95	**Benefit:** 75% = $241.50	85% = $273.70
32739	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (Anaes. 17721 = 8B + 13T) (Assist.) **Fee:** $1,007.00	**Benefit:** 75% = $755.25	85% = $956.10
32742	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to below knee popliteal artery (Anaes. 17721 = 8B + 13T) (Assist.) **Fee:** $1,153.40	**Benefit:** 75% = $865.05	85% = $1,102.50
32745	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal artery (Anaes. 17723 = 8B + 15T) (Assist.) **Fee:** $1,317.20	**Benefit:** 75% = $987.90	85% = $1,266.30
32748	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis within 5cms of the ankle joint (Anaes. 17724 = 8B + 16T) (Assist.) **Fee:** $1,428.50	**Benefit:** 75% = $1,071.40	85% = $1,377.60
32751	FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (Anaes. 17720 = 8B + 12T) (Assist.) **Fee:** $925.05	**Benefit:** 75% = $693.80	85% = $874.15
32754	FEMORAL ARTERY BYPASS GRAFTING, using a composite graft (synthetic material and vein) with lower anastomosis above or below the knee, including use of a cuff or sleeve of vein at 1 or both anastomoses (Anaes. 17722 = 8B + 14T) (Assist.) **Fee:** $1,153.40	**Benefit:** 75% = $865.05	85% = $1,102.50
32757	FEMORAL ARTERY SEQUENTIAL BYPASS GRAFTING, (using a vein or synthetic material) where an additional anastomosis is made to separately revascularise more than 1 artery - each additional artery revascularised beyond a femoral bypass (Anaes. 17718 = 8B + 10T) (Assist.) **Fee:** $321.95	**Benefit:** 75% = $241.50	85% = $273.70
32760	VEIN, HARVESTING OF, FROM LEG OR ARM for bypass or replacement graft when not performed on the limb which is the subject of the bypass or graft - each vein (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $316.05	**Benefit:** 75% = $237.05	85% = $268.65
32763	ARTERIAL BYPASS GRAFTING, using vein or synthetic material, not being a service to which another item in this Sub-group applies (Anaes. 17724 = 12B + 12T) (Assist.) **Fee:** $925.05	**Benefit:** 75% = $693.80	85% = $874.15
32766	ARTERIAL OR VENOUS ANASTOMOSIS, not being a service to which another item in this Sub-group applies, as an independent procedure (Anaes. 17722 = 12B + 10T) (Assist.) **Fee:** $614.75	**Benefit:** 75% = $461.10	85% = $563.85

32769	ARTERIAL OR VENOUS ANASTOMOSIS not being a service to which another item in this Sub-group applies, when performed in combination with another vascular operation (including graft to graft anastomosis) (Anaes. 17722 = 12B + 10T) (Assist.) **Fee:** $213.10 **Benefit:** 75% = $159.85 85% = $181.15
	BYPASS, REPLACEMENT, LIGATION OF ANEURYSMS
33050	BYPASS GRAFTING to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Anaes. 17724 = 8B + 16T) (Assist.) **Fee:** $1,132.95 **Benefit:** 75% = $849.75 85% = $1,082.05
33055	BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Anaes. 17722 = 8B + 14T) (Assist.) **Fee:** $908.60 **Benefit:** 75% = $681.45 85% = $857.70
33070	ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes. 17720 = 8B + 12T) (Assist.) **Fee:** $655.55 **Benefit:** 75% = $491.70 85% = $604.65
33075	ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes. 17722 = 10B + 12T) (Assist.) **Fee:** $833.90 **Benefit:** 75% = $625.45 85% = $783.00
33080	INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes. 17729 = 15B + 14T) (Assist.) **Fee:** $1,017.90 **Benefit:** 75% = $763.45 85% = $967.00
33100	ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replacement by graft of vein or synthetic material (Anaes. 17723 = 10B + 13T) (Assist.) **Fee:** $1,118.25 **Benefit:** 75% = $838.70 85% = $1,067.35
33103	THORACIC ANEURYSM, replacement by graft (Anaes. 17745 = 15B + 30T) (Assist.) **Fee:** $1,568.95 **Benefit:** 75% = $1,176.75 85% = $1,518.05
33109	THORACO-ABDOMINAL ANEURYSM, replacement by graft including re-implantation of arteries (Anaes. 17748 = 15B + 33T) (Assist.) **Fee:** $1,896.90 **Benefit:** 75% = $1,422.70 85% = $1,846.00
33112	SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (Anaes. 17745 = 15B + 30T) (Assist.) **Fee:** $1,645.10 **Benefit:** 75% = $1,233.85 85% = $1,594.20
33115	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a service associated with a service to which item 33116 applies (Anaes. 17734 = 15B + 19T) (Assist.) **Fee:** $1,106.60 **Benefit:** 75% = $829.95 85% = $1,055.70
33116	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Ministerial Determination) (Anaes. 17734 = 15B + 19T) (Assist.) *(See para T8.26 of explanatory notes to this Category)* **Fee:** $1,106.60 **Benefit:** 75% = $829.95 85% = $1,055.70
33118	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision of common iliac aneurysms) not being a service associated with a service to which item 33119 applies (Anaes. 17737 = 15B + 22T) (Assist.) **Fee:** $1,229.60 **Benefit:** 75% = $922.20 85% = $1,178.70
33119	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to one or both iliac arteries using endovascular repair procedure, excluding associated radiological services (Ministerial Determination) (Anaes. 17737 = 15B + 22T) (Assist.) *(See para T8.26 of explanatory notes to this Category)* **Fee:** $1,229.60 **Benefit:** 75% = $922.20 85% = $1,178.70
33121	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (with or without excision or bypass of common iliac aneurysms) (Anaes. 17737 = 15B + 22T) (Assist.) **Fee:** $1,352.55 **Benefit:** 75% = $1,014.45 85% = $1,301.65

33124	ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft - unilateral (Anaes. 17726 = 15B + 11T) (Assist.) **Fee:** $942.55 **Benefit:** 75% = $706.95 85% = $891.65
33127	ANEURYSMS OF ILIAC ARTERIES (common, external or internal), replacement by graft - bilateral (Anaes. 17728 = 15B + 13T) (Assist.) **Fee:** $1,235.30 **Benefit:** 75% = $926.50 85% = $1,184.40
33130	ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (Anaes. 17726 = 15B + 11T) (Assist.) **Fee:** $1,077.20 **Benefit:** 75% = $807.90 85% = $1,026.30
33133	ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of continuity (Anaes. 17724 = 15B + 9T) (Assist.) **Fee:** $807.90 **Benefit:** 75% = $605.95 85% = $757.00
33136	FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes. 17733 = 15B + 18T) (Assist.) **Fee:** $2,037.30 **Benefit:** 75% = $1,528.00 85% = $1,986.40
33139	FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (Anaes. 17727 = 15B + 12T) (Assist.) **Fee:** $1,235.30 **Benefit:** 75% = $926.50 85% = $1,184.40
33142	FALSE ANEURYSM, repair of, in femoral artery and restoration of arterial continuity (Anaes. 17726 = 15B + 11T) (Assist.) **Fee:** $1,153.40 **Benefit:** 75% = $865.05 85% = $1,102.50
33145	RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (Anaes. 17749 = 15B + 34T) (Assist.) **Fee:** $1,984.70 **Benefit:** 75% = $1,488.55 85% = $1,933.80
33148	RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes. 17752 = 15B + 37T) (Assist.) **Fee:** $2,464.75 **Benefit:** 75% = $1,848.60 85% = $2,413.85
33151	RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes. 17749 = 15B + 34T) (Assist.) **Fee:** $2,341.80 **Benefit:** 75% = $1,756.35 85% = $2,290.90
33154	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (Anaes. 17736 = 15B + 21T) (Assist.) **Fee:** $1,733.00 **Benefit:** 75% = $1,299.75 85% = $1,682.10
33157	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms) (Anaes. 17738 = 15B + 23T) (Assist.) **Fee:** $1,932.00 **Benefit:** 75% = $1,449.00 85% = $1,881.10
33160	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (Anaes. 17738 = 15B + 23T) (Assist.) **Fee:** $1,932.00 **Benefit:** 75% = $1,449.00 85% = $1,881.10
33163	RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (Anaes. 17730 = 15B + 15T) (Assist.) **Fee:** $1,639.35 **Benefit:** 75% = $1,229.55 85% = $1,588.45
33166	RUPTURED ANEURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes. 17730 = 15B + 15T) (Assist.) **Fee:** $1,639.35 **Benefit:** 75% = $1,229.55 85% = $1,588.45
33169	RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (Anaes. 17726 = 15B + 11T) (Assist.) **Fee:** $1,276.35 **Benefit:** 75% = $957.30 85% = $1,225.45
33172	ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item in this Sub-group applies (Anaes. 17726 = 12B + 14T) (Assist.) **Fee:** $995.25 **Benefit:** 75% = $746.45 85% = $944.35
33175	RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes. 17721 = 8B + 13T) (Assist.) **Fee:** $917.20 **Benefit:** 75% = $687.90 85% = $866.30

33178	RUPTURED ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes. 17723 = 10B + 13T) (Assist.) **Fee:** $1,166.40 **Benefit:** 75% = $874.80 85% = $1,115.50
33181	RUPTURED INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes. 17730 = 15B + 15T) (Assist.) **Fee:** $1,426.10 **Benefit:** 75% = $1,069.60 85% = $1,375.20
	ENDARTERECTOMY AND ARTERIAL PATCH
33500	ARTERY OR ARTERIES OF NECK, endarterectomy of, including closure by suture (where endarterectomy of 1 or more arteries is undertaken through 1 arteriotomy incision) (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $884.00 **Benefit:** 75% = $663.00 85% = $833.10
33506	INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $989.45 **Benefit:** 75% = $742.10 85% = $938.55
33509	AORTIC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the aorta (Anaes. 17728 = 15B + 13T) (Assist.) **Fee:** $1,106.60 **Benefit:** 75% = $829.95 85% = $1,055.70
33512	AORTO-ILIAC ENDARTERECTOMY (1 or both iliac arteries), including closure by suture not being a service associated with a service to which item 33515 applies (Anaes. 17729 = 15B + 14T) (Assist.) **Fee:** $1,229.60 **Benefit:** 75% = $922.20 85% = $1,178.70
33515	AORTO-FEMORAL ENDARTERECTOMY (1 or both femoral arteries) or BILATERAL ILIO-FEMORAL ENDARTERECTOMY, including closure by suture, not being a service associated with a service to which item 33512 applies (Anaes. 17730 = 15B + 15T) (Assist.) **Fee:** $1,352.55 **Benefit:** 75% = $1,014.45 85% = $1,301.65
33518	ILIAC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the iliac artery (Anaes. 17728 = 15B + 13T) (Assist.) **Fee:** $989.45 **Benefit:** 75% = $742.10 85% = $938.55
33521	ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (Anaes. 17727 = 15B + 12T) (Assist.) **Fee:** $1,071.35 **Benefit:** 75% = $803.55 85% = $1,020.45
33524	RENAL ARTERY, endarterectomy of (Anaes. 17729 = 15B + 14T) (Assist.) **Fee:** $1,264.60 **Benefit:** 75% = $948.45 85% = $1,213.70
33527	RENAL ARTERIES (both), endarterectomy of (Anaes. 17731 = 15B + 16T) (Assist.) **Fee:** $1,469.40 **Benefit:** 75% = $1,102.05 85% = $1,418.50
33530	COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes. 17729 = 15B + 14T) (Assist.) **Fee:** $1,264.60 **Benefit:** 75% = $948.45 85% = $1,213.70
33533	COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes. 17733 = 15B + 18T) (Assist.) **Fee:** $1,469.40 **Benefit:** 75% = $1,102.05 85% = $1,418.50
33536	INFERIOR MESENTERIC ARTERY, endarterectomy of, not being a service associated with a service to which another other item in this Sub-group applies (Anaes. 17730 = 15B + 15T) (Assist.) **Fee:** $1,048.05 **Benefit:** 75% = $786.05 85% = $997.15
33539	ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (Anaes. 17714 = 8B + 6T) (Assist.) **Fee:** $755.20 **Benefit:** 75% = $566.40 85% = $704.30
33542	EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long (Anaes. 17716 = 8B + 8T) (Assist.) **Fee:** $1,077.20 **Benefit:** 75% = $807.90 85% = $1,026.30
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 T8.27 of explanatory notes to this Category)* **Fee:** $213.10 **Benefit:** 75% = $159.85 85% = $181.15

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 T8.27 of explanatory notes to this Category)* **Fee:** $433.35 **Benefit:** 75% = $325.05 85% = $382.45
33551	VEIN, harvesting of from leg or arm for patch when not performed through same incision as operation (Anaes. 17708 = 3B + 5T) (Assist.) *(See para T8.27 of explanatory notes to this Category)* **Fee:** $213.10 **Benefit:** 75% = $159.85 85% = $181.15
33554	ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (Anaes. 17715 = 12B + 3T) (Assist.) **Fee:** $212.05 **Benefit:** 75% = $159.05 85% = $180.25
	EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA
33800	EMBOLUS, removal of, from artery of neck (Anaes. 17715 = 10B + 5T) (Assist.) **Fee:** $919.15 **Benefit:** 75% = $689.40 85% = $868.25
33803	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (Anaes. 17723 = 15B + 8T) (Assist.) **Fee:** $878.20 **Benefit:** 75% = $658.65 85% = $827.30
33806	EMBOLECTOMY OR THROMBECTOMY, from an artery or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery (Anaes. 17711 = 7B + 4T) (Assist.) **Fee:** $632.35 **Benefit:** 75% = $474.30 85% = $581.45
33810	INFERIOR VENA CAVA OR ILIAC VEIN, closed thrombectomy by catheter via the femoral vein (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $461.25 **Benefit:** 75% = $345.95 85% = $410.35
33811	INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes. 17723 = 15B + 8T) (Assist.) **Fee:** $1,373.10 **Benefit:** 75% = $1,029.85 85% = $1,322.20
33812	THROMBUS, removal of, from femoral or other similar large vein (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $726.00 **Benefit:** 75% = $544.50 85% = $675.10
33815	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (Anaes. 17713 = 6B + 7T) (Assist.) **Fee:** $667.40 **Benefit:** 75% = $500.55 85% = $616.50
33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $778.70 **Benefit:** 75% = $584.05 85% = $727.80
33821	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes. 17717 = 7B + 10T) (Assist.) **Fee:** $889.90 **Benefit:** 75% = $667.45 85% = $839.00
33824	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (Anaes. 17718 = 10B + 8T) (Assist.) **Fee:** $848.85 **Benefit:** 75% = $636.65 85% = $797.95
33827	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes. 17718 = 10B + 8T) (Assist.) **Fee:** $995.25 **Benefit:** 75% = $746.45 85% = $944.35
33830	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $1,141.60 **Benefit:** 75% = $856.20 85% = $1,090.70
33833	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (Anaes. 17727 = 15B + 12T) (Assist.) **Fee:** $1,036.30 **Benefit:** 75% = $777.25 85% = $985.40

33836	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes. 17728 = 15B + 13T) (Assist.) **Fee:** $1,235.30 **Benefit:** 75% = $926.50 85% = $1,184.40
33839	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes. 17729 = 15B + 14T) (Assist.) **Fee:** $1,446.05 **Benefit:** 75% = $1,084.55 85% = $1,395.15
33842	ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes. 17716 = 10B + 6T) (Assist.) **Fee:** $714.25 **Benefit:** 75% = $535.70 85% = $663.35
33845	LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes. 17723 = 15B + 8T) (Assist.) **Fee:** $497.65 **Benefit:** 75% = $373.25 85% = $446.75
33848	EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $497.65 **Benefit:** 75% = $373.25 85% = $446.75
	LIGATION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS
34100	MAJOR ARTERY OF NECK, elective ligation or exploration of, not being a service associated with any other vascular procedure (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $550.35 **Benefit:** 75% = $412.80 85% = $499.45
34103	GREAT ARTERY OR GREAT VEIN (including subclavian, axillary, iliac, femoral or popliteal), ligation of, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes. 17715 = 6B + 9T) (Assist.) **Fee:** $321.95 **Benefit:** 75% = $241.50 85% = $273.70
34106	ARTERY OR VEIN (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $227.15 **Benefit:** 75% = $170.40 85% = $193.10
34109	TEMPORAL ARTERY, biopsy of (Anaes. 17708 = 5B + 3T) (Assist.) **Fee:** $263.40 **Benefit:** 75% = $197.55 85% = $223.90
34112	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and ligation (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $667.40 **Benefit:** 75% = $500.55 85% = $616.50
34115	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and ligation (Anaes. 17718 = 10B + 8T) (Assist.) **Fee:** $755.20 **Benefit:** 75% = $566.40 85% = $704.30
34118	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and ligation (Anaes. 17727 = 15B + 12T) (Assist.) **Fee:** $1,077.20 **Benefit:** 75% = $807.90 85% = $1,026.30
34121	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $860.60 **Benefit:** 75% = $645.45 85% = $809.70
34124	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (Anaes. 17718 = 10B + 8T) (Assist.) **Fee:** $942.55 **Benefit:** 75% = $706.95 85% = $891.65
34127	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes. 17729 = 15B + 14T) (Assist.) **Fee:** $1,235.30 **Benefit:** 75% = $926.50 85% = $1,184.40
34130	SURGICALLY CREATED ARTERIO-VENOUS FISTULA OF AN EXTREMITY, closure of (Anaes. 17712 = 8B + 4T) (Assist.) **Fee:** $386.45 **Benefit:** 75% = $289.85 85% = $335.55
34133	SCALENOTOMY (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $433.35 **Benefit:** 75% = $325.05 85% = $382.45

34136	FIRST RIB, resection of portion of (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $696.60 **Benefit:** 75% = $522.45 85% = $645.70
34139	CERVICAL RIB, removal of, or other operation for removal of thoracic outlet compression, not being a service to which another item in this Sub-group applies (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $696.60 **Benefit:** 75% = $522.45 85% = $645.70
34142	COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent procedure (Anaes. 17727 = 15B + 12T) (Assist.) **Fee:** $860.60 **Benefit:** 75% = $645.45 85% = $809.70
34145	POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Anaes. 17714 = 8B + 6T) (Assist.) **Fee:** $626.50 **Benefit:** 75% = $469.90 85% = $575.60
34148	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is 4cm or less in maximum diameter (Anaes. 17725 = 10B + 15T) (Assist.) **Fee:** $1,118.25 **Benefit:** 75% = $838.70 85% = $1,067.35
34151	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is greater than 4cm in maximum diameter (Anaes. 17725 = 10B + 15T) (Assist.) **Fee:** $1,528.05 **Benefit:** 75% = $1,146.05 85% = $1,477.15
34154	RECURRENT CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes. 17725 = 10B + 15T) (Assist.) **Fee:** $1,820.80 **Benefit:** 75% = $1,365.60 85% = $1,769.90
34157	NECK, excision of infected bypass graft, including closure of vessel or vessels (Anaes. 17722 = 10B + 12T) (Assist.) **Fee:** $925.05 **Benefit:** 75% = $693.80 85% = $874.15
34160	AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes. 17732 = 15B + 17T) (Assist.) **Fee:** $1,733.00 **Benefit:** 75% = $1,299.75 85% = $1,682.10
34163	AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (Anaes. 17735 = 15B + 20T) (Assist.) **Fee:** $2,224.75 **Benefit:** 75% = $1,668.60 85% = $2,173.85
34166	AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (Anaes. 17737 = 15B + 22T) (Assist.) **Fee:** $2,224.75 **Benefit:** 75% = $1,668.60 85% = $2,173.85
34169	INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes. 17728 = 15B + 13T) (Assist.) **Fee:** $1,235.30 **Benefit:** 75% = $926.50 85% = $1,184.40
34172	INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (Anaes. 17722 = 10B + 12T) (Assist.) **Fee:** $1,007.00 **Benefit:** 75% = $755.25 85% = $956.10
34175	INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (Anaes. 17718 = 8B + 10T) (Assist.) **Fee:** $925.05 **Benefit:** 75% = $693.80 85% = $874.15
	OPERATIONS FOR VASCULAR ACCESS
34500	ARTERIOVENOUS SHUNT, EXTERNAL, insertion of (Anaes. 17714 = 8B + 6T) (Assist.) **Fee:** $240.05 **Benefit:** 75% = $180.05 85% = $204.05
34503	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (Anaes. 17717 = 8B + 9T) (Assist.) **Fee:** $321.95 **Benefit:** 75% = $241.50 85% = $273.70
34506	ARTERIOVENOUS SHUNT, EXTERNAL, removal of (Anaes. 17710 = 8B + 2T) (Assist.) **Fee:** $163.95 **Benefit:** 75% = $123.00 85% = $139.40
34509	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conjunction with another venous or arterial operation (Anaes. 17717 = 8B + 9T) (Assist.) **Fee:** $761.05 **Benefit:** 75% = $570.80 85% = $710.15

34512	ARTERIOVENOUS ACCESS DEVICE, insertion of (Anaes. 17716 = 8B + 8T) (Assist.) **Fee:** $837.25 **Benefit:** 75% = $627.95 85% = $786.35
34515	ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (Anaes. 17714 = 8B + 6T) (Assist.) **Fee:** $597.15 **Benefit:** 75% = $447.90 85% = $546.25
34518	STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (Anaes. 17718 = 8B + 10T) (Assist.) **Fee:** $1,001.10 **Benefit:** 75% = $750.85 85% = $950.20
34521	INTRA-ABDOMINAL ARTERY OR VEIN, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $615.00 **Benefit:** 75% = $461.25 85% = $564.10
34524	ARTERIAL CANNULATION for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Anaes. 17714 = 8B + 6T) (Assist.) **Fee:** $321.95 **Benefit:** 75% = $241.50 85% = $273.70
34527	CENTRAL VEIN CATHETERISATION by open technique, using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation (Anaes. 17711 = 5B + 6T) **Fee:** $429.45 **Benefit:** 75% = $322.10 85% = $378.55
34528	CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device (Anaes. 17709 = 5B + 4T) **Fee:** $212.05 **Benefit:** 75% = $159.05 85% = $180.25
34530	HICKMAN OR BROVIAC CATHETER, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital or approved day-hospital (Anaes. 17709 = 5B + 4T) **Fee:** $159.05 **Benefit:** 75% = $119.30 85% = $135.20
34533	ISOLATED LIMB PERFUSION, including cannulation of artery and vein at commencement of procedure, regional perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy at conclusion of procedure (excluding aftercare) (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $965.95 **Benefit:** 75% = $724.50 85% = $915.05
	COMPLEX VENOUS OPERATIONS
34800	INFERIOR VENA CAVA, plication, ligation, or application of caval clip (Anaes. 17718 = 10B + 8T) (Assist.) **Fee:** $632.35 **Benefit:** 75% = $474.30 85% = $581.45
34803	INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (Anaes. 17729 = 10B + 19T) (Assist.) **Fee:** $1,393.40 **Benefit:** 75% = $1,045.05 85% = $1,342.50
34806	CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes. 17714 = 3B + 11T) (Assist.) **Fee:** $755.20 **Benefit:** 75% = $566.40 85% = $704.30
34809	SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes. 17714 = 3B + 11T) (Assist.) **Fee:** $755.20 **Benefit:** 75% = $566.40 85% = $704.30
34812	VENOUS STENOSIS OR OCCLUSION, vein bypass for, using vein or synthetic material, not being a service associated with a service to which item 34806 or 34809 applies (Anaes. 17714 = 4B + 10T) (Assist.) **Fee:** $913.35 **Benefit:** 75% = $685.05 85% = $862.45
34815	VEIN STENOSIS, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material (Anaes. 17714 = 4B + 10T) (Assist.) *(See para T8.27 of explanatory notes to this Category)* **Fee:** $755.20 **Benefit:** 75% = $566.40 85% = $704.30
34818	VENOUS VALVE, plication or repair to restore valve competency (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $831.35 **Benefit:** 75% = $623.55 85% = $780.45
34821	VEIN TRANSPLANT to restore valvular function (Anaes. 17713 = 3B + 10T) (Assist.) **Fee:** $1,129.95 **Benefit:** 75% = $847.50 85% = $1,079.05

34824	EXTERNAL STENT, application of, to restore venous valve competency to superficial vein - 1 stent (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $386.45 **Benefit:** 75% = $289.85 85% = $335.55
34827	EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $468.35 **Benefit:** 75% = $351.30 85% = $417.45
34830	EXTERNAL STENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $550.35 **Benefit:** 75% = $412.80 85% = $499.45
34833	EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Anaes. 17712 = 3B + 9T) (Assist.) **Fee:** $714.25 **Benefit:** 75% = $535.70 85% = $663.35
	SYMPATHECTOMY
35000	LUMBAR SYMPATHECTOMY (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $550.35 **Benefit:** 75% = $412.80 85% = $499.45
35003	CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes. 17718 = 10B + 8T) (Assist.) **Fee:** $714.25 **Benefit:** 75% = $535.70 85% = $663.35
35006	CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $895.75 **Benefit:** 75% = $671.85 85% = $844.85
35009	LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $696.60 **Benefit:** 75% = $522.45 85% = $645.70
35012	SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $550.35 **Benefit:** 75% = $412.80 85% = $499.45
	DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE
35100	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, when debridement includes muscle, tendon or bone (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $286.95 **Benefit:** 75% = $215.25 85% = $243.95
35103	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes. 17711 = 4B + 7T) **Fee:** $182.65 **Benefit:** 75% = $137.00 85% = $155.30
	MISCELLANEOUS VASCULAR PROCEDURES
35200	OPERATIVE ARTERIOGRAPHY OR VENOGRAPHY, 1 or more of, performed during the course of an operative procedure on an artery or vein, 1 site (Anaes. 17708 = 5B + 3T) **Fee:** $133.50 **Benefit:** 75% = $100.15 85% = $113.50
35202	MAJOR ARTERIES OR VEINS IN THE NECK, ABDOMEN OR EXTREMITIES, access to, as part of RE-OPERATION after prior surgery on these vessels (Anaes. 17720 = 12B + 8T) (Assist.) **Fee:** $636.20 **Benefit:** 75% = $477.15 85% = $585.30
	ENDOVASCULAR INTERVENTIONAL PROCEDURES
35300	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes. 17712 = 8B + 4T) (Assist.) **Fee:** $401.30 **Benefit:** 75% = $301.00 85% = $350.40
35303	TRANSLUMINAL BALLOON ANGIOPLASTY of aortic arch branches, aortic visceral branches, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes. 17714 = 10B + 4T) (Assist.) **Fee:** $514.45 **Benefit:** 75% = $385.85 85% = $463.55

35304	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes. 17721 = 15B + 6T) (Assist.) **Fee:** $401.30	**Benefit:** 75% = $301.00	85% = $350.40
35305	TRANSLUMINAL BALLOON ANGIOPLASTY of more than 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation and excluding aftercare (Anaes. 17723 = 15B + 8T) (Assist.) **Fee:** $514.45	**Benefit:** 75% = $385.85	85% = $463.55
35306	TRANSLUMINAL STENT INSERTION including associated balloon dilatation for 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $474.85	**Benefit:** 75% = $356.15	85% = $423.95
35309	TRANSLUMINAL STENT INSERTION including associated balloon dilatation for visceral arteries or veins, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $593.55	**Benefit:** 75% = $445.20	85% = $542.65
35310	TRANSLUMINAL STENT INSERTION including associated balloon dilatation for coronary artery, percutaneous or by open exposure, excluding associated radiological services and preparation, and excluding aftercare (Anaes. 17723 = 15B + 8T) (Assist.) **Fee:** $593.55	**Benefit:** 75% = $445.20	85% = $542.65
35312	PERIPHERAL ARTERIAL ATHERECTOMY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes. 17714 = 8B + 6T) (Assist.) **Fee:** $672.70	**Benefit:** 75% = $504.55	85% = $621.80
35315	PERIPHERAL LASER ANGIOPLASTY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes. 17714 = 8B + 6T) (Assist.) **Fee:** $672.70	**Benefit:** 75% = $504.55	85% = $621.80
35317	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY CONTINUOUS INFUSION, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35319 or 35320 applies) (Anaes. 17708 = 6B + 2T) (Assist.) *(See para T8.28 of explanatory notes to this Category)* **Fee:** $277.00	**Benefit:** 75% = $207.75	85% = $235.45
35319	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY PULSE SPRAY TECHNIQUE, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35320 applies) (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $496.55	**Benefit:** 75% = $372.45	85% = $445.65
35320	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY OPEN EXPOSURE, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35319 applies) (Anaes. 17713 = 6B + 7T) (Assist.) **Fee:** $667.05	**Benefit:** 75% = $500.30	85% = $616.15
35321	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION to administer agents to occlude arteries, veins or arterio-venous fistulae or to arrest haemorrhage, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes. 17712 = 8B + 4T) (Assist.) **Fee:** $633.10	**Benefit:** 75% = $474.85	85% = $582.20
35324	ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes. 17712 = 8B + 4T) (Assist.) **Fee:** $237.35	**Benefit:** 75% = $178.05	85% = $201.75
35327	ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes. 17712 = 8B + 4T) (Assist.) **Fee:** $318.10	**Benefit:** 75% = $238.60	85% = $270.40
35330	INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes. 17722 = 15B + 7T) (Assist.) **Fee:** $401.30	**Benefit:** 75% = $301.00	85% = $350.40

SUBGROUP 4 - GYNAECOLOGICAL

35500	GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes. 17704 = 3B + 1T) **Fee:** $63.25	**Benefit:** 75% = $47.45	85% = $53.80
35503	INTRAUTERINE CONTRACEPTIVE DEVICE, INTRODUCTION OF, not being a service associated with a service to which another item in this Group applies (Anaes. 17704 = 3B + 1T) **Fee:** $41.70	**Benefit:** 75% = $31.30	85% = $35.45
35506	INTRAUTERINE CONTRACEPTIVE DEVICE, REMOVAL OF UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes. 17704 = 3B + 1T) **Fee:** $41.80	**Benefit:** 75% = $31.35	85% = $35.55
35507	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital or approved day-hospital facility, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes. 17706 = 3B + 3T) **Fee:** $135.90	**Benefit:** 75% = $101.95	85% = $115.55
35508	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital or approved day-hospital facility, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $200.05	**Benefit:** 75% = $150.05	85% = $170.05
35509	HYMENECTOMY (Anaes. 17705 = 3B + 2T) **Fee:** $69.75	**Benefit:** 75% = $52.35	85% = $59.30
35512 G 35513 S	BARTHOLIN'S CYST, excision of (Anaes. 17705 = 3B + 2T) **Fee:** $139.60 **Fee:** $172.65	**Benefit:** 75% = $104.70 **Benefit:** 75% = $129.50	85% = $118.70 85% = $146.80
35516 G 35517 S	BARTHOLIN'S CYST OR GLAND, marsupialisation of (Anaes. 17705 = 3B + 2T) **Fee:** $90.60 **Fee:** $113.65	**Benefit:** 75% = $67.95 **Benefit:** 75% = $85.25	85% = $77.05 85% = $96.65
35518	OVARIAN CYST ASPIRATION, for cysts of at least 4cm in diameter in premenopausal women and at least 2cm in diameter in postmenopausal women, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques (Anaes. 17707 = 4B + 3T) **Fee:** $161.75	**Benefit:** 75% = $121.35	85% = $137.50
35520	BARTHOLIN'S ABSCESS, incision of (Anaes. 17704 = 3B + 1T) **Fee:** $45.35	**Benefit:** 75% = $34.05	85% = $38.55
35523	URETHRA OR URETHRAL CARUNCLE, cauterisation of (Anaes. 17705 = 3B + 2T) **Fee:** $45.35	**Benefit:** 75% = $34.05	85% = $38.55
35526 G 35527 S	URETHRAL CARUNCLE, excision of (Anaes. 17705 = 3B + 2T) **Fee:** $90.60 **Fee:** $113.65	**Benefit:** 75% = $67.95 **Benefit:** 75% = $85.25	85% = $77.05 85% = $96.65
35530	CLITORIS, amputation of, where medically indicated (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $210.05	**Benefit:** 75% = $157.55	85% = $178.55
35533	VULVOPLASTY or LABIOPLASTY, where medically indicated, not being a service associated with a service to which item 35536 applies (Anaes. 17709 = 3B + 6T) **Fee:** $272.40	**Benefit:** 75% = $204.30	85% = $231.55
35536	VULVA, wide local excision of suspected malignancy or hemivulvectomy, 1 or both procedures (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $271.25	**Benefit:** 75% = $203.45	85% = $230.60
35539	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 1 anatomical site (Anaes. 17705 = 3B + 2T) **Fee:** $212.50	**Benefit:** 75% = $159.40	85% = $180.65

35542	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 2 or more anatomical sites (Anaes. 17705 = 3B + 2T) (Assist.) **Fee:** $248.80	**Benefit:** 75% = $186.60	85% = $211.50
35545	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for condylomata, unsuccessfully treated by other methods (Anaes. 17705 = 3B + 2T) **Fee:** $143.00	**Benefit:** 75% = $107.25	85% = $121.55
35548	VULVECTOMY, radical, for malignancy (Anaes. 17720 = 7B + 13T) (Assist.) **Fee:** $649.40	**Benefit:** 75% = $487.05	85% = $598.50
35551	PELVIC LYMPH GLANDS, excision of (radical) (Anaes. 17718 = 8B + 10T) (Assist.) **Fee:** $532.45	**Benefit:** 75% = $399.35	85% = $481.55
35554	VAGINA, DILATATION OF, as an independent procedure including any associated consultation (Anaes. 17704 = 3B + 1T) **Fee:** $33.85	**Benefit:** 75% = $25.40	85% = $28.80
35557	VAGINA, removal of simple tumour (including Gartner duct cyst) (Anaes. 17705 = 3B + 2T) **Fee:** $167.00	**Benefit:** 75% = $125.25	85% = $141.95
35560	VAGINA, partial or complete removal of (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $532.45	**Benefit:** 75% = $399.35	85% = $481.55
35561	VAGINECTOMY, radical, for proven invasive malignancy - 1 surgeon (Anaes. 17724 = 4B + 20T) (Assist.) **Fee:** $1,074.05	**Benefit:** 75% = $805.55	85% = $1,023.15
35562	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (Anaes. 17724 = 4B + 20T) (Assist.) **Fee:** $881.85	**Benefit:** 75% = $661.40	85% = $830.95
35564	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - perineal surgeon (Assist.) **Fee:** $407.10	**Benefit:** 75% = $305.35	85% = $356.20
35565	VAGINAL RECONSTRUCTION for congenital absence, gynatresia or urogenital sinus (Anaes. 17718 = 4B + 14T) (Assist.) **Fee:** $532.45	**Benefit:** 75% = $399.35	85% = $481.55
35566	VAGINAL SEPTUM, excision of, for correction of double vagina (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $309.30	**Benefit:** 75% = $232.00	85% = $262.95
35567	VAGINAL REPAIR including 1 or more of anterior, posterior or entrocele repair, with sacrospinous colpopexy (Anaes. 17714 = 4B + 10T) (Assist.) **Fee:** $546.55	**Benefit:** 75% = $409.95	85% = $495.65
35569	PLASTIC REPAIR TO ENLARGE VAGINAL ORIFICE (Anaes. 17705 = 3B + 2T) **Fee:** $125.20	**Benefit:** 75% = $93.90	85% = $106.45
35572	COLPOTOMY not being a service to which another item in this Group applies (Anaes. 17706 = 4B + 2T) **Fee:** $96.40	**Benefit:** 75% = $72.30	85% = $81.95
35576	ANTERIOR VAGINAL REPAIR OR POSTERIOR VAGINAL REPAIR (involving repair of rectocele or enterocele or both) not being a service to which item 35580 or 35584 applies (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $330.90	**Benefit:** 75% = $248.20	85% = $281.30
35580	ANTERIOR VAGINAL REPAIR AND POSTERIOR VAGINAL REPAIR (involving repair of rectocele or enterocele or both) not being a service to which item 35584 applies (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $417.30	**Benefit:** 75% = $313.00	85% = $366.40
35584	MANCHESTER (DONALDFOTHERGILL) OPERATION OR LE FORT OPERATION for genital prolapse (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $525.15	**Benefit:** 75% = $393.90	85% = $474.25
35587	URETHROCELE, operation for (Anaes. 17709 = 4B + 5T) **Fee:** $136.70	**Benefit:** 75% = $102.55	85% = $116.20

35590	Operation involving ABDOMINAL APPROACH for repair of ENTEROCELE OR SUSPENSION OF VAGINAL VAULT OR ENTEROCELE AND SUSPENSION OF VAGINAL VAULT (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $417.30	**Benefit:** 75% = $313.00	85% = $366.40
35593	VAGINAL REPAIR OF ENTEROCELE with or without repair of rectocele, not being a service associated with a service to which item 35576, 35580, 35584, 35590, 35657, 35673, 35750 or 35753 applies, and where on a previous occasion there has been performed surgery reflected by a procedure to which item 35576, 35580, 35584, 35590, 35657, 35673, 35750 or 35753 applies (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $417.30	**Benefit:** 75% = $313.00	85% = $366.40
35596	FISTULA BETWEEN GENITAL AND URINARY OR ALIMENTARY TRACTS, repair of, not being a service to which item 37029, 37333 or 37336 applies (Anaes. 17715 = 6B + 9T) (Assist.) **Fee:** $532.45	**Benefit:** 75% = $399.35	85% = $481.55
35599	STRESS INCONTINENCE, sling operation for (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $525.15	**Benefit:** 75% = $393.90	85% = $474.25
35600	STRESS INCONTINENCE, VAGINAL PROCEDURE FOR (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $407.70	**Benefit:** 75% = $305.80	85% = $356.80
35602	STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; abdominal procedure (including aftercare) (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $525.15	**Benefit:** 75% = $393.90	85% = $474.25
35605	STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; vaginal procedure (including aftercare) (Assist.) **Fee:** $284.90	**Benefit:** 75% = $213.70	85% = $242.20
35608	CERVIX, cauterisation (other than by chemical means), ionisation, diathermy or biopsy of, with or without dilatation of cervix (Anaes. 17705 = 3B + 2T) **Fee:** $49.80	**Benefit:** 75% = $37.35	85% = $42.35
35611	CERVIX, removal of polyp or polypi, with or without dilatation of cervix, not being a service associated with a service to which item 35608 applies (Anaes. 17705 = 3B + 2T) **Fee:** $49.80	**Benefit:** 75% = $37.35	85% = $42.35
35612	CERVIX, RESIDUAL STUMP, removal of, by abdominal approach (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $393.90	**Benefit:** 75% = $295.45	85% = $343.00
35613	CERVIX, RESIDUAL STUMP, removal of, by vaginal approach (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $315.20	**Benefit:** 75% = $236.40	85% = $267.95
35614	EXAMINATION OF LOWER FEMALE GENITAL TRACT by a Hinselmanntype colposcope in a patient with a previous abnormal cervical smear or a history of maternal ingestion of oestrogen or where a patient, because of suspicious signs of cancer, has been referred by another medical practitioner (Anaes. 17705 = 3B + 2T) *(See para T8.29 of explanatory notes to this Category)* **Fee:** $49.70	**Benefit:** 75% = $37.30	85% = $42.25
35615	VULVA, biopsy of, when performed in conjunction with a service to which item 35614 applies **Fee:** $41.80	**Benefit:** 75% = $31.35	85% = $35.55
35617 G 35618 S	CERVIX, cone biopsy, amputation or repair of, not being a service to which item 35584 applies (Anaes. 17705 = 3B + 2T) **Fee:** $135.20 **Fee:** $169.75	**Benefit:** 75% = $101.40 **Benefit:** 75% = $127.35	85% = $114.95 85% = $144.30
35620	ENDOMETRIAL BIOPSY where malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (Anaes. 17705 = 3B + 2T) **Fee:** $41.50	**Benefit:** 75% = $31.15	85% = $35.30
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 (Anaes. 17710 = 4B + 6T) **Fee:** $469.10	**Benefit:** 75% = $351.85	85% = $418.20
‡@ 35623	HYSTEROSCOPIC RESECTION of myoma, or myoma and uterine septum resection (where both are performed), followed by endometrial ablation by laser or diathermy (Anaes. 17716 = 4B + 12T) **Fee:** $637.80	**Benefit:** 75% = $478.35	85% = $586.90

35626	HYSTEROSCOPY, including biopsy, performed by a specialist in the practice of his or her specialty where the patient is referred to him or her for the investigation of suspected intrauterine pathology (with or without local anaesthetic), not being a service associated with a service to which item 35627 or 35630 applies *(See para T8.30 of explanatory notes to this Category)* **Fee:** $64.45	**Benefit:** 75% = $48.35	85% = $54.80
35627	HYSTEROSCOPY with dilatation of the cervix performed in the operating theatre of a hospital or approved day-hospital facility - not being a service associated with a service to which item 35626 or 35630 applies (Anaes. 17707 = 4B + 3T) **Fee:** $83.45	**Benefit:** 75% = $62.60	85% = $70.95
35630	HYSTEROSCOPY, with endometrial biopsy, performed in the operating theatre of a hospital or approved day-hospital facility - not being a service associated with a service to which item 35626 or 35627 applies (Anaes. 17707 = 4B + 3T) **Fee:** $142.50	**Benefit:** 75% = $106.90	85% = $121.15
35633	HYSTEROSCOPY with uterine adhesiolysis or polypectomy or tubal catheterisation or removal of IUD which cannot be removed by other means, 1 or more of (Anaes. 17707 = 4B + 3T) **Fee:** $169.75	**Benefit:** 75% = $127.35	85% = $144.30
† 35634	HYSTEROSCOPIC RESECTION of uterine septum followed by endometrial ablation by laser or diathermy (Anaes. 17712 = 4B + 8T) **Fee:** $533.85	**Benefit:** 75% = $400.40	85% = $482.95
† 35635	HYSTEROSCOPY involving resection of the uterine septum (Anaes. 17710 = 4B + 6T) **Fee:** $233.15	**Benefit:** 75% = $174.90	85% = $198.20
A ‡@ 35636	HYSTEROSCOPY, involving resection of myoma, or resection of myoma and uterine septum (where both are performed) (Anaes. 17714 = 4B + 10T) **Fee:** $337.15	**Benefit:** 75% = $252.90	85% = $286.60
35637	LAPAROSCOPY, involving puncture of cysts, diathermy of endometriosis, ventrosuspension, division of adhesions or similar procedure - 1 or more procedures with or without biopsy - not being a service associated with any other laparoscopic procedure or hysterectomy (Anaes. 17709 = 6B + 3T) (Assist.) **Fee:** $316.60	**Benefit:** 75% = $237.45	85% = $269.15
‡ 35638	COMPLICATED OPERATIVE LAPAROSCOPY, including use of laser when required, for 1 or more of the following procedures; oophorectomy, ovarian cystectomy, myomectomy, salpingectomy or salpingostomy, ablation of moderate or severe endometriosis requiring more than 1 hours operating time, or division of utero-sacral ligaments for significant dysmenorrhoea - not being a service associated with any other intraperitoneal procedure except item 30393 (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $554.00	**Benefit:** 75% = $415.50	85% = $503.10
35639 G 35640 S	UTERUS, CURETTAGE OF, with or without dilatation (including curettage for incomplete miscarriage) under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital or approved day hospital facility, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes. 17705 = 3B + 2T) *(See para T8.31 of explanatory notes to this Category)* **Fee:** $105.05 **Fee:** $142.50	**Benefit:** 75% = $78.80 **Benefit:** 75% = $106.90	85% = $89.30 85% = $121.15
† 35641	ENDOMETRIOSIS LEVEL 4 OR 5, LAPAROSCOPIC RESECTION OF, involving any two of the following procedures, resection of the pelvic side wall with ureterolysis, resection of the Pouch of Douglas, resection of an ovarian endometrioma greater than 2 cms in diameter, dissection of bowel from uterus from the level of the endocervical junction or above: where the operating time exceeds 90 minutes (Anaes. 17722 = 6B + 16T) (Assist.) **Fee:** $967.45	**Benefit:** 75% = $725.60	85% = $916.55
35643	EVACUATION OF THE CONTENTS OF THE GRAVID UTERUS BY CURETTAGE OR SUCTION CURETTAGE not being a service to which item 35639/35640 applies, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes. 17705 = 3B + 2T) **Fee:** $169.75	**Benefit:** 75% = $127.35	85% = $144.30
35644	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35639, 35640 or 35647 applies (Anaes. 17707 = 5B + 2T) *(See para T8.32 of explanatory notes to this Category)* **Fee:** $158.50	**Benefit:** 75% = $118.90	85% = $134.75

35645	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative therapy of additional areas of intraepithelial change in 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35648 applies (Anaes. 17707 = 5B + 2T) *(See para T8.32 of explanatory notes to this Category)* **Fee:** $248.20 **Benefit:** 75% = $186.15 85% = $211.00
35646	CERVIX, colposcopy with radical diathermy of, with or without cervical biopsy, for previously confirmed intraepithelial neoplastic changes of the cervix, where performed in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17707 = 5B + 2T) *(See para T8.32 of explanatory notes to this Category)* **Fee:** $158.50 **Benefit:** 75% = $118.90 85% = $134.75
35647	CERVIX, large loop excision of transformation zone together with colposcopy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35644 applies (Anaes. 17707 = 5B + 2T) *(See para T8.32 of explanatory notes to this Category)* **Fee:** $158.50 **Benefit:** 75% = $118.90 85% = $134.75
35648	CERVIX, large loop excision diathermy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of intraepithelial change of 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35645 applies (Anaes. 17707 = 5B + 2T) *(See para T8.32 of explanatory notes to this Category)* **Fee:** $248.20 **Benefit:** 75% = $186.15 85% = $211.00
35649	HYSTEROTOMY or UTERINE MYOMECTOMY, abdominal (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $417.30 **Benefit:** 75% = $313.00 85% = $366.40
35653	HYSTERECTOMY, ABDOMINAL, SUBTOTAL or TOTAL, with or without removal of uterine adnexae (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $525.25 **Benefit:** 75% = $393.95 85% = $474.35
35657	HYSTERECTOMY, VAGINAL, with or without uterine curettage, not being a service to which item 35673 applies (Anaes. 17712 = 6B + 6T) (Assist.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $525.25 **Benefit:** 75% = $393.95 85% = $474.35
35658	UTERUS (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal removal at hysterectomy (Anaes. 17711 = 6B + 5T) (Assist.) *(See para T8.34 of explanatory notes to this Category)* **Fee:** $323.85 **Benefit:** 75% = $242.90 85% = $275.30
35661	HYSTERECTOMY, ABDOMINAL, requiring extensive retroperitoneal dissection, with or without exposure of 1 or both ureters, for the management of severe endometriosis, pelvic inflammatory disease or benign pelvic tumours, with or without conservation of the ovaries (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $678.35 **Benefit:** 75% = $508.80 85% = $627.45
35664	RADICAL HYSTERECTOMY with radical excision of pelvic lymph glands (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes. 17721 = 9B + 12T) (Assist.) **Fee:** $1,130.55 **Benefit:** 75% = $847.95 85% = $1,079.65
35667	RADICAL HYSTERECTOMY without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes. 17720 = 9B + 11T) (Assist.) **Fee:** $960.90 **Benefit:** 75% = $720.70 85% = $910.00
35670	HYSTERECTOMY, abdominal, with radical excision of pelvic lymph glands, with or without removal of uterine adnexae (Anaes. 17718 = 8B + 10T) (Assist.) **Fee:** $791.25 **Benefit:** 75% = $593.45 85% = $740.35

	HYSTERECTOMY, VAGINAL (with or without uterine curettage) with salpingectomy, oophorectomy or excision of ovarian cyst, 1 or more, 1 or both sides (Anaes. 17712 = 6B + 6T) (Assist.)		
35673	**Fee:** $589.95	**Benefit:** 75% = $442.50	85% = $539.05
	ULTRASOUND GUIDED NEEDLING and injection of ectopic pregnancy		
35674	**Fee:** $161.75	**Benefit:** 75% = $121.35	85% = $137.50
	ECTOPIC PREGNANCY, removal of (Anaes. 17711 = 6B + 5T) (Assist.)		
35676 G	**Fee:** $330.90	**Benefit:** 75% = $248.20	85% = $281.30
35677 S	**Fee:** $417.30	**Benefit:** 75% = $313.00	85% = $366.40
	ECTOPIC PREGNANCY, laparoscopic removal of (Anaes. 17712 = 6B + 6T) (Assist.)		
35678	**Fee:** $503.10	**Benefit:** 75% = $377.35	85% = $452.20
	BICORNUATE UTERUS, plastic reconstruction for (Anaes. 17714 = 6B + 8T) (Assist.)		
35680	**Fee:** $453.15	**Benefit:** 75% = $339.90	85% = $402.25
	UTERUS, SUSPENSION OR FIXATION OF, as an independent procedure (Anaes. 17710 = 6B + 4T) (Assist.)		
35683 G	**Fee:** $273.45	**Benefit:** 75% = $205.10	85% = $232.45
35684 S	**Fee:** $366.90	**Benefit:** 75% = $275.20	85% = $316.00
	STERILISATION BY TRANSECTION OR RESECTION OF FALLOPIAN TUBES, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method (Anaes. 17708 = 6B + 2T) (Assist.) *(See para T8.33 of explanatory notes to this Category)*		
35687 G	**Fee:** $253.20	**Benefit:** 75% = $189.90	85% = $215.25
35688 S	**Fee:** $309.30	**Benefit:** 75% = $232.00	85% = $262.95
	STERILISATION BY INTERRUPTION OF FALLOPIAN TUBES, when performed in conjunction with Caesarean section (Anaes. 17707 = 6B + 1T)		
35691	**Fee:** $123.55	**Benefit:** 75% = $92.70	85% = $105.05
	TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes. 17712 = 6B + 6T) (Assist.)		
35694	**Fee:** $496.45	**Benefit:** 75% = $372.35	85% = $445.55
	MICROSURGICAL TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes. 17716 = 6B + 10T) (Assist.)		
35697	**Fee:** $736.65	**Benefit:** 75% = $552.50	85% = $685.75
	FALLOPIAN TUBES, unilateral microsurgical anastomosis of, using operating microscope, for other than reversal of previous sterilisation (Anaes. 17717 = 6B + 11T) (Assist.)		
35700	**Fee:** $568.40	**Benefit:** 75% = $426.30	85% = $517.50
	HYDROTUBATION OF FALLOPIAN TUBES as a nonrepetitive procedure not being a service associated with a service to which another item in this Sub-group applies (Anaes. 17707 = 3B + 4T)		
35703	**Fee:** $52.50	**Benefit:** 75% = $39.40	85% = $44.65
	RUBIN TEST FOR PATENCY OF FALLOPIAN TUBES (Anaes. 17705 = 3B + 2T)		
35706	**Fee:** $52.50	**Benefit:** 75% = $39.40	85% = $44.65
	FALLOPIAN TUBES, hydrotubation of, as a repetitive postoperative procedure (Anaes. 17705 = 3B + 2T)		
35709	**Fee:** $33.85	**Benefit:** 75% = $25.40	85% = $28.80
	FALLOPOSCOPY, unilateral or bilateral, including hysteroscopy and tubal catheterization (Anaes. 17710 = 4B + 6T) (Assist.)		
35710	**Fee:** $360.75	**Benefit:** 75% = $270.60	85% = $309.85
	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGOOOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - 1 such procedure, not being a service associated with hysterectomy (Anaes. 17711 = 6B + 5T) (Assist.)		
35712 G	**Fee:** $282.00	**Benefit:** 75% = $211.50	85% = $239.70
35713 S	**Fee:** $352.55	**Benefit:** 75% = $264.45	85% = $301.65
	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGOOOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - 2 or more such procedures, unilateral or bilateral, not being a service associated with hysterectomy (Anaes. 17712 = 6B + 6T) (Assist.)		
35716 G	**Fee:** $338.15	**Benefit:** 75% = $253.65	85% = $287.45
35717 S	**Fee:** $424.50	**Benefit:** 75% = $318.40	85% = $373.60

35720	RADICAL OR DEBULKING OPERATION for advanced gynaecological malignancy, with or without omentectomy (Anaes. 17721 = 10B + 11T) (Assist.) *(See para T8.35 of explanatory notes to this Category)* **Fee:** $525.15 **Benefit:** 75% = $393.90 85% = $474.25
35723	RETROPERITONEAL LYMPH NODE BIOPSIES from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (Anaes. 17719 = 6B + 13T) (Assist.) **Fee:** $376.10 **Benefit:** 75% = $282.10 85% = $325.20
35726	INFRACOLIC OMENTECTOMY with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $376.10 **Benefit:** 75% = $282.10 85% = $325.20
35729	OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (Anaes. 17718 = 6B + 12T) **Fee:** $169.60 **Benefit:** 75% = $127.20 85% = $144.20
35750	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, including any associated laparoscopy (Anaes. 17718 = 6B + 12T) (Assist.) **Fee:** $610.90 **Benefit:** 75% = $458.20 85% = $560.00
35753	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, with salpingectomy, oophorectomy or excision of ovarian cyst, one or both sides, including any associated laparoscopy (Anaes. 17719 = 6B + 13T) (Assist.) **Fee:** $675.50 **Benefit:** 75% = $506.65 85% = $624.60
35756	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, when procedure is completed by open hysterectomy, including any associated laparoscopy (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $610.90 **Benefit:** 75% = $458.20 85% = $560.00
† 35759	Procedure for the control of POST OPERATIVE HAEMORRHAGE following gynaecological surgery, under general anaesthesia, utilising a vaginal or abdominal and vaginal approach where no other procedure is performed (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $438.55 **Benefit:** 75% = $328.95 85% = $387.65
	SUBGROUP 5 - UROLOGICAL
	GENERAL
36500	ADRENAL GLAND, excision of partial or total (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $719.85 **Benefit:** 75% = $539.90 85% = $668.95
36502	PELVIC LYMPHADENECTOMY, open or laparoscopic, or both, unilateral or bilateral (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $532.45 **Benefit:** 75% = $399.35 85% = $481.55
36503	RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes. 17727 = 10B + 17T) (Assist.) **Fee:** $1,083.05 **Benefit:** 75% = $812.30 85% = $1,032.15
36506	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together vascular anastomosis including aftercare (Anaes. 17727 = 10B + 17T) (Assist.) **Fee:** $719.85 **Benefit:** 75% = $539.90 85% = $668.95
36509	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together ureterovesical anastomosis including aftercare (Assist.) **Fee:** $609.60 **Benefit:** 75% = $457.20 85% = $558.70
36516	NEPHRECTOMY, complete (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $719.85 **Benefit:** 75% = $539.90 85% = $668.95
36519	NEPHRECTOMY, complete, complicated by previous surgery on the same kidney (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $1,005.20 **Benefit:** 75% = $753.90 85% = $954.30
36522	NEPHRECTOMY, partial (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $862.60 **Benefit:** 75% = $646.95 85% = $811.70
36525	NEPHRECTOMY, partial, complicated by previous surgery on the same kidney (Anaes. 17717 = 7B + 10T) (Assist.) **Fee:** $1,225.80 **Benefit:** 75% = $919.35 85% = $1,174.90

36528	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $1,005.20	**Benefit:** 75% = $753.90	85% = $954.30
36531	NEPHROURETERECTOMY, complete, including associated bladder repair and any associated endoscopic procedures (Anaes. 17719 = 7B + 12T) (Assist.) **Fee:** $901.45	**Benefit:** 75% = $676.10	85% = $850.55
36537	KIDNEY OR PERINEPHRIC AREA, EXPLORATION OF, with or without drainage of, by open exposure, not being a service to which another item in this Sub-group applies (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $538.35	**Benefit:** 75% = $403.80	85% = $487.45
36540	NEPHROLITHOTOMY OR PYELOLITHOTOMY, or both, through the same skin incision, for 1 or 2 stones (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $862.60	**Benefit:** 75% = $646.95	85% = $811.70
36543	NEPHROLITHOTOMY OR PYELOLITHOTOMY, or both, extended, for staghorn stone or 3 or more stones, including 1 or more of the following: nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $1,005.20	**Benefit:** 75% = $753.90	85% = $954.30
36546	EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment care for 3 days, including pretreatment consultation, unilateral (Anaes. 17712 = 7B + 5T) **Fee:** $538.35	**Benefit:** 75% = $403.80	85% = $487.45
36549	URETEROLITHOTOMY (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $648.55	**Benefit:** 75% = $486.45	85% = $597.65
36552	NEPHROSTOMY or pyelostomy, open, as an independent procedure (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $577.25	**Benefit:** 75% = $432.95	85% = $526.35
36558	RENAL CYST OR CYSTS, excision or unroofing of (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $505.90	**Benefit:** 75% = $379.45	85% = $455.00
36561	RENAL BIOPSY (closed) (Anaes. 17708 = 7B + 1T) **Fee:** $134.30	**Benefit:** 75% = $100.75	85% = $114.20
36564	PYELOPLASTY, by open exposure (Anaes. 17716 = 7B + 9T) (Assist.) **Fee:** $719.85	**Benefit:** 75% = $539.90	85% = $668.95
36567	PYELOPLASTY in congenitally abnormal kidney or solitary kidney, by open exposure (Anaes. 17717 = 7B + 10T) (Assist.) **Fee:** $791.25	**Benefit:** 75% = $593.45	85% = $740.35
36570	PYELOPLASTY, complicated by previous surgery on the same kidney, by open exposure (Anaes. 17718 = 7B + 11T) (Assist.) **Fee:** $1,005.20	**Benefit:** 75% = $753.90	85% = $954.30
36573	DIVIDED URETER, repair of (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $719.85	**Benefit:** 75% = $539.90	85% = $668.95
36576	KIDNEY, exposure and exploration of, including repair or nephrectomy, for trauma, not being a service associated with any other procedure performed on the kidney, renal pelvis or renal pedicle (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $901.45	**Benefit:** 75% = $676.10	85% = $850.55
36579	URETERECTOMY, COMPLETE OR PARTIAL, with or without associated bladder repair, not being a service associated with a service to which item 37000 applies (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $577.25	**Benefit:** 75% = $432.95	85% = $526.35
36585	URETER, transplantation of, into skin (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $577.25	**Benefit:** 75% = $432.95	85% = $526.35
36588	URETER, reimplantation into bladder (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $719.85	**Benefit:** 75% = $539.90	85% = $668.95
36591	URETER, reimplantation into bladder with psoas hitch or Boari flap or both (Anaes. 17713 = 6B + 7T) (Assist.) **Fee:** $862.60	**Benefit:** 75% = $646.95	85% = $811.70

36594	URETER, transplantation of, into intestine (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $719.85	**Benefit:** 75% = $539.90	85% = $668.95
36597	URETER, transplantation of, into another ureter (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $719.85	**Benefit:** 75% = $539.90	85% = $668.95
36600	URETER, transplantation of, into isolated intestinal segment, unilateral (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $862.60	**Benefit:** 75% = $646.95	85% = $811.70
36603	URETERS, transplantation of, into isolated intestinal segment, bilateral (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $1,005.20	**Benefit:** 75% = $753.90	85% = $954.30
36604	URETERIC STENT, passage of through percutaneous nephrostomy tube, using interventional imaging techniques (Anaes. 17714 = 7B + 7T) **Fee:** $208.35	**Benefit:** 75% = $156.30	85% = $177.10
36606	INTESTINAL URINARY RESERVOIR, continent, formation of, including formation of nonretum valves and implantation of ureters (1 or both) into reservoir (Anaes. 17729 = 6B + 23T) (Assist.) **Fee:** $1,802.95	**Benefit:** 75% = $1,352.25	85% = $1,752.05
36609	INTESTINAL URINARY CONDUIT OR URETEROSTOMY, revision of (Anaes. 17715 = 6B + 9T) (Assist.) **Fee:** $577.25	**Benefit:** 75% = $432.95	85% = $526.35
36612	URETER, exploration of, with or without drainage of, as an independent procedure (Anaes. 17713 = 6B + 7T) (Assist.) **Fee:** $505.90	**Benefit:** 75% = $379.45	85% = $455.00
36615	URETEROLYSIS, with or without repositioning of ureter, for retroperitoneal fibrosis, ovarian vein syndrome or similar condition (Anaes. 17713 = 6B + 7T) (Assist.) **Fee:** $577.25	**Benefit:** 75% = $432.95	85% = $526.35
36618	REDUCTION URETEROPLASTY (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $505.90	**Benefit:** 75% = $379.45	85% = $455.00
36621	CLOSURE OF CUTANEOUS URETEROSTOMY (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $361.60	**Benefit:** 75% = $271.20	85% = $310.70
36624	NEPHROSTOMY, percutaneous, using interventional imaging techniques (Anaes. 17711 = 7B + 4T) (Assist.) **Fee:** $434.50	**Benefit:** 75% = $325.90	85% = $383.60
36627	NEPHROSCOPY, percutaneous, with or without any 1 or more of; stone extraction, biopsy or diathermy, not being a service to which item 36639, 36642, 36645 or 36648 applies (Anaes. 17713 = 7B + 6T) **Fee:** $538.35	**Benefit:** 75% = $403.80	85% = $487.45
36630	NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36627 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (Anaes. 17712 = 7B + 5T) (Assist.) **Fee:** $265.95	**Benefit:** 75% = $199.50	85% = $226.10
36633	NEPHROSCOPY, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, not being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $577.25	**Benefit:** 75% = $432.95	85% = $526.35
36636	NEPHROSCOPY, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $311.35	**Benefit:** 75% = $233.55	85% = $264.65
36639	NEPHROSCOPY, percutaneous, with destruction and extraction of 1 or 2 stones using ultrasound or electrohydraulic shock waves or lasers (not being a service to which item 36645 or 36648 applies) (Anaes. 17715 = 7B + 8T) **Fee:** $648.55	**Benefit:** 75% = $486.45	85% = $597.65
36642	NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36639 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $324.25	**Benefit:** 75% = $243.20	85% = $275.65

36645	NEPHROSCOPY, percutaneous, with removal or destruction of a stone greater than 3 cm in any dimension, or for 3 or more stones (Anaes. 17719 = 7B + 12T) (Assist.) **Fee:** $830.10 **Benefit:** 75% = $622.60 85% = $779.20
36648	NEPHROSCOPY, being a service to which item 36645 applies, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION (Anaes. 17718 = 7B + 11T) (Assist.) **Fee:** $739.35 **Benefit:** 75% = $554.55 85% = $688.45
36649	NEPHROSTOMY DRAINAGE TUBE, exchange of - but not including imaging (Anaes. 17709 = 7B + 2T) (Assist.) **Fee:** $208.35 **Benefit:** 75% = $156.30 85% = $177.10
	OPERATIONS ON THE BLADDER (CLOSED)
36800	BLADDER, catheterisation of, where no other procedure is performed (Anaes. 17704 = 3B + 1T) **Fee:** $21.50 **Benefit:** 75% = $16.15 85% = $18.30
36803	URETEROSCOPY, with or without any 1 or more of; cystoscopy, ureteric meatotomy, ureteric dilatation and pyeloscopy, not being a service associated with a service to which item 36806, 36809, 36812, 36824, 36848 or 36857 applies (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $363.10 **Benefit:** 75% = $272.35 85% = $312.20
36806	URETEROSCOPY, BEING A SERVICE TO WHICH ITEM 36803 APPLIES, PLUS 1 or more of extraction of stone, biopsy or diathermy (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $505.90 **Benefit:** 75% = $379.45 85% = $455.00
36809	URETEROSCOPY, BEING A SERVICE TO WHICH ITEM 36803 APPLIES, PLUS destruction of stone with ultrasound, electrohydraulic shock waves, or laser, with extraction of fragments (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $648.55 **Benefit:** 75% = $486.45 85% = $597.65
36811	CYSTOSCOPY with insertion of urethral prosthesis (Anaes. 17707 = 3B + 4T) **Fee:** $251.75 **Benefit:** 75% = $188.85 85% = $214.00
36812	CYSTOSCOPY with urethroscopy with or without urethral dilatation, not being a service associated with any other urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies (Anaes. 17705 = 3B + 2T) **Fee:** $129.70 **Benefit:** 75% = $97.30 85% = $110.25
36815	CYSTOSCOPY, with or without urethroscopy, for the treatment of penile warts or uretheral warts, not being a service associated with a service to which item 30189 applies (Anaes. 17705 = 3B + 2T) *(See para T8.12 of explanatory notes to this Category)* **Fee:** $185.25 **Benefit:** 75% = $138.95 85% = $157.50
36818	CYSTOSCOPY with ureteric catheterisation including fluoroscopic imaging of the upper urinary tract, unilateral or bilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes. 17705 = 3B + 2T) (Assist.) **Fee:** $215.30 **Benefit:** 75% = $161.50 85% = $183.05
36821	CYSTOSCOPY with 1 or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or renal pelvis, unilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes. 17705 = 3B + 2T) (Assist.) **Fee:** $251.60 **Benefit:** 75% = $188.70 85% = $213.90
36824	CYSTOSCOPY, with ureteric catheterisation, unilateral or bilateral, not being a service associated with a service to which item 36818 or 36821 applies (Anaes. 17705 = 3B + 2T) **Fee:** $166.00 **Benefit:** 75% = $124.50 85% = $141.10
36825	CYSTOSCOPY, with endoscopic incision of pelviureteric junction or ureteric stricture, including removal or replacement of ureteric stent, not being a service associated with a service to which item 36818, 36821, 36824, 36830 or 36833 applies (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $452.55 **Benefit:** 75% = $339.45 85% = $401.65
36827	CYSTOSCOPY, with controlled hydrodilatation of the bladder (Anaes. 17705 = 3B + 2T) **Fee:** $179.00 **Benefit:** 75% = $134.25 85% = $152.15
36830	CYSTOSCOPY, with ureteric meatotomy (Anaes. 17705 = 3B + 2T) **Fee:** $158.30 **Benefit:** 75% = $118.75 85% = $134.60
36833	CYSTOSCOPY, with removal of ureteric stent or other foreign body (Anaes. 17705 = 3B + 2T) (Assist.) **Fee:** $215.30 **Benefit:** 75% = $161.50 85% = $183.05

36836	CYSTOSCOPY, with biopsy of bladder, not being a service associated with a service to which item 36812, 36830, 36839, 36845, 36848, 36854, 37203, 37206 or 37215 applies (Anaes. 17705 = 3B + 2T) **Fee:** $179.00	**Benefit:** 75% = $134.25	85% = $152.15
36839	CYSTOSCOPY, with resection, diathermy or visual laser destruction of bladder tumour or other lesion of the bladder or prostate, not being a service associated with a service to which item 36845 applies (Anaes. 17707 = 5B + 2T) **Fee:** $251.60	**Benefit:** 75% = $188.70	85% = $213.90
36842	CYSTOSCOPY, with lavage of blood clots from bladder including any associated diathermy of prostate or bladder and not being a service associated with a service to which item 36812, 36827 to 36863, 37203 or 37206 apply (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $253.20	**Benefit:** 75% = $189.90	85% = $215.25
36845	CYSTOSCOPY, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 quadrants of the bladder or solitary tumour greater than 2cm in diameter (Anaes. 17707 = 5B + 2T) **Fee:** $538.35	**Benefit:** 75% = $403.80	85% = $487.45
36848	CYSTOSCOPY, with resection of ureterocele (Anaes. 17705 = 3B + 2T) **Fee:** $179.00	**Benefit:** 75% = $134.25	85% = $152.15
36851	CYSTOSCOPY, with injection into bladder wall (Anaes. 17705 = 3B + 2T) **Fee:** $179.00	**Benefit:** 75% = $134.25	85% = $152.15
36854	CYSTOSCOPY, with endoscopic incision or resection of external sphincter, bladder neck or both (Anaes. 17705 = 3B + 2T) **Fee:** $363.10	**Benefit:** 75% = $272.35	85% = $312.20
36857	ENDOSCOPIC MANIPULATION OR EXTRACTION of ureteric calculus (Anaes. 17705 = 3B + 2T) **Fee:** $285.30	**Benefit:** 75% = $214.00	85% = $242.55
36860	ENDOSCOPIC EXAMINATION of intestinal conduit or reservoir (Anaes. 17705 = 3B + 2T) **Fee:** $129.70	**Benefit:** 75% = $97.30	85% = $110.25
36863	LITHOLAPAXY, with or without cystoscopy (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $363.10	**Benefit:** 75% = $272.35	85% = $312.20
	OPERATIONS ON THE BLADDER (OPEN)		
37000	BLADDER, partial excision of (Anaes. 17715 = 6B + 9T) (Assist.) **Fee:** $577.25	**Benefit:** 75% = $432.95	85% = $526.35
37004	BLADDER, repair of rupture (Anaes. 17715 = 6B + 9T) (Assist.) **Fee:** $505.90	**Benefit:** 75% = $379.45	85% = $455.00
37008	CYSTOSTOMY OR CYSTOTOMY, suprapubic, not being a service to which item 37011 applies and not being a service associated with other open bladder procedure (Anaes. 17709 = 6B + 3T) **Fee:** $324.25	**Benefit:** 75% = $243.20	85% = $275.65
37011	SUPRAPUBIC STAB CYSTOTOMY, not being a service associated with a service to which items 37200 to 37221 apply (Anaes. 17705 = 3B + 2T) **Fee:** $72.60	**Benefit:** 75% = $54.45	85% = $61.75
37014	BLADDER, total excision of (Anaes. 17732 = 10B + 22T) (Assist.) **Fee:** $830.10	**Benefit:** 75% = $622.60	85% = $779.20
37020	BLADDER DIVERTICULUM, excision or obliteration of (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $577.25	**Benefit:** 75% = $432.95	85% = $526.35
37023	VESICAL FISTULA, cutaneous, operation for (Anaes. 17714 = 6B + 8T) **Fee:** $324.25	**Benefit:** 75% = $243.20	85% = $275.65
37026	CUTANEOUS VESICOSTOMY, establishment of (Anaes. 17715 = 6B + 9T) (Assist.) **Fee:** $324.25	**Benefit:** 75% = $243.20	85% = $275.65
37029	VESICOVAGINAL FISTULA, closure of, by abdominal approach (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $719.85	**Benefit:** 75% = $539.90	85% = $668.95

37038	VESICOINTESTINAL FISTULA, closure of, excluding bowel resection (Anaes. 17713 = 6B + 7T) (Assist.) **Fee:** $538.65 **Benefit:** 75% = $404.00 85% = $487.75
37041	BLADDER ASPIRATION by needle **Fee:** $36.30 **Benefit:** 75% = $27.25 85% = $30.90
37044	BLADDER STRESS INCONTINENCE, suprapubic procedure for, not being a service to which item 35599 applies (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $538.65 **Benefit:** 75% = $404.00 85% = $487.75
37045	MITROFANOFF CONTINENT VALVE, formation of (Anaes. 17722 = 6B + 16T) (Assist.) **Fee:** $1,112.35 **Benefit:** 75% = $834.30 85% = $1,061.45
37047	BLADDER ENLARGEMENT using intestine (Anaes. 17725 = 6B + 19T) (Assist.) **Fee:** $1,297.10 **Benefit:** 75% = $972.85 85% = $1,246.20
37050	BLADDER EXSTROPHY CLOSURE, not involving sphincter reconstruction (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $577.25 **Benefit:** 75% = $432.95 85% = $526.35
37053	BLADDER TRANSECTION AND RE-ANASTOMOSIS TO TRIGONE (Anaes. 17718 = 6B + 12T) (Assist.) **Fee:** $667.05 **Benefit:** 75% = $500.30 85% = $616.15
	OPERATIONS ON THE PROSTATE
37200	PROSTATECTOMY, open (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $791.25 **Benefit:** 75% = $593.45 85% = $740.35
37203	PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37207, 37208, 37303, 37321 or 37324 applies (Anaes. 17710 = 6B + 4T) **Fee:** $811.30 **Benefit:** 75% = $608.50 85% = $760.40
A 37206	PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37203 or 37208 which had to be discontinued for medical reasons (Anaes. 17709 = 6B + 3T) **Fee:** $434.50 **Benefit:** 75% = $325.90 85% = $383.60
A 37207	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which items 36854, 37203, 37206, 37321 or 37324 applies (Anaes. 17710 = 6B + 4T) **Fee:** $674.60 **Benefit:** 75% = $505.95 85% = $623.70
A 37208	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which items 36854, 37203, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by items 37203 or 37207, which had to be discontinued for medical reasons (Anaes. 17709 = 6B + 3T) **Fee:** $323.85 **Benefit:** 75% = $242.90 85% = $275.30
37209	PROSTATE, total excision of (Anaes. 17723 = 7B + 16T) (Assist.) **Fee:** $1,005.20 **Benefit:** 75% = $753.90 85% = $954.30
37210	PROSTATECTOMY, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Anaes. 17723 = 7B + 16T) (Assist.) **Fee:** $1,240.55 **Benefit:** 75% = $930.45 85% = $1,189.65
37211	PROSTATECTOMY, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, ***with pelvic lymphadenectomy***, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Anaes. 17725 = 7B + 18T) (Assist.) **Fee:** $1,506.70 **Benefit:** 75% = $1,130.05 85% = $1,455.80
37212	PROSTATE, open perineal biopsy or open drainage of abscess (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $215.30 **Benefit:** 75% = $161.50 85% = $183.05
37215	PROSTATE, biopsy of, endoscopic, with or without cystoscopy (Anaes. 17705 = 3B + 2T) (Assist.) **Fee:** $324.25 **Benefit:** 75% = $243.20 85% = $275.65
37218	PROSTATE, needle biopsy of, or injection into (Anaes. 17704 = 3B + 1T) **Fee:** $107.70 **Benefit:** 75% = $80.80 85% = $91.55

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 55600 or 55603 applies (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $218.65 **Benefit:** 75% = $164.00 85% = $185.90
37221	PROSTATIC ABSCESS, endoscopic drainage of (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $363.10 **Benefit:** 75% = $272.35 85% = $312.20
37223	PROSTATIC COIL, insertion of, under ultrasound control (Anaes. 17707 = 3B + 4T) **Fee:** $160.55 **Benefit:** 75% = $120.45 85% = $136.50
	OPERATIONS ON URETHRA, PENIS OR SCROTUM
37300	URETHRAL SOUNDS, passage of, as an independent procedure (Anaes. 17704 = 3B + 1T) **Fee:** $36.30 **Benefit:** 75% = $27.25 85% = $30.90
37303	URETHRAL STRICTURE, dilatation of (Anaes. 17705 = 3B + 2T) **Fee:** $57.70 **Benefit:** 75% = $43.30 85% = $49.05
37306	URETHRA, repair of rupture of distal section (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $505.90 **Benefit:** 75% = $379.45 85% = $455.00
37309	URETHRA, repair of rupture of prostatic or membranous segment (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $719.85 **Benefit:** 75% = $539.90 85% = $668.95
37315	URETHROSCOPY, as an independent procedure (Anaes. 17704 = 3B + 1T) **Fee:** $107.70 **Benefit:** 75% = $80.80 85% = $91.55
37318	URETHROSCOPY with any 1 or more of - biopsy, diathermy, visual laser destruction of stone or removal of foreign body or stone (Anaes. 17705 = 3B + 2T) (Assist.) **Fee:** $215.30 **Benefit:** 75% = $161.50 85% = $183.05
37321	URETHRAL MEATOTOMY, EXTERNAL (Anaes. 17704 = 3B + 1T) **Fee:** $72.60 **Benefit:** 75% = $54.45 85% = $61.75
37324	URETHROTOMY OR URETHROSTOMY, internal or external (Anaes. 17705 = 3B + 2T) **Fee:** $179.00 **Benefit:** 75% = $134.25 85% = $152.15
37327	URETHROTOMY, optical, for urethral stricture (Anaes. 17705 = 3B + 2T) (Assist.) **Fee:** $251.60 **Benefit:** 75% = $188.70 85% = $213.90
37330	URETHRECTOMY, partial or complete, for removal of tumour (Anaes. 17712 = 7B + 5T) (Assist.) **Fee:** $505.90 **Benefit:** 75% = $379.45 85% = $455.00
37333	URETHROVAGINAL FISTULA, closure of (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $434.50 **Benefit:** 75% = $325.90 85% = $383.60
37336	URETHRORECTAL FISTULA, closure of (Anaes. 17713 = 6B + 7T) (Assist.) **Fee:** $577.25 **Benefit:** 75% = $432.95 85% = $526.35
37339	PERIURETHRAL OR TRANSURETHRAL INJECTION of materials for the treatment of urinary incontinence, including cystoscopy and urethroscopy (Anaes. 17705 = 3B + 2T) **Fee:** $186.75 **Benefit:** 75% = $140.10 85% = $158.75
37342	URETHROPLASTY single stage operation (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $648.55 **Benefit:** 75% = $486.45 85% = $597.65
37345	URETHROPLASTY 2 stage operation first stage (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $538.35 **Benefit:** 75% = $403.80 85% = $487.45
37348	URETHROPLASTY 2 stage operation second stage (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $538.35 **Benefit:** 75% = $403.80 85% = $487.45
37351	URETHROPLASTY, not being a service to which another item in this Group applies (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $215.30 **Benefit:** 75% = $161.50 85% = $183.05
37354	HYPOSPADIAS, meatotomy and hemicircumcision (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $251.60 **Benefit:** 75% = $188.70 85% = $213.90

37369	URETHRA, excision of prolapse of (Anaes. 17707 = 3B + 4T) **Fee:** $145.25	**Benefit:** 75% = $108.95	85% = $123.50
37372	URETHRAL DIVERTICULUM, excision of (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $363.10	**Benefit:** 75% = $272.35	85% = $312.20
37375	URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (Anaes. 17718 = 6B + 12T) (Assist.) **Fee:** $901.45	**Benefit:** 75% = $676.10	85% = $850.55
37381	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, perineal approach (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $577.25	**Benefit:** 75% = $432.95	85% = $526.35
37384	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $901.45	**Benefit:** 75% = $676.10	85% = $850.55
37387	ARTIFICIAL URINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $251.60	**Benefit:** 75% = $188.70	85% = $213.90
37390	ARTIFICIAL URINARY SPHINCTER, revision or removal of, with or without replacement (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $719.85	**Benefit:** 75% = $539.90	85% = $668.95
37393	PRIAPISM, decompression by glanular stab cavernosospongiosum shunt or penile aspiration with or without lavage (Anaes. 17707 = 3B + 4T) **Fee:** $179.00	**Benefit:** 75% = $134.25	85% = $152.15
37396	PRIAPISM, shunt operation for, not being a service to which item 37393 applies (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $577.25	**Benefit:** 75% = $432.95	85% = $526.35
37402	PENIS, partial amputation of (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $363.10	**Benefit:** 75% = $272.35	85% = $312.20
37405	PENIS, complete or radical amputation of (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $719.85	**Benefit:** 75% = $539.90	85% = $668.95
37408	PENIS, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $363.10	**Benefit:** 75% = $272.35	85% = $312.20
37411	PENIS, repair of avulsion (Anaes. 17712 = 3B + 9T) (Assist.) **Fee:** $719.85	**Benefit:** 75% = $539.90	85% = $668.95
37415	PENIS, injection of, for the investigation and treatment of impotence - 2 services only in a period of 36 consecutive months **Fee:** $36.30	**Benefit:** 75% = $27.25	85% = $30.90
37417	PENIS, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $434.50	**Benefit:** 75% = $325.90	85% = $383.60
37420	PENIS, surgery to inhibit rapid penile drainage causing impotence, by ligation of veins deep to Buck's fascia including 1 or more deep cavernosal veins with or without pharmacological erection test (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $285.30	**Benefit:** 75% = $214.00	85% = $242.55
37423	PENIS, lengthening by translocation of corpora (Anaes. 17714 = 3B + 11T) (Assist.) **Fee:** $719.85	**Benefit:** 75% = $539.90	85% = $668.95
37426	PENIS, artificial erection device, insertion of, into 1 or both corpora (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $758.75	**Benefit:** 75% = $569.10	85% = $707.85
37429	PENIS, artificial erection device, insertion of pump and pressure regulating reservoir (Anaes. 17714 = 4B + 10T) (Assist.) **Fee:** $251.60	**Benefit:** 75% = $188.70	85% = $213.90
37432	PENIS, artificial erection device, complete or partial revision or removal of components, with or without replacement (Anaes. 17716 = 4B + 12T) (Assist.) **Fee:** $719.85	**Benefit:** 75% = $539.90	85% = $668.95
37435	PENIS, frenuloplasty as an independent procedure (Anaes. 17705 = 3B + 2T) **Fee:** $72.60	**Benefit:** 75% = $54.45	85% = $61.75

37438	SCROTUM, partial excision of (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $215.30	**Benefit:** 75% = $161.50	85% = $183.05
37444	URETEROLITHOTOMY COMPLICATED BY PREVIOUS SURGERY at the same site of the same ureter (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $778.30	**Benefit:** 75% = $583.75	85% = $727.40
	OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES		
37601	SPERMATOCELE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (Anaes. 17706 = 3B + 3T) **Fee:** $215.30	**Benefit:** 75% = $161.50	85% = $183.05
37604	EXPLORATION OF SCROTAL CONTENTS, with or without fixation and with or without biopsy, unilateral (Anaes. 17706 = 3B + 3T) **Fee:** $215.30	**Benefit:** 75% = $161.50	85% = $183.05
37607	RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $719.85	**Benefit:** 75% = $539.90	85% = $668.95
37610	RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies, following previous similar retroperitoneal dissection, retroperitoneal irradiation or chemotherapy (Anaes. 17720 = 6B + 14T) (Assist.) **Fee:** $1,083.05	**Benefit:** 75% = $812.30	85% = $1,032.15
37613	EPIDIDYMECTOMY (Anaes. 17706 = 3B + 3T) **Fee:** $215.30	**Benefit:** 75% = $161.50	85% = $183.05
37616	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, using operating microscope, for other than reversal of previous sterilisation (Anaes. 17712 = 3B + 9T) (Assist.) **Fee:** $538.35	**Benefit:** 75% = $403.80	85% = $487.45
37619	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, for other than reversal of previous sterilisation (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $215.30	**Benefit:** 75% = $161.50	85% = $183.05
37622 G 37623 S	VASOTOMY OR VASECTOMY, unilateral or bilateral (Anaes. 17705 = 3B + 2T) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $150.50 **Fee:** $179.00	**Benefit:** 75% = $112.90 **Benefit:** 75% = $134.25	85% = $127.95 85% = $152.15
	PAEDIATRIC GENITOURINARY SURGERY		
37800	PATENT URACHUS, excision of (Anaes. 17710 = 6B + 4T) (Assist.) **Fee:** $405.80	**Benefit:** 75% = $304.35	85% = $354.90
37803	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37806 applies (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $405.80	**Benefit:** 75% = $304.35	85% = $354.90
37806	UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $468.90	**Benefit:** 75% = $351.70	85% = $418.00
37809	UNDESCENDED TESTIS, revision orchidopexy for (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $468.90	**Benefit:** 75% = $351.70	85% = $418.00
37812	IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37803 to 37809 applies (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $432.90	**Benefit:** 75% = $324.70	85% = $382.00
37815	HYPOSPADIAS, examination under anaesthesia with erection test (Anaes. 17705 = 3B + 2T) **Fee:** $72.15	**Benefit:** 75% = $54.15	85% = $61.35
37818	HYPOSPADIAS, glanuloplasty incorporating meatal advancement (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $382.65	**Benefit:** 75% = $287.00	85% = $331.75

37821	HYPOSPADIAS, distal, 1 stage repair (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $648.55	**Benefit:** 75% = $486.45	85% = $597.65
37824	HYPOSPADIAS, proximal, 1 stage repair (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $901.80	**Benefit:** 75% = $676.35	85% = $850.90
37827	HYPOSPADIAS, staged repair, first stage (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $415.45	**Benefit:** 75% = $311.60	85% = $364.55
37830	HYPOSPADIAS, staged repair, second stage (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $538.35	**Benefit:** 75% = $403.80	85% = $487.45
37833	HYPOSPADIAS, repair of post operative urethral fistula (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $256.90	**Benefit:** 75% = $192.70	85% = $218.40
37836	EPISPADIAS, staged repair, first stage (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $541.10	**Benefit:** 75% = $405.85	85% = $490.20
37839	EPISPADIAS, staged repair, second stage (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $613.20	**Benefit:** 75% = $459.90	85% = $562.30
37842	EXSTROPHY OF BLADDER OR EPISPADIAS, secondary repair with bladder neck tightening, with or without ureteric reimplantation (Anaes. 17718 = 6B + 12T) (Assist.) **Fee:** $1,190.45	**Benefit:** 75% = $892.85	85% = $1,139.55
37845	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty, with or without endoscopy (Anaes. 17713 = 3B + 10T) (Assist.) **Fee:** $541.10	**Benefit:** 75% = $405.85	85% = $490.20
37848	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty with endoscopy and vaginoplasty (Anaes. 17715 = 3B + 12T) (Assist.) **Fee:** $973.90	**Benefit:** 75% = $730.45	85% = $923.00
37851	CONGENITAL ADRENAL HYPERPLASIA, mixed gonadal dysgenesis or similar condition, vaginoplasty for, with or without endoscopy (Anaes. 17715 = 3B + 12T) (Assist.) **Fee:** $721.50	**Benefit:** 75% = $541.15	85% = $670.60
37854	URETHRAL VALVE, destruction of, including cystoscopy and urethroscopy (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $285.30	**Benefit:** 75% = $214.00	85% = $242.55
	SUBGROUP 6 - CARDIO-THORACIC		
	MISCELLANEOUS CARDIAC PROCEDURES		
38200	RIGHT HEART CATHERISATION, including fluoroscopy, oximetry, dye dilution curves, cardiac output measurement by any method, shunt detection and exercise stress test (Anaes. 17712 = 7B + 5T) **Fee:** $346.80	**Benefit:** 75% = $260.10	85% = $295.90
38203	LEFT HEART CATHETERISATION by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture including fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection and exercise stress test (Anaes. 17712 = 7B + 5T) **Fee:** $413.85	**Benefit:** 75% = $310.40	85% = $362.95
38206	RIGHT HEART CATHETERISATION WITH LEFT HEART CATHETERISATION via the right heart or by any other procedure including fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection and exercise stress test (Anaes. 17714 = 7B + 7T) **Fee:** $500.30	**Benefit:** 75% = $375.25	85% = $449.40
38209	CARDIAC ELECTROPHYSIOLOGICAL STUDY up to and including 3 catheter investigation of any 1 or more of syncope, atrioventricular conduction, sinus node function or simple ventricular tachycardia studies, not being a service associated with a service to which item 38212 or 38213 applies (Anaes. 17719 = 7B + 12T) *(See para T8.36 of explanatory notes to this Category)* **Fee:** $642.35	**Benefit:** 75% = $481.80	85% = $591.45

38212	CARDIAC ELECTROPHYSIOLOGICAL STUDY 4 or more catheter supraventricular tachycardia investigation; or complex tachycardia inductions, or multiple catheter mapping, or acute intravenous antiarrhythmic drug testing with pre and post drug inductions; or catheter ablation to intentionally induce complete AV block; or intraoperative mapping; or electrophysiological services during defibrillator implantation not being a service associated with a service to which item 38209 or 38213 applies (Anaes. 17727 = 7B + 20T) *(See para T8.36 of explanatory notes to this Category)* **Fee:** $1,068.50	**Benefit:** 75% = $801.40	85% = $1,017.60
38213	CARDIAC ELECTROPHYSIOLOGICAL STUDY, for follow-up testing of implanted defibrillator - not being a service associated with a service to which item 38209 or 38212 applies (Anaes. 17711 = 7B + 4T) **Fee:** $318.10	**Benefit:** 75% = $238.60	85% = $270.40
38215	SELECTIVE CORONARY ARTERIOGRAPHY placement of catheters and injection of opaque material (Anaes. 17714 = 7B + 7T) **Fee:** $352.05	**Benefit:** 75% = $264.05	85% = $301.15
38218	SELECTIVE CORONARY ARTERIOGRAPHY placement of catheters and injection of opaque material with right or left heart catheterisation, or both (Anaes. 17716 = 7B + 9T) **Fee:** $580.65	**Benefit:** 75% = $435.50	85% = $529.75
38256	TEMPORARY TRANSVENOUS PACEMAKING ELECTRODE, insertion of (Anaes. 17710 = 6B + 4T) **Fee:** $208.00	**Benefit:** 75% = $156.00	85% = $176.80
38270	BALLOON VALVULOPLASTY OR SEPTOSTOMY, including cardiac catheterisations before and after balloon dilatation (Anaes. 17728 = 20B + 8T) (Assist.) **Fee:** $710.25	**Benefit:** 75% = $532.70	85% = $659.35
38275	MYOCARDIAL BIOPSY, by cardiac catheterisation (Anaes. 17710 = 7B + 3T) **Fee:** $232.20	**Benefit:** 75% = $174.15	85% = $197.40
38278	SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of (Anaes. 17711 = 6B + 5T) **Fee:** $497.25	**Benefit:** 75% = $372.95	85% = $446.35
38281	PERMANENT PACEMAKER, insertion, removal or replacement of (Anaes. 17710 = 6B + 4T) *(See para T8.36 of explanatory notes to this Category)* **Fee:** $198.85	**Benefit:** 75% = $149.15	85% = $169.05
38284	DUAL CHAMBER PERMANENT TRANSVENOUS ELECTRODES, insertion, removal or replacement of (Anaes. 17713 = 6B + 7T) *(See para T8.36 of explanatory notes to this Category)* **Fee:** $651.95	**Benefit:** 75% = $489.00	85% = $601.05

	ARRHYTHMIA ABLATION		
38287	ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation procedure involving 1 atrial chamber (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $1,633.65	**Benefit:** 75% = $1,225.25	85% = $1,582.75
38290	ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes. 17738 = 20B + 18T) (Assist.) **Fee:** $2,080.20	**Benefit:** 75% = $1,560.15	85% = $2,029.30
38293	VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes. 17744 = 20B + 24T) (Assist.) **Fee:** $2,232.85	**Benefit:** 75% = $1,674.65	85% = $2,181.95
	THORACIC SURGERY		
38400	THORACIC CAVITY, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38403 applies **Fee:** $30.00	**Benefit:** 75% = $22.50	85% = $25.50
38403	THORACIC CAVITY, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample **Fee:** $59.85	**Benefit:** 75% = $44.90	85% = $50.90
38406	PERICARDIUM, paracentesis of (excluding aftercare) (Anaes. 17708 = 6B + 2T) **Fee:** $104.00	**Benefit:** 75% = $78.00	85% = $88.40
38409	INTERCOSTAL DRAIN, insertion of, not involving resection of rib (excluding aftercare) (Anaes. 17706 = 4B + 2T) **Fee:** $104.00	**Benefit:** 75% = $78.00	85% = $88.40
38410	INTERCOSTAL DRAIN, insertion of, with pleurodesis and not involving resection of rib (excluding aftercare) (Anaes. 17707 = 4B + 3T) **Fee:** $128.15	**Benefit:** 75% = $96.15	85% = $108.95
38412	PERCUTANEOUS NEEDLE BIOPSY of lung (Anaes. 17706 = 4B + 2T) **Fee:** $162.85	**Benefit:** 75% = $122.15	85% = $138.45
38415	EMPYEMA, radical operation for, involving resection of rib (Anaes. 17721 = 13B + 8T) (Assist.) **Fee:** $310.90	**Benefit:** 75% = $233.20	85% = $264.30
38418	THORACOTOMY, exploratory, with or without biopsy (Anaes. 17719 = 13B + 6T) (Assist.) **Fee:** $746.15	**Benefit:** 75% = $559.65	85% = $695.25
38421	THORACOTOMY, with pulmonary decortication (Anaes. 17726 = 15B + 11T) (Assist.) **Fee:** $1,192.70	**Benefit:** 75% = $894.55	85% = $1,141.80
38424	THORACOTOMY, with pleurectomy or pleurodesis, OR ENUCLEATION OF HYDATID cysts (Anaes. 17721 = 13B + 8T) (Assist.) **Fee:** $746.15	**Benefit:** 75% = $559.65	85% = $695.25
38427	THORACOPLASTY (complete) - 3 or more ribs (Anaes. 17730 = 15B + 15T) (Assist.) **Fee:** $921.30	**Benefit:** 75% = $691.00	85% = $870.40
38430	THORACOPLASTY (in stages) each stage (Anaes. 17723 = 15B + 8T) (Assist.) **Fee:** $474.85	**Benefit:** 75% = $356.15	85% = $423.95
38436	THORACOSCOPY, with or without division of pleural adhesions, including insertion of intercostal catheter, with or without biopsy (Anaes. 17716 = 10B + 6T) **Fee:** $194.45	**Benefit:** 75% = $145.85	85% = $165.30
38438	PNEUMONECTOMY or LOBECTOMY or SEGMENTECTOMY not being a service associated with a service to which Item 38418 applies (Anaes. 17724 = 13B + 11T) (Assist.) **Fee:** $1,192.70	**Benefit:** 75% = $894.55	85% = $1,141.80

38440	LUNG, wedge resection of (Anaes. 17722 = 13B + 9T) (Assist.) **Fee:** $893.15	**Benefit:** 75% = $669.90	85% = $842.25
38441	RADICAL LOBECTOMY or PNEUMONECTOMY including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (Anaes. 17728 = 13B + 15T) (Assist.) **Fee:** $1,413.15	**Benefit:** 75% = $1,059.90	85% = $1,362.25
38446	THORACOTOMY or STERNOTOMY, for removal of thymus or mediastinal tumour (Anaes. 17723 = 13B + 10T) (Assist.) **Fee:** $921.30	**Benefit:** 75% = $691.00	85% = $870.40
38447	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Anaes. 17727 = 15B + 12T) (Assist.) **Fee:** $1,192.70	**Benefit:** 75% = $894.55	85% = $1,141.80
38448	MEDIASTINUM, cervical exploration of, with or without biopsy (Anaes. 17712 = 8B + 4T) (Assist.) **Fee:** $282.65	**Benefit:** 75% = $212.00	85% = $240.30
38449	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (Anaes. 17732 = 20B + 12T) (Assist.) **Fee:** $1,668.60	**Benefit:** 75% = $1,251.45	85% = $1,617.70
38450	PERICARDIUM, transthoracic drainage of (Anaes. 17719 = 13B + 6T) (Assist.) **Fee:** $667.00	**Benefit:** 75% = $500.25	85% = $616.10
38452	PERICARDIUM, sub-xyphoid drainage of (Anaes. 17717 = 13B + 4T) (Assist.) **Fee:** $446.60	**Benefit:** 75% = $334.95	85% = $395.70
38453	TRACHEAL excision and repair without cardiopulmonary bypass (Anaes. 17731 = 15B + 16T) (Assist.) **Fee:** $1,339.70	**Benefit:** 75% = $1,004.80	85% = $1,288.80
38455	TRACHEAL EXCISION AND REPAIR OF, with cardiopulmonary bypass (Anaes. 17738 = 20B + 18T) (Assist.) **Fee:** $1,812.20	**Benefit:** 75% = $1,359.15	85% = $1,761.30
38456	INTRATHORACIC OPERATION on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than 1 of those organs, not being a service to which another item in this Group applies (Anaes. 17731 = 15B + 16T) (Assist.) **Fee:** $1,192.70	**Benefit:** 75% = $894.55	85% = $1,141.80
38457	PECTUS EXCAVATUM or PECTUS CARINATUM, repair or radical correction of (Anaes. 17724 = 13B + 11T) (Assist.) **Fee:** $1,113.55	**Benefit:** 75% = $835.20	85% = $1,062.65
38458	PECTUS EXCAVATUM, repair of, with implantation of subcutaneous prosthesis (Anaes. 17724 = 13B + 11T) (Assist.) **Fee:** $593.55	**Benefit:** 75% = $445.20	85% = $542.65
38460	STERNAL WIRE OR WIRES, removal of (Anaes. 17709 = 5B + 4T) **Fee:** $214.40	**Benefit:** 75% = $160.80	85% = $182.25
38462	STERNOTOMY WOUND, debridement of, not involving reopening of the mediastinum (Anaes. 17710 = 5B + 5T) **Fee:** $254.10	**Benefit:** 75% = $190.60	85% = $216.00
38464	STERNOTOMY WOUND, debridement of, involving curettage of infected bone with or without removal of wires but not involving reopening of the mediastinum (Anaes. 17711 = 5B + 6T) **Fee:** $276.25	**Benefit:** 75% = $207.20	85% = $234.85
38466	STERNUM, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (Anaes. 17721 = 13B + 8T) (Assist.) **Fee:** $745.90	**Benefit:** 75% = $559.45	85% = $695.00
38468	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps or greater omentum (Anaes. 17729 = 13B + 16T) (Assist.) **Fee:** $1,149.30	**Benefit:** 75% = $862.00	85% = $1,098.40
38469	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps and greater omentum (Anaes. 17733 = 13B + 20T) (Assist.) **Fee:** $1,339.70	**Benefit:** 75% = $1,004.80	85% = $1,288.80

	PACEMAKER PROCEDURES
38470	PERMANENT MYOCARDIAL ELECTRODE, insertion of, by thoracotomy or sternotomy (Anaes. 17721 = 15B + 6T) (Assist.) **Fee:** $746.15 **Benefit:** 75% = $559.65 85% = $695.25
38473	PERMANENT PACEMAKER ELECTRODE, insertion by sub-xyphoid approach (Anaes. 17720 = 15B + 5T) (Assist.) **Fee:** $446.60 **Benefit:** 75% = $334.95 85% = $395.70
	VALVULAR PROCEDURES
38475	VALVE ANNULOPLASTY without insertion of ring, not being a service associated with a service to which item 38480 or 38481 applies (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $647.65 **Benefit:** 75% = $485.75 85% = $596.75
38477	VALVE ANNULOPLASTY with insertion of ring not being a service to which item 38478 applies (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $1,559.75 **Benefit:** 75% = $1,169.85 85% = $1,508.85
38478	VALVE ANNULOPLASTY with insertion of ring performed in conjunction with item 38480 or 38481 (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $755.55 **Benefit:** 75% = $566.70 85% = $704.65
38480	VALVE REPAIR, 1 leaflet (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $1,559.75 **Benefit:** 75% = $1,169.85 85% = $1,508.85
38481	VALVE REPAIR, 2 or more leaflets (Anaes. 17736 = 20B + 16T) (Assist.) **Fee:** $1,775.60 **Benefit:** 75% = $1,331.70 85% = $1,724.70
38483	AORTIC VALVE LEAFLET OR LEAFLETS, decalcification of, not being a service to which item 38475, 38477, 38480, 38481, 38488 or 38489 applies (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $1,339.70 **Benefit:** 75% = $1,004.80 85% = $1,288.80
38485	MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with valve surgery (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $636.20 **Benefit:** 75% = $477.15 85% = $585.30
38487	MITRAL VALVE, open valvotomy of (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $1,339.70 **Benefit:** 75% = $1,004.80 85% = $1,288.80
38488	VALVE REPLACEMENT with BIOPROSTHESIS OR MECHANICAL PROSTHESIS (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $1,486.70 **Benefit:** 75% = $1,115.05 85% = $1,435.80
38489	VALVE REPLACEMENT with allograft (subcoronary or cylindrical implant), or unstented xenograft (Anaes. 17736 = 20B + 16T) (Assist.) **Fee:** $1,768.05 **Benefit:** 75% = $1,326.05 85% = $1,717.15
38490	SUB-VALVULAR STRUCTURES, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (Anaes. 17723 = 20B + 3T) (Assist.) **Fee:** $431.70 **Benefit:** 75% = $323.80 85% = $380.80
38493	OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes. 17740 = 20B + 20T) (Assist.) **Fee:** $1,524.10 **Benefit:** 75% = $1,143.10 85% = $1,473.20
38496	ARTERY HARVESTING (other than internal mammary), for coronary artery bypass (Anaes. 17711 = 8B + 3T) (Assist.) **Fee:** $485.75 **Benefit:** 75% = $364.35 85% = $434.85
	SURGERY FOR ISCHAEMIC HEART DISEASE
38497	CORONARY ARTERY BYPASS using saphenous vein graft or grafts only, including harvesting of vein graft material where performed (Anaes. 17736 = 20B + 16T) (Assist.) *(See para T8.37 of explanatory notes to this Category)* **Fee:** $1,594.10 **Benefit:** 75% = $1,195.60 85% = $1,543.20

38500	CORONARY ARTERY BYPASS using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed (Anaes. 17736 = 20B + 16T) (Assist.) *(See para T8.37 of explanatory notes to this Category)* **Fee:** $1,712.75	**Benefit:** 75% = $1,284.60	85% = $1,661.85
38503	CORONARY ARTERY BYPASS using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed (Anaes. 17738 = 20B + 18T) (Assist.) *(See para T8.37 of explanatory notes to this Category)* **Fee:** $1,859.70	**Benefit:** 75% = $1,394.80	85% = $1,808.80
38505	CORONARY ENDARTERECTOMY, by open operation, including repair with 1 or more patch grafts, each vessel (Anaes. 17723 = 20B + 3T) (Assist.) **Fee:** $215.85	**Benefit:** 75% = $161.90	85% = $183.50
38506	LEFT VENTRICULAR ANEURYSM, plication of (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $1,266.15	**Benefit:** 75% = $949.65	85% = $1,215.25
38507	LEFT VENTRICULAR ANEURYSM resection with primary repair (Anaes. 17736 = 20B + 16T) (Assist.) **Fee:** $1,486.40	**Benefit:** 75% = $1,114.80	85% = $1,435.50
38508	LEFT VENTRICULAR ANEURYSM resection with patch reconstruction of the left ventricle (Anaes. 17740 = 20B + 20T) (Assist.) **Fee:** $1,859.70	**Benefit:** 75% = $1,394.80	85% = $1,808.80
38509	ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (Anaes. 17738 = 20B + 18T) (Assist.) **Fee:** $1,859.70	**Benefit:** 75% = $1,394.80	85% = $1,808.80
	ARRHYTHMIA SURGERY		
38512	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $1,633.65	**Benefit:** 75% = $1,225.25	85% = $1,582.75
38515	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation (Anaes. 17738 = 20B + 18T) (Assist.) **Fee:** $2,080.20	**Benefit:** 75% = $1,560.15	85% = $2,029.30
38518	VENTRICULAR ARRHYTHMIA with mapping and muscle ablation, with or without aneurysmeotomy (Anaes. 17744 = 20B + 24T) (Assist.) **Fee:** $2,232.85	**Benefit:** 75% = $1,674.65	85% = $2,181.95
38521	AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrode for - not being a service associated with a service to which item 38213 applies (Anaes. 17721 = 15B + 6T) (Assist.) **Fee:** $819.60	**Benefit:** 75% = $614.70	85% = $768.70
38524	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of - not being a service associated with a service to which item 38213 applies (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $224.05	**Benefit:** 75% = $168.05	85% = $190.45
	PROCEDURES ON THE THORACIC AORTA		
38550	ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes. 17742 = 20B + 22T) (Assist.) **Fee:** $1,670.90	**Benefit:** 75% = $1,253.20	85% = $1,620.00
38553	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes. 17747 = 20B + 27T) (Assist.) **Fee:** $2,117.40	**Benefit:** 75% = $1,588.05	85% = $2,066.50
38556	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes. 17753 = 20B + 33T) (Assist.) **Fee:** $2,417.10	**Benefit:** 75% = $1,812.85	85% = $2,366.20
38559	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes. 17747 = 20B + 27T) (Assist.) **Fee:** $1,970.50	**Benefit:** 75% = $1,477.90	85% = $1,919.60

38562	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes. 17753 = 20B + 33T) (Assist.) **Fee:** $2,417.10	**Benefit:** 75% = $1,812.85	85% = $2,366.20
38565	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes. 17756 = 20B + 36T) (Assist.) **Fee:** $2,711.00	**Benefit:** 75% = $2,033.25	85% = $2,660.10
38568	DESCENDING THORACIC AORTA, repair or replacement of, without shunt or cardiopulmonary bypass (Anaes. 17733 = 15B + 18T) (Assist.) **Fee:** $1,450.40	**Benefit:** 75% = $1,087.80	85% = $1,399.50
38571	DESCENDING THORACIC AORTA, repair or replacement of, using shunt or cardiopulmonary bypass (Anaes. 17738 = 20B + 18T) (Assist.) **Fee:** $1,597.40	**Benefit:** 75% = $1,198.05	85% = $1,546.50
38572	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISSECTION, in conjunction with procedures on the thoracic aorta (Anaes. 17725 = 15B + 10T) (Assist.) **Fee:** $1,547.00	**Benefit:** 75% = $1,160.25	85% = $1,496.10
38577	CANNULATION FOR, and supervision and monitoring of, the administration of retrograde cerebral perfusion during deep hypothermic arrest (Assist.) **Fee:** $431.70	**Benefit:** 75% = $323.80	85% = $380.80
	TECHNIQUES FOR PRESERVATION OF THE ARRESTED HEART		
38588	CANNULATION of the coronary sinus for, and supervision of, the retrograde administration of blood or crystalloid for cardioplegia, including pressure monitoring (Assist.) **Fee:** $323.85	**Benefit:** 75% = $242.90	85% = $275.30
	CIRCULATORY SUPPORT PROCEDURES		
38600	CENTRAL CANNULATION for cardiopulmonary bypass excluding post-operative management, not being a service associated with a service to which another item in this Subgroup applies (Anaes. 17726 = 20B + 6T) (Assist.) **Fee:** $1,192.70	**Benefit:** 75% = $894.55	85% = $1,141.80
38603	PERIPHERAL CANNULATION for cardiopulmonary bypass excluding post-operative management (Anaes. 17713 = 8B + 5T) (Assist.) **Fee:** $746.15	**Benefit:** 75% = $559.65	85% = $695.25
38606	INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (Anaes. 17711 = 8B + 3T) **Fee:** $299.65	**Benefit:** 75% = $224.75	85% = $254.75
38609	INTRA-AORTIC BALLOON PUMP, insertion of, by arteriotomy (Anaes. 17713 = 8B + 5T) (Assist.) **Fee:** $373.05	**Benefit:** 75% = $279.80	85% = $322.15
38612	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by direct suture (Anaes. 17713 = 8B + 5T) (Assist.) **Fee:** $418.20	**Benefit:** 75% = $313.65	85% = $367.30
38613	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by patch graft (Anaes. 17715 = 8B + 7T) (Assist.) **Fee:** $524.85	**Benefit:** 75% = $393.65	85% = $473.95
38615	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, insertion of (Anaes. 17735 = 20B + 15T) (Assist.) **Fee:** $1,192.70	**Benefit:** 75% = $894.55	85% = $1,141.80
38618	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, insertion of (Anaes. 17737 = 20B + 17T) (Assist.) **Fee:** $1,486.70	**Benefit:** 75% = $1,115.05	85% = $1,435.80
38621	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes. 17726 = 20B + 6T) (Assist.) **Fee:** $593.55	**Benefit:** 75% = $445.20	85% = $542.65
38624	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes. 17727 = 20B + 7T) (Assist.) **Fee:** $667.00	**Benefit:** 75% = $500.25	85% = $616.10

38627	EXTRA-CORPOREAL MEMBRANE OXYGENATION, BYPASS OR VENTRICULAR ASSIST DEVICE CANNULAE, adjustment and re-positioning of, by open operation, in patients supported by these devices (Anaes. 17726 = 20B + 6T) (Assist.) **Fee:** $521.30 **Benefit:** 75% = $391.00 85% = $470.40
	RE-OPERATION
38637	PATENT DISEASED coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of (Anaes. 17723 = 20B + 3T) (Assist.) **Fee:** $431.70 **Benefit:** 75% = $323.80 85% = $380.80
38640	RE-OPERATION via median sternotomy, for any procedure, including any divisions of adhesions where the time taken to divide the adhesions is 45 minutes or less (Anaes. 17723 = 13B + 10T) (Assist.) *(See para T8.38 of explanatory notes to this Category)* **Fee:** $746.15 **Benefit:** 75% = $559.65 85% = $695.25
	MISCELLANEOUS PROCEDURES
38643	THORACOTOMY OR STERNOTOMY involving division of adhesions where the time taken to divide the adhesions exceeds 45 minutes (Anaes. 17726 = 13B + 13T) (Assist.) **Fee:** $830.95 **Benefit:** 75% = $623.25 85% = $780.05
38647	THORACOTOMY OR STERNOTOMY involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (Anaes. 17729 = 13B + 16T) (Assist.) **Fee:** $1,661.85 **Benefit:** 75% = $1,246.40 85% = $1,610.95
38650	MYOMECTOMY or MYOTOMY for hypertrophic obstructive cardiomyopathy (Anaes. 17732 = 20B + 12T) (Assist.) **Fee:** $1,486.70 **Benefit:** 75% = $1,115.05 85% = $1,435.80
38653	OPEN HEART SURGERY, not being a service to which another item in this Group applies (Anaes. 17736 = 20B + 16T) (Assist.) **Fee:** $1,486.70 **Benefit:** 75% = $1,115.05 85% = $1,435.80
38656	THORACOTOMY or median sternotomy for post-operative bleeding (Anaes. 17721 = 15B + 6T) (Assist.) **Fee:** $746.15 **Benefit:** 75% = $559.65 85% = $695.25
	CARDIAC TUMOURS
38670	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction (Anaes. 17736 = 20B + 16T) (Assist.) **Fee:** $1,486.40 **Benefit:** 75% = $1,114.80 85% = $1,435.50
38673	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Anaes. 17738 = 20B + 18T) (Assist.) **Fee:** $1,673.05 **Benefit:** 75% = $1,254.80 85% = $1,622.15
38677	CARDIAC TUMOUR arising from ventricular myocardium, partial thickness excision of (Anaes. 17736 = 20B + 16T) (Assist.) **Fee:** $1,565.10 **Benefit:** 75% = $1,173.85 85% = $1,514.20
38680	CARDIAC TUMOUR arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Anaes. 17740 = 20B + 20T) (Assist.) **Fee:** $1,856.50 **Benefit:** 75% = $1,392.40 85% = $1,805.60
	CONGENITAL CARDIAC SURGERY
38700	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease (Anaes. 17727 = 15B + 12T) (Assist.) **Fee:** $830.95 **Benefit:** 75% = $623.25 85% = $780.05
38703	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease (Anaes. 17732 = 20B + 12T) (Assist.) **Fee:** $1,498.00 **Benefit:** 75% = $1,123.50 85% = $1,447.10
38706	AORTA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes. 17729 = 15B + 14T) (Assist.) **Fee:** $1,418.80 **Benefit:** 75% = $1,064.10 85% = $1,367.90

38709	AORTA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes. 17736 = 20B + 16T) (Assist.) **Fee:** $1,661.85 **Benefit:** 75% = $1,246.40 85% = $1,610.95
38712	AORTIC INTERRUPTION, repair of, for congenital heart disease (Anaes. 17729 = 15B + 14T) (Assist.) **Fee:** $1,995.45 **Benefit:** 75% = $1,496.60 85% = $1,944.55
38715	MAIN PULMONARY ARTERY, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes. 17727 = 15B + 12T) (Assist.) **Fee:** $1,328.40 **Benefit:** 75% = $996.30 85% = $1,277.50
38718	MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $1,661.85 **Benefit:** 75% = $1,246.40 85% = $1,610.95
38721	VENA CAVA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes. 17731 = 15B + 16T) (Assist.) **Fee:** $1,164.45 **Benefit:** 75% = $873.35 85% = $1,113.55
38724	VENA CAVA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes. 17738 = 20B + 18T) (Assist.) **Fee:** $1,661.85 **Benefit:** 75% = $1,246.40 85% = $1,610.95
38727	INTRATHORACIC VESSELS, anastomosis or repair of, without cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes. 17732 = 15B + 17T) (Assist.) **Fee:** $1,164.45 **Benefit:** 75% = $873.35 85% = $1,113.55
38730	INTRATHORACIC VESSELS, anastomosis or repair of, with cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes. 17736 = 20B + 16T) (Assist.) **Fee:** $1,661.85 **Benefit:** 75% = $1,246.40 85% = $1,610.95
38733	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, without cardiopulmonary bypass, for congenital heart disease (Anaes. 17733 = 15B + 18T) (Assist.) **Fee:** $1,164.45 **Benefit:** 75% = $873.35 85% = $1,113.55
38736	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, with cardiopulmonary bypass, for congenital heart disease (Anaes. 17740 = 20B + 20T) (Assist.) **Fee:** $1,661.85 **Benefit:** 75% = $1,246.40 85% = $1,610.95
38739	ATRIAL SEPTECTOMY, with or without cardiopulmonary bypass, for congenital heart disease (Anaes. 17733 = 15B + 18T) (Assist.) **Fee:** $1,498.00 **Benefit:** 75% = $1,123.50 85% = $1,447.10
38742	ATRIAL SEPTAL DEFECT, closure by direct suture or patch, for congenital heart disease (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $1,498.00 **Benefit:** 75% = $1,123.50 85% = $1,447.10
38745	INTRA-ATRIAL BAFFLE, insertion of, for congenital heart disease (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $1,661.85 **Benefit:** 75% = $1,246.40 85% = $1,610.95
38748	VENTRICULAR SEPTECTOMY, for congenital heart disease (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $1,661.85 **Benefit:** 75% = $1,246.40 85% = $1,610.95
38751	VENTRICULAR SEPTAL DEFECT, closure by direct suture or patch, for congenital heart disease (Anaes. 17736 = 20B + 16T) (Assist.) **Fee:** $1,661.85 **Benefit:** 75% = $1,246.40 85% = $1,610.95
38754	INTRAVENTRICULAR BAFFLE OR CONDUIT, insertion of, for congenital heart disease (Anaes. 17738 = 20B + 18T) (Assist.) **Fee:** $2,080.20 **Benefit:** 75% = $1,560.15 85% = $2,029.30
38757	EXTRACARDIAC CONDUIT, insertion of, for congenital heart disease (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $1,661.85 **Benefit:** 75% = $1,246.40 85% = $1,610.95
38760	EXTRACARDIAC CONDUIT, replacement of, for congenital heart disease (Anaes. 17736 = 20B + 16T) (Assist.) **Fee:** $1,661.85 **Benefit:** 75% = $1,246.40 85% = $1,610.95

38763	VENTRICULAR MYECTOMY, for relief of ventricular obstruction, right or left, for congenital heart disease (Anaes. 17734 = 20B + 14T) (Assist.) **Fee:** $1,661.85 **Benefit:** 75% = $1,246.40 85% = $1,610.95
38766	VENTRICULAR AUGMENTATION, right or left, for congenital heart disease (Anaes. 17736 = 20B + 16T) (Assist.) **Fee:** $1,661.85 **Benefit:** 75% = $1,246.40 85% = $1,610.95
	SUBGROUP 7 - NEUROSURGICAL
	GENERAL
39000	LUMBAR PUNCTURE (Anaes. 17706 = 5B + 1T) **Fee:** $58.60 **Benefit:** 75% = $43.95 85% = $49.85
39003	CISTERNAL PUNCTURE (Anaes. 17707 = 5B + 2T) **Fee:** $66.70 **Benefit:** 75% = $50.05 85% = $56.70
39006	VENTRICULAR PUNCTURE (not including burr-hole) (Anaes. 17707 = 5B + 2T) **Fee:** $124.10 **Benefit:** 75% = $93.10 85% = $105.50
39009	SUBDURAL HAEMORRHAGE, tap for, each tap (Anaes. 17707 = 5B + 2T) **Fee:** $46.20 **Benefit:** 75% = $34.65 85% = $39.30
39012	BURR-HOLE, single, preparatory to ventricular puncture or for inspection purpose - not being a service to which another item applies (Anaes. 17713 = 9B + 4T) **Fee:** $185.00 **Benefit:** 75% = $138.75 85% = $157.25
39013	INJECTION UNDER IMAGE INTENSIFICATION with 1 or more of contrast media, local anaesthetic or corticosteroid into 1 or more zygo-apophyseal or costo-transverse joints or 1 or more primary posterior rami of spinal nerves (Anaes. 17708 = 5B + 3T) **Fee:** $85.05 **Benefit:** 75% = $63.80 85% = $72.30
39015	VENTRICULAR RESERVOIR, EXTERNAL VENTRICULAR DRAIN or INTRACRANIAL PRESSURE MONITORING DEVICE, insertion of - including burr-hole (excluding after-care) (Anaes. 17713 = 9B + 4T) (Assist.) **Fee:** $292.70 **Benefit:** 75% = $219.55 85% = $248.80
39018	CEREBROSPINAL FLUID reservoir, insertion of (Anaes. 17714 = 9B + 5T) (Assist.) **Fee:** $292.70 **Benefit:** 75% = $219.55 85% = $248.80
	PROCEDURES FOR PAIN RELIEF
39100	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes. 17709 = 5B + 4T) **Fee:** $185.00 **Benefit:** 75% = $138.75 85% = $157.25
39106	NEURECTOMY, INTRACRANIAL, for trigeminal neuralgia (Anaes. 17724 = 12B + 12T) (Assist.) **Fee:** $925.05 **Benefit:** 75% = $693.80 85% = $874.15
39109	TRIGEMINAL GANGLIOTOMY by radiofrequency, balloon or glycerol (Anaes. 17711 = 6B + 5T) **Fee:** $345.40 **Benefit:** 75% = $259.05 85% = $294.50
39112	CRANIAL NERVE, intracranial decompression of, using microsurgical techniques (Anaes. 17729 = 12B + 17T) (Assist.) **Fee:** $1,200.20 **Benefit:** 75% = $900.15 85% = $1,149.30
39115	PERCUTANEOUS NEUROTOMY of posterior divisions (or rami) of spinal nerves by any method, including any associated spinal, epidural or regional nerve block (payable once only in a 30 day period) (Anaes. 17707 = 5B + 2T) **Fee:** $58.60 **Benefit:** 75% = $43.95 85% = $49.85
39118	PERCUTANEOUS NEUROTOMY for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes. 17707 = 5B + 2T) (Assist.) **Fee:** $231.85 **Benefit:** 75% = $173.90 85% = $197.10
39121	PERCUTANEOUS CORDOTOMY (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $491.85 **Benefit:** 75% = $368.90 85% = $440.95

39124	CORDOTOMY OR MYELOTOMY, laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes. 17718 = 10B + 8T) (Assist.) **Fee:** $1,258.75 **Benefit:** 75% = $944.10 85% = $1,207.85
39125	SPINAL CATHETER, insertion of - for an automated infusion device (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $232.05 **Benefit:** 75% = $174.05 85% = $197.25
39126	AUTOMATED SUBCUTANEOUS INFUSION DEVICE, insertion of (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $281.75 **Benefit:** 75% = $211.35 85% = $239.50
39127	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER FOR PAIN, insertion of (Anaes. 17709 = 5B + 4T) **Fee:** $368.80 **Benefit:** 75% = $276.60 85% = $317.90
39128	AUTOMATED SUBCUTANEOUS INFUSION DEVICE AND SPINAL CATHETER, insertion of (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $513.80 **Benefit:** 75% = $385.35 85% = $462.90
39130	PERCUTANEOUS EPIDURAL ELECTRODE, insertion of 1 or more of - for spinal stimulation (Anaes. 17711 = 5B + 6T) **Fee:** $475.15 **Benefit:** 75% = $356.40 85% = $424.25
39131	PERCUTANEOUS EPIDURAL ELECTRODES, management, adjustment, electronic programming and trial of stimulation of, by a medical practitioner - each day **Fee:** $99.50 **Benefit:** 75% = $74.65 85% = $84.60
39133	EPIDURAL STIMULATOR or INTRATHECAL INFUSION DEVICE, revision of (Anaes. 17709 = 5B + 4T) **Fee:** $124.10 **Benefit:** 75% = $93.10 85% = $105.50
39134	SPINAL NEUROSTIMULATOR RECEIVER or pulse generator, subcutaneous placement of (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $265.15 **Benefit:** 75% = $198.90 85% = $225.40
39136	PERCUTANEOUS EPIDURAL IMPLANT for management of pain, removal of (Anaes. 17709 = 5B + 4T) **Fee:** $124.10 **Benefit:** 75% = $93.10 85% = $105.50
39139	EPIDURAL ELECTRODE for management of pain, insertion of 1 or more of by laminectomy, including implantation of pulse generator (1 or 2 stages) (Anaes. 17718 = 10B + 8T) (Assist.) **Fee:** $837.25 **Benefit:** 75% = $627.95 85% = $786.35
39140	EPIDURAL CATHETER, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes. 17709 = 5B + 4T) **Fee:** $228.00 **Benefit:** 75% = $171.00 85% = $193.80
	PERIPHERAL NERVES
39300	CUTANEOUS NERVE (including digital nerve), primary repair of, using microsurgical techniques (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $275.15 **Benefit:** 75% = $206.40 85% = $233.90
39303	CUTANEOUS NERVE (including digital nerve), secondary repair of, using microsurgical techniques (Anaes. 17711 = 4B + 7T) (Assist.) **Fee:** $362.90 **Benefit:** 75% = $272.20 85% = $312.00
39306	NERVE TRUNK, primary repair of, using microsurgical techniques (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $526.95 **Benefit:** 75% = $395.25 85% = $476.05
39309	NERVE TRUNK, secondary repair of, using microsurgical techniques (Anaes. 17713 = 4B + 9T) (Assist.) **Fee:** $556.10 **Benefit:** 75% = $417.10 85% = $505.20
39312	NERVE TRUNK, (interfascicular), neurolysis of, using microsurgical techniques (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $310.25 **Benefit:** 75% = $232.70 85% = $263.75
39315	NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes. 17717 = 4B + 13T) (Assist.) **Fee:** $802.00 **Benefit:** 75% = $601.50 85% = $751.10
39318	CUTANEOUS NERVE (including digital nerve), nerve graft to, using microsurgical techniques (Anaes. 17713 = 4B + 9T) (Assist.) **Fee:** $497.65 **Benefit:** 75% = $373.25 85% = $446.75

39321	NERVE, transposition of (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $368.80	**Benefit:** 75% = $276.60	85% = $317.90
39323	PERCUTANEOUS NEUROTOMY by cryoneurotomy or radiofrequency lesion generator, not being a service to which another item applies (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $215.45	**Benefit:** 75% = $161.60	85% = $183.15
39324	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $215.45	**Benefit:** 75% = $161.60	85% = $183.15
39327	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral nerve, by open operation (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $368.80	**Benefit:** 75% = $276.60	85% = $317.90
39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item 39312 applies (Anaes. 17706 = 4B + 2T) (Assist.) **Fee:** $215.45	**Benefit:** 75% = $161.60	85% = $183.15
39331	CARPAL TUNNEL RELEASE (division of transverse carpal ligament), by any method (Anaes. 17705 = 3B + 2T) **Fee:** $215.45	**Benefit:** 75% = $161.60	85% = $183.15
39333	BRACHIAL PLEXUS, exploration of, not being a service to which another item in this Group applies (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $310.25	**Benefit:** 75% = $232.70	85% = $263.75
	CRANIAL NERVES		
39500	VESTIBULAR NERVE, section of, via posterior fossa (Anaes. 17729 = 12B + 17T) (Assist.) **Fee:** $989.45	**Benefit:** 75% = $742.10	85% = $938.55
39503	FACIO-HYPOGLOSSAL nerve or FACIO-ACCESSORY nerve, anastomosis of (Anaes. 17733 = 12B + 21T) (Assist.) **Fee:** $743.50	**Benefit:** 75% = $557.65	85% = $692.60
	CRANIO-CEREBRAL INJURIES		
39600	INTRACRANIAL HAEMORRHAGE, burr-hole craniotomy for - including burr-holes (Anaes. 17715 = 9B + 6T) (Assist.) **Fee:** $368.80	**Benefit:** 75% = $276.60	85% = $317.90
39603	INTRACRANIAL HAEMORRHAGE, osteoplastic craniotomy or extensive craniectomy and removal of haematoma (Anaes. 17723 = 12B + 11T) (Assist.) **Fee:** $930.85	**Benefit:** 75% = $698.15	85% = $879.95
39606	FRACTURED SKULL, depressed or comminuted, operation for (Anaes. 17719 = 12B + 7T) (Assist.) **Fee:** $620.55	**Benefit:** 75% = $465.45	85% = $569.65
39609	FRACTURED SKULL, compound, without dural penetration, operation for (Anaes. 17719 = 12B + 7T) (Assist.) **Fee:** $743.50	**Benefit:** 75% = $557.65	85% = $692.60
39612	FRACTURED SKULL, compound, depressed or complicated, with dural penetration and brain laceration, operation for (Anaes. 17721 = 12B + 9T) (Assist.) **Fee:** $872.40	**Benefit:** 75% = $654.30	85% = $821.50
39615	FRACTURED SKULL with rhinorrhoea or otorrhoea, cranioplasty and repair of (Anaes. 17723 = 12B + 11T) (Assist.) **Fee:** $930.85	**Benefit:** 75% = $698.15	85% = $879.95
	SKULL BASE SURGERY		
39640	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving craniotomy, radical excision of the skull base, and dural repair (Anaes. 17748 = 12B + 36T) (Assist.) *(See para T8.39 of explanatory notes to this Category)* **Fee:** $2,360.30	**Benefit:** 75% = $1,770.25	85% = $2,309.40
39642	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy for clearance of paranasal sinus extension (intracranial procedure) (Anaes. 17751 = 12B + 39T) (Assist.) *(See para T8.39 of explanatory notes to this Category)* **Fee:** $2,481.40	**Benefit:** 75% = $1,861.05	85% = $2,430.50

39646	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy and radical clearance of paranasal sinus and orbital fossa extensions, with intracranial decompression of the optic nerve, (intracranial procedure) (Anaes. 17754 = 12B + 42T) (Assist.) *(See para T8.39 of explanatory notes to this Category)* **Fee:** $2,844.50 **Benefit:** 75% = $2,133.40 85% = $2,793.60
39650	TUMOUR INVOLVING MIDDLE CRANIAL FOSSA AND INFRA-TEMPORAL FOSSA, removal of, craniotomy and radical or sub-total radical excision, with division and reconstruction of zygomatic arch, (intracranial procedure) (Anaes. 17763 = 12B + 51T) (Assist.) *(See para T8.39 of explanatory notes to this Category)* **Fee:** $2,057.70 **Benefit:** 75% = $1,543.30 85% = $2,006.80
39653	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision (intracranial procedure), not being a service to which item 39654 or 39656 applies (Anaes. 17763 = 12B + 51T) (Assist.) *(See para T8.39 of explanatory notes to this Category)* **Fee:** $3,661.50 **Benefit:** 75% = $2,746.15 85% = $3,610.60
39654	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure), conjoint surgery, principal surgeon (Anaes. 17763 = 12B + 51T) (Assist.) *(See para T8.39 of explanatory notes to this Category)* **Fee:** $2,662.95 **Benefit:** 75% = $1,997.25 85% = $2,612.05
39656	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure) conjoint surgery, co-surgeon (Assist.) *(See para T8.39 of explanatory notes to this Category)* **Fee:** $1,997.20 **Benefit:** 75% = $1,497.90 85% = $1,946.30
39658	TUMOUR INVOLVING THE CLIVUS, radical or sub-total radical excision of, involving transoral or transmaxillary approach (Anaes. 17763 = 12B + 51T) (Assist.) *(See para T8.39 of explanatory notes to this Category)* **Fee:** $2,360.30 **Benefit:** 75% = $1,770.25 85% = $2,309.40
39660	TUMOUR OR VASCULAR LESION OF CAVERNOUS SINUS, radical excision of, involving craniotomy with or without intracranial carotid artery exposure (Anaes. 17762 = 20B + 42T) (Assist.) *(See para T8.39 of explanatory notes to this Category)* **Fee:** $2,360.30 **Benefit:** 75% = $1,770.25 85% = $2,309.40
39662	TUMOUR OR VASCULAR LESION OF FORAMEN MAGNUM, radical excision of, via transcondylar or far lateral suboccipital approach (Anaes. 17762 = 20B + 42T) (Assist.) *(See para T8.39 of explanatory notes to this Category)* **Fee:** $2,360.30 **Benefit:** 75% = $1,770.25 85% = $2,309.40
	INTRACRANIAL NEOPLASMS
39700	SKULL TUMOUR, benign or malignant, excision of, excluding cranioplasty (Anaes. 17727 = 12B + 15T) (Assist.) **Fee:** $433.35 **Benefit:** 75% = $325.05 85% = $382.45
39703	INTRACRANIAL tumour, cyst or other brain tissue, burr-hole and biopsy of, or drainage of, or both (Anaes. 17714 = 9B + 5T) (Assist.) **Fee:** $404.00 **Benefit:** 75% = $303.00 85% = $353.10
39706	INTRACRANIAL tumour, biopsy or decompression of via osteoplastic flap OR biopsy and decompression of via osteoplastic flap (Anaes. 17720 = 12B + 8T) (Assist.) **Fee:** $866.40 **Benefit:** 75% = $649.80 85% = $815.50
39709	CRANIOTOMY for removal of glioma, metastatic carcinoma or any other tumour in cerebrum, cerebellum or brain stem - not being a service to which another item in this Sub-group applies (Anaes. 17730 = 12B + 18T) (Assist.) **Fee:** $1,235.30 **Benefit:** 75% = $926.50 85% = $1,184.40
39712	CRANIOTOMY FOR REMOVAL OF MENINGIOMA, pinealoma, cranio-pharyngioma, intraventricular tumour or any other intracranial tumour, not being a service to which another item in this Sub-group applies (Anaes. 17730 = 12B + 18T) (Assist.) **Fee:** $2,230.55 **Benefit:** 75% = $1,672.95 85% = $2,179.65
39715	PITUITARY TUMOUR, removal of, by transcranial or transphenoidal approach (Anaes. 17730 = 12B + 18T) (Assist.) **Fee:** $1,545.60 **Benefit:** 75% = $1,159.20 85% = $1,494.70

39718	ARACHNOIDAL CYST, craniotomy for (Anaes. 17720 = 12B + 8T) (Assist.) **Fee:** $679.15	**Benefit:** 75% = $509.40	85% = $628.25
39721	CRANIOTOMY, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling, etc (Anaes. 17720 = 12B + 8T) (Assist.) **Fee:** $620.55	**Benefit:** 75% = $465.45	85% = $569.65
	CEREBROVASCULAR DISEASE		
39800	ANEURYSM, clipping or reinforcement of sac (Anaes. 17740 = 20B + 20T) (Assist.) **Fee:** $2,224.75	**Benefit:** 75% = $1,668.60	85% = $2,173.85
39803	INTRACRANIAL ARTERIOVENOUS MALFORMATION, excision of (Anaes. 17744 = 20B + 24T) (Assist.) **Fee:** $2,224.75	**Benefit:** 75% = $1,668.60	85% = $2,173.85
39806	ANEURYSM, or arteriovenous malformation, intracranial proximal artery clipping of (Anaes. 17736 = 20B + 16T) (Assist.) **Fee:** $1,001.10	**Benefit:** 75% = $750.85	85% = $950.20
39812	INTRACRANIAL ANEURYSM or arteriovenous fistula, ligation of cervical vessel or vessels (Anaes. 17715 = 10B + 5T) (Assist.) **Fee:** $491.85	**Benefit:** 75% = $368.90	85% = $440.95
39815	CAROTID-CAVERNOUS FISTULA, obliteration of - combined cervical and intracranial procedure (Anaes. 17756 = 20B + 36T) (Assist.) **Fee:** $1,422.60	**Benefit:** 75% = $1,066.95	85% = $1,371.70
39818	EXTRACRANIAL TO INTRACRANIAL BYPASS using superficial temporal artery (Anaes. 17744 = 20B + 24T) (Assist.) **Fee:** $1,422.60	**Benefit:** 75% = $1,066.95	85% = $1,371.70
39821	EXTRACRANIAL TO INTRACRANIAL BYPASS using saphenous vein graft (Anaes. 17750 = 20B + 30T) (Assist.) **Fee:** $1,689.25	**Benefit:** 75% = $1,266.95	85% = $1,638.35
	INFECTION		
39900	INTRACRANIAL INFECTION, drainage of, via burr-hole - including burr-hole (Anaes. 17714 = 9B + 5T) (Assist.) **Fee:** $404.00	**Benefit:** 75% = $303.00	85% = $353.10
39903	INTRACRANIAL ABSCESS, excision of (Anaes. 17722 = 12B + 10T) (Assist.) **Fee:** $1,235.30	**Benefit:** 75% = $926.50	85% = $1,184.40
39906	OSTEOMYELITIS OF SKULL or removal of infected bone flap, craniectomy for (Anaes. 17717 = 12B + 5T) (Assist.) **Fee:** $620.55	**Benefit:** 75% = $465.45	85% = $569.65
	CEREBRO-SPINAL FLUID CIRCULATION DISORDERS		
40000	VENTRICULO-CISTERNOSTOMY (Torkildsen's operation) (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $714.25	**Benefit:** 75% = $535.70	85% = $663.35
40003	CRANIAL OR CISTERNAL SHUNT DIVERSION, insertion of (Anaes. 17719 = 10B + 9T) (Assist.) **Fee:** $714.25	**Benefit:** 75% = $535.70	85% = $663.35
40006	LUMBAR SHUNT DIVERSION, insertion of (Anaes. 17719 = 10B + 9T) (Assist.) **Fee:** $562.00	**Benefit:** 75% = $421.50	85% = $511.10
40009	CRANIAL, CISTERNAL OR LUMBAR SHUNT, revision or removal of (Anaes. 17718 = 10B + 8T) (Assist.) **Fee:** $409.80	**Benefit:** 75% = $307.35	85% = $358.90
40012	THIRD VENTRICULOSTOMY (open or endoscopic) with or without endoscopic septum pellucidotomy (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $802.00	**Benefit:** 75% = $601.50	85% = $751.10
40015	SUBTEMPORAL DECOMPRESSION (Anaes. 17724 = 12B + 12T) (Assist.) **Fee:** $497.25	**Benefit:** 75% = $372.95	85% = $446.35
40018	LUMBAR CEREBROSPINAL FLUID DRAIN, insertion of (Anaes. 17710 = 8B + 2T) **Fee:** $124.10	**Benefit:** 75% = $93.10	85% = $105.50

	CONGENITAL DISORDERS
40100	MENINGOCELE, excision and closure of (Anaes. 17717 = 8B + 9T) (Assist.) **Fee:** $538.65 **Benefit:** 75% = $404.00 85% = $487.75
40103	MYELOMENINGOCELE, excision and closure of, including skin flaps or Z plasty where performed (Anaes. 17719 = 8B + 11T) (Assist.) **Fee:** $790.35 **Benefit:** 75% = $592.80 85% = $739.45
40106	ARNOLD-CHIARI MALFORMATION, decompression of (Anaes. 17735 = 12B + 23T) (Assist.) **Fee:** $802.00 **Benefit:** 75% = $601.50 85% = $751.10
40109	ENCEPHALOCOELE, excision and closure of (Anaes. 17734 = 12B + 22T) (Assist.) **Fee:** $866.40 **Benefit:** 75% = $649.80 85% = $815.50
40112	TETHERED CORD, release of, including lipomeningocele or diastematomyelia (Anaes. 17736 = 8B + 28T) (Assist.) **Fee:** $1,112.35 **Benefit:** 75% = $834.30 85% = $1,061.45
40115	CRANIOSTENOSIS, operation for - single suture (Anaes. 17723 = 12B + 11T) (Assist.) **Fee:** $562.00 **Benefit:** 75% = $421.50 85% = $511.10
40118	CRANIOSTENOSIS, operation for - more than 1 suture (Anaes. 17725 = 12B + 13T) (Assist.) **Fee:** $743.50 **Benefit:** 75% = $557.65 85% = $692.60
	SPINAL DISORDERS
40300	INTERVERTEBRAL DISC OR DISCS, laminectomy for removal of (Anaes. 17715 = 9B + 6T) (Assist.) **Fee:** $743.50 **Benefit:** 75% = $557.65 85% = $692.60
40301	INTERVERTEBRAL DISC OR DISCS, microsurgical discectomy of (Anaes. 17717 = 9B + 8T) (Assist.) **Fee:** $745.90 **Benefit:** 75% = $559.45 85% = $695.00
40303	RECURRENT DISC LESION OR SPINAL STENOSIS, or both, laminectomy for - 1 level (Anaes. 17715 = 9B + 6T) (Assist.) **Fee:** $848.85 **Benefit:** 75% = $636.65 85% = $797.95
40306	SPINAL STENOSIS, laminectomy for, involving more than 1 vertebral interspace (disc level) (Anaes. 17717 = 9B + 8T) (Assist.) **Fee:** $1,118.25 **Benefit:** 75% = $838.70 85% = $1,067.35
40309	EXTRADURAL TUMOUR OR ABSCESS, laminectomy for (Anaes. 17715 = 9B + 6T) (Assist.) **Fee:** $848.85 **Benefit:** 75% = $636.65 85% = $797.95
40312	INTRADURAL LESION, laminectomy for, not being a service to which another item in this Group applies (Anaes. 17715 = 9B + 6T) (Assist.) **Fee:** $1,141.60 **Benefit:** 75% = $856.20 85% = $1,090.70
40315	CRANIOCERVICAL JUNCTION LESION, transoral approach for (Anaes. 17733 = 13B + 20T) (Assist.) **Fee:** $1,235.30 **Benefit:** 75% = $926.50 85% = $1,184.40
40316	ODONTOID screw fixation (Anaes. 17728 = 10B + 18T) (Assist.) **Fee:** $1,619.10 **Benefit:** 75% = $1,214.35 85% = $1,568.20
40318	INTRAMEDULLARY TUMOUR OR ARTERIOVENOUS MALFORMATION, laminectomy and radical excision of (Anaes. 17725 = 13B + 12T) (Assist.) **Fee:** $1,545.60 **Benefit:** 75% = $1,159.20 85% = $1,494.70
40321	POSTERIOR SPINAL FUSION, not being a service to which items 40324 and 40327 apply (Anaes. 17722 = 9B + 13T) (Assist.) **Fee:** $848.85 **Benefit:** 75% = $636.65 85% = $797.95
40324	LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together - laminectomy, including aftercare (Anaes. 17722 = 9B + 13T) (Assist.) **Fee:** $497.65 **Benefit:** 75% = $373.25 85% = $446.75
40327	LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together - posterior fusion, including aftercare (Assist.) **Fee:** $497.65 **Benefit:** 75% = $373.25 85% = $446.75

40330	SPINAL RHIZOLYSIS involving exposure of spinal nerve roots - for lateral recess, exit foraminal stenosis, adhesive radiculopathy or extensive epidural fibrosis, at 1 or more levels - with or without laminectomy (Anaes. 17719 = 9B + 10T) (Assist.) **Fee:** $743.50 **Benefit:** 75% = $557.65 85% = $692.60
40331	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, without fusion, 1 level, by any approach, not being a service to which item 40330 applies (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $743.50 **Benefit:** 75% = $557.65 85% = $692.60
40332	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, including anterior fusion, 1 level, not being a service to which item 40330 applies (Anaes. 17724 = 10B + 14T) (Assist.) **Fee:** $1,213.25 **Benefit:** 75% = $909.95 85% = $1,162.35
40333	CERVICAL DISCECTOMY (ANTERIOR), without fusion (Anaes. 17724 = 10B + 14T) (Assist.) **Fee:** $620.55 **Benefit:** 75% = $465.45 85% = $569.65
40334	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, without fusion, more than 1 level, by any approach, not being a service to which item 40330 applies (Anaes. 17724 = 10B + 14T) (Assist.) **Fee:** $820.40 **Benefit:** 75% = $615.30 85% = $769.50
40335	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, including anterior fusion, more than 1 level, by any approach, not being a service to which item 40330 applies (Anaes. 17728 = 10B + 18T) (Assist.) **Fee:** $1,506.85 **Benefit:** 75% = $1,130.15 85% = $1,455.95
40336	INTRADISCAL INJECTION OF CHYMOPAPAIN (DISCASE) - 1 disc (Anaes. 17709 = 5B + 4T) (Assist.) *(See para T8.40 of explanatory notes to this Category)* **Fee:** $245.95 **Benefit:** 75% = $184.50 85% = $209.10
40339	HYDROMYELIA, plugging of obex for, with or without duroplasty (Anaes. 17728 = 8B + 20T) (Assist.) **Fee:** $1,235.30 **Benefit:** 75% = $926.50 85% = $1,184.40
40342	HYDROMYELIA, craniotomy and laminectomy for, with cavity packing and CSF shunt (Anaes. 17730 = 12B + 18T) (Assist.) **Fee:** $1,141.60 **Benefit:** 75% = $856.20 85% = $1,090.70
40345	THORACIC DECOMPRESSION of spinal cord with or without involvement of nerve roots, via pedicle or costotransversectomy (Anaes. 17726 = 10B + 16T) (Assist.) **Fee:** $1,062.80 **Benefit:** 75% = $797.10 85% = $1,011.90
40348	THORACIC DECOMPRESSION of spinal cord via thoracotomy with vertebrectomy, not including stabilisation procedure (Anaes. 17735 = 13B + 22T) (Assist.) **Fee:** $1,349.25 **Benefit:** 75% = $1,011.95 85% = $1,298.35
40351	THORACO-LUMBAR or high lumbar anterior decompression of spinal cord, not including stabilisation procedure (Anaes. 17732 = 10B + 22T) (Assist.) **Fee:** $1,349.25 **Benefit:** 75% = $1,011.95 85% = $1,298.35
	SKULL RECONSTRUCTION
40600	CRANIOPLASTY, reconstructive (Anaes. 17722 = 12B + 10T) (Assist.) **Fee:** $743.50 **Benefit:** 75% = $557.65 85% = $692.60
	EPILEPSY
40700	CORPUS CALLOSUM, anterior section of, for epilepsy (Anaes. 17730 = 12B + 18T) (Assist.) **Fee:** $1,358.30 **Benefit:** 75% = $1,018.75 85% = $1,307.40
40703	CORTICECTOMY, TOPECTOMY or PARTIAL LOBECTOMY for epilepsy (Anaes. 17728 = 12B + 16T) (Assist.) **Fee:** $1,141.60 **Benefit:** 75% = $856.20 85% = $1,090.70
40706	HEMISPHERECTOMY for intractable epilepsy (Anaes. 17742 = 12B + 30T) (Assist.) **Fee:** $1,668.50 **Benefit:** 75% = $1,251.40 85% = $1,617.60
40709	BURR-HOLE PLACEMENT of intracranial depth or surface electrodes (Anaes. 17720 = 12B + 8T) (Assist.) **Fee:** $404.00 **Benefit:** 75% = $303.00 85% = $353.10

40712	INTRACRANIAL ELECTRODE PLACEMENT via craniotomy (Anaes. 17724 = 12B + 12T) (Assist.) **Fee:** $813.75 **Benefit:** 75% = $610.35 85% = $762.85
	STEREOTACTIC PROCEDURES
40800	STEREOTACTIC ANATOMICAL LOCALISATION, as an independent procedure (Anaes. 17720 = 12B + 8T) (Assist.) **Fee:** $497.25 **Benefit:** 75% = $372.95 85% = $446.35
40801	FUNCTIONAL STEREOTACTIC procedure including computer assisted anatomical localisation, physiological localisation, and lesion production in the basal ganglia, brain stem or deep white matter tracts (Anaes. 17725 = 12B + 13T) (Assist.) **Fee:** $1,359.15 **Benefit:** 75% = $1,019.40 85% = $1,308.25
40803	INTRACRANIAL STEREOTACTIC PROCEDURE BY ANY METHOD, not being a service to which item 40800 or 40801 applies (Anaes. 17721 = 12B + 9T) (Assist.) **Fee:** $930.85 **Benefit:** 75% = $698.15 85% = $879.95
	MISCELLANEOUS
40903	NEUROENDOSCOPY, for inspection of an intraventricular lesion, with or without biopsy including burr hole (Anaes. 17722 = 12B + 10T) (Assist.) **Fee:** $431.70 **Benefit:** 75% = $323.80 85% = $380.80
	SUBGROUP 8 - EAR, NOSE AND THROAT
41500	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes. 17706 = 5B + 1T) *(See para T8.41 of explanatory notes to this Category)* **Fee:** $64.20 **Benefit:** 75% = $48.15 85% = $54.60
41503	EAR, foreign body in, removal of, involving incision of external auditory canal (Anaes. 17708 = 5B + 3T) **Fee:** $185.95 **Benefit:** 75% = $139.50 85% = $158.10
41506	AURAL POLYP, removal of (Anaes. 17707 = 5B + 2T) **Fee:** $112.15 **Benefit:** 75% = $84.15 85% = $95.35
41509	EXTERNAL AUDITORY MEATUS, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (Anaes. 17709 = 5B + 4T) **Fee:** $126.90 **Benefit:** 75% = $95.20 85% = $107.90
41512	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $456.15 **Benefit:** 75% = $342.15 85% = $405.25
41515	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, being a service associated with a service to which item 41530, 41548, 41557, 41560 or 41563 applies (Anaes. 17709 = 5B + 4T) (Assist.) *(See para T8.42 of explanatory notes to this Category)* **Fee:** $299.35 **Benefit:** 75% = $224.55 85% = $254.45
41518	EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $723.10 **Benefit:** 75% = $542.35 85% = $672.20
41521	Correction of AUDITORY CANAL STENOSIS, including meatoplasty, with or without grafting (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $769.90 **Benefit:** 75% = $577.45 85% = $719.00
41524	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL, being a service associated with a service to which items 41557, 41560 and 41563 apply (Anaes. 17710 = 5B + 5T) (Assist.) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $222.40 **Benefit:** 75% = $166.80 85% = $189.05
41527	MYRINGOPLASTY, transcanal approach (Rosen incision) (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $457.55 **Benefit:** 75% = $343.20 85% = $406.65
41530	MYRINGOPLASTY, postaural or endaural approach with or without mastoid inspection (Anaes. 17711 = 5B + 6T) **Fee:** $745.30 **Benefit:** 75% = $559.00 85% = $694.40
41533	ATTICOTOMY without reconstruction of the bony defect, with or without myringoplasty (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $890.95 **Benefit:** 75% = $668.25 85% = $840.05

41536	ATTICOTOMY with reconstruction of the bony defect, with or without myringoplasty (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $997.90	**Benefit:** 75% = $748.45	85% = $947.00
41539	OSSICULAR CHAIN RECONSTRUCTION (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $848.55	**Benefit:** 75% = $636.45	85% = $797.65
41542	OSSICULAR CHAIN RECONSTRUCTION AND MYRINGOPLASTY (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $929.80	**Benefit:** 75% = $697.35	85% = $878.90
41545	MASTOIDECTOMY (CORTICAL) (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $405.80	**Benefit:** 75% = $304.35	85% = $354.90
41548	OBLITERATION OF THE MASTOID CAVITY (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $538.65	**Benefit:** 75% = $404.00	85% = $487.75
41551	MASTOIDECTOMY, intact wall technique, with myringoplasty (Anaes. 17717 = 5B + 12T) (Assist.) **Fee:** $1,240.25	**Benefit:** 75% = $930.20	85% = $1,189.35
41554	MASTOIDECTOMY, intact wall technique, with myringoplasty and ossicular chain reconstruction (Anaes. 17719 = 5B + 14T) (Assist.) **Fee:** $1,461.25	**Benefit:** 75% = $1,095.95	85% = $1,410.35
41557	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $848.55	**Benefit:** 75% = $636.45	85% = $797.65
41560	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) AND MYRINGOPLASTY (Anaes. 17714 = 5B + 9T) **Fee:** $929.80	**Benefit:** 75% = $697.35	85% = $878.90
41563	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), MYRINGOPLASTY AND OSSICULAR CHAIN RECONSTRUCTION (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $1,151.05	**Benefit:** 75% = $863.30	85% = $1,100.15
41564	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), OBLITERATION OF THE MASTOID CAVITY, BLIND SAC CLOSURE OF EXTERNAL AUDITORY CANAL AND OBLITERATION OF EUSTACHIAN TUBE (Anaes. 17717 = 5B + 12T) (Assist.) **Fee:** $1,488.50	**Benefit:** 75% = $1,116.40	85% = $1,437.60
41566	REVISION OF MASTOIDECTOMY (radical, modified radical or intact wall), including myringoplasty (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $848.55	**Benefit:** 75% = $636.45	85% = $797.65
41569	DECOMPRESSION OF FACIAL NERVE in its mastoid portion (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $929.80	**Benefit:** 75% = $697.35	85% = $878.90
41572	LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $804.30	**Benefit:** 75% = $603.25	85% = $753.40
41575	CEREBELLO PONTINE ANGLE TUMOUR, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach transmastoid, translabyrinthine or retromastoid procedure (including aftercare) (Anaes. 17748 = 12B + 36T) (Assist.) **Fee:** $1,896.35	**Benefit:** 75% = $1,422.30	85% = $1,845.45
41576	CEREBELLO - PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach - intracranial procedure (including aftercare) not being a service to which item 41578 or 41579 applies (Anaes. 17748 = 12B + 36T) (Assist.) **Fee:** $2,844.50	**Benefit:** 75% = $2,133.40	85% = $2,793.60
41578	CEREBELLO PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes. 17748 = 12B + 36T) (Assist.) **Fee:** $1,896.35	**Benefit:** 75% = $1,422.30	85% = $1,845.45
41579	CEREBELLO-PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,422.20	**Benefit:** 75% = $1,066.65	85% = $1,371.30

41581	TUMOUR INVOLVING INFRA-TEMPORAL FOSSA, removal of, involving craniotomy and radical excision of (Anaes. 17749 = 12B + 37T) (Assist.) **Fee:** $2,181.10	**Benefit:** 75% = $1,635.85	85% = $2,130.20
41584	PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes. 17733 = 12B + 21T) (Assist.) **Fee:** $1,496.85	**Benefit:** 75% = $1,122.65	85% = $1,445.95
41587	TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes. 17737 = 12B + 25T) (Assist.) **Fee:** $2,038.60	**Benefit:** 75% = $1,528.95	85% = $1,987.70
41590	ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $929.80	**Benefit:** 75% = $697.35	85% = $878.90
41593	TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (Anaes. 17722 = 5B + 17T) (Assist.) **Fee:** $1,211.80	**Benefit:** 75% = $908.85	85% = $1,160.90
41596	RETROLABYRINTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTION, or BOTH (Anaes. 17733 = 12B + 21T) (Assist.) **Fee:** $1,354.35	**Benefit:** 75% = $1,015.80	85% = $1,303.45
41599	INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes. 17729 = 12B + 17T) (Assist.) **Fee:** $1,354.35	**Benefit:** 75% = $1,015.80	85% = $1,303.45
41602	FENESTRATION OPERATION each ear (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $929.80	**Benefit:** 75% = $697.35	85% = $878.90
41605	VENOUS GRAFT TO FENESTRATION CAVITY (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $457.55	**Benefit:** 75% = $343.20	85% = $406.65
41608	STAPEDECTOMY (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $848.55	**Benefit:** 75% = $636.45	85% = $797.65
41611	STAPES MOBILISATION (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $545.95	**Benefit:** 75% = $409.50	85% = $495.05
41614	ROUND WINDOW SURGERY including repair of cochleotomy (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $848.55	**Benefit:** 75% = $636.45	85% = $797.65
41615	OVAL WINDOW SURGERY, including repair of fistula, not being a service associated with a service to which any other item in this Group applies (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $848.55	**Benefit:** 75% = $636.45	85% = $797.65
41617	COCHLEAR IMPLANT, insertion of, including mastoidectomy (Anaes. 17722 = 5B + 17T) (Assist.) **Fee:** $1,475.50	**Benefit:** 75% = $1,106.65	85% = $1,424.60
41620	GLOMUS TUMOUR, transtympanic removal of (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $641.95	**Benefit:** 75% = $481.50	85% = $591.05
41623	GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $929.80	**Benefit:** 75% = $697.35	85% = $878.90
41626	ABSCESS OR INFLAMMATION OF MIDDLE EAR, operation for (excluding aftercare) (Anaes. 17707 = 5B + 2T) **Fee:** $112.15	**Benefit:** 75% = $84.15	85% = $95.35
41629	MIDDLE EAR, EXPLORATION OF (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $405.80	**Benefit:** 75% = $304.35	85% = $354.90
41632	MIDDLE EAR, insertion of tube for DRAINAGE OF (including myringotomy) (Anaes. 17707 = 5B + 2T) **Fee:** $185.95	**Benefit:** 75% = $139.50	85% = $158.10
41635	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $890.95	**Benefit:** 75% = $668.25	85% = $840.05

41638	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty with ossicular chain reconstruction (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $1,112.00	**Benefit:** 75% = $834.00	85% = $1,061.10
41641	PERFORATION OF TYMPANUM, cauterisation or diathermy of (Anaes. 17707 = 5B + 2T) **Fee:** $36.95	**Benefit:** 75% = $27.75	85% = $31.45
41644	EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (Anaes. 17707 = 5B + 2T) **Fee:** $111.15	**Benefit:** 75% = $83.40	85% = $94.50
41647	EAR TOILET requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (Anaes. 17706 = 4B + 2T) **Fee:** $85.60	**Benefit:** 75% = $64.20	85% = $72.80
41650	TYMPANIC MEMBRANE, microinspection of 1 or both ears under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes. 17706 = 4B + 2T) **Fee:** $85.60	**Benefit:** 75% = $64.20	85% = $72.80
41653	EXAMINATION OF NASAL CAVITY or POSTNASAL SPACE, or NASAL CAVITY AND POSTNASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes. 17707 = 5B + 2T) **Fee:** $56.05	**Benefit:** 75% = $42.05	85% = $47.65
41656	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes. 17709 = 5B + 4T) **Fee:** $95.55	**Benefit:** 75% = $71.70	85% = $81.25
41659	NOSE, removal of FOREIGN BODY IN, other than by simple probing (Anaes. 17707 = 5B + 2T) **Fee:** $60.45	**Benefit:** 75% = $45.35	85% = $51.40
41662	NASAL POLYP OR POLYPI (SIMPLE), removal of *(See para T8.44 of explanatory notes to this Category)* **Fee:** $64.20	**Benefit:** 75% = $48.15	85% = $54.60
41665 G 41668 S	NASAL POLYP OR POLYPI (requiring admission to hospital), removal of (Anaes. 17707 = 5B + 2T) *(See para T8.44 of explanatory notes to this Category)* **Fee:** $134.30 **Fee:** $171.20	**Benefit:** 75% = $100.75 **Benefit:** 75% = $128.40	85% = $114.20 85% = $145.55
41671	NASAL SEPTUM, SEPTOPLASTY, SUBMUCOUS RESECTION or closure of septal perforation (Anaes. 17708 = 5B + 3T) **Fee:** $376.25	**Benefit:** 75% = $282.20	85% = $325.35
41672	NASAL SEPTUM, reconstruction of (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $469.45	**Benefit:** 75% = $352.10	85% = $418.55
41674	CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES OR PHARYNX - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes. 17707 = 5B + 2T) **Fee:** $78.20	**Benefit:** 75% = $58.65	85% = $66.50
41677	NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes. 17709 = 5B + 4T) **Fee:** $70.05	**Benefit:** 75% = $52.55	85% = $59.55
41680	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes. 17708 = 5B + 3T) **Fee:** $126.90	**Benefit:** 75% = $95.20	85% = $107.90
41683	DIVISION OF NASAL ADHESIONS, with or without stenting not being a service associated with any other operation on the nose and not performed during the postoperative period of a nasal operation (Anaes. 17708 = 5B + 3T) **Fee:** $91.20	**Benefit:** 75% = $68.40	85% = $77.55
41686	DISLOCATION OF TURBINATE OR TURBINATES, 1 or both sides, not being a service associated with a service to which another item in this Group applies (Anaes. 17707 = 5B + 2T) **Fee:** $56.05	**Benefit:** 75% = $42.05	85% = $47.65

41689	TURBINECTOMY or turbinectomies, partial or total, unilateral (Anaes. 17707 = 5B + 2T) **Fee:** $106.25 **Benefit:** 75% = $79.70 85% = $90.35
41692	TURBINATES, submucous resection of, unilateral (Anaes. 17707 = 5B + 2T) **Fee:** $138.65 **Benefit:** 75% = $104.00 85% = $117.90
41695	TURBINATES, cryotherapy to (Anaes. 17707 = 5B + 2T) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
41698	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes. 17707 = 5B + 2T) **Fee:** $25.30 **Benefit:** 75% = $19.00 85% = $21.55
41701	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in this Group applies (Anaes. 17707 = 5B + 2T) **Fee:** $71.65 **Benefit:** 75% = $53.75 85% = $60.95
41704	MAXILLARY ANTRUM, LAVAGE OF each attendance at which the procedure is performed, including any associated consultation (Anaes. 17707 = 5B + 2T) **Fee:** $27.00 **Benefit:** 75% = $20.25 85% = $22.95
41707	MAXILLARY ARTERY, transantral ligation of (Anaes. 17712 = 7B + 5T) (Assist.) **Fee:** $349.20 **Benefit:** 75% = $261.90 85% = $298.30
41710	ANTROSTOMY (RADICAL) (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $405.80 **Benefit:** 75% = $304.35 85% = $354.90
41713	ANTROSTOMY (RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $472.20 **Benefit:** 75% = $354.15 85% = $421.30
41716	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $230.20 **Benefit:** 75% = $172.65 85% = $195.70
41719	ANTRUM, drainage of, through tooth socket (Anaes. 17708 = 5B + 3T) **Fee:** $91.50 **Benefit:** 75% = $68.65 85% = $77.80
41722	OROANTRAL FISTULA, plastic closure of (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $457.55 **Benefit:** 75% = $343.20 85% = $406.65
41725	ETHMOIDAL ARTERY OR ARTERIES, transorbital ligation of (unilateral) (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $349.20 **Benefit:** 75% = $261.90 85% = $298.30
41728	LATERAL RHINOTOMY with removal of tumour (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $698.55 **Benefit:** 75% = $523.95 85% = $647.65
41729	DERMOID OF NOSE, excision of, with intranasal extension (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $442.70 **Benefit:** 75% = $332.05 85% = $391.80
41731	FRONTONASAL ETHMOIDECTOMY by external approach with or without sphenoidectomy (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $605.05 **Benefit:** 75% = $453.80 85% = $554.15
41734	RADICAL FRONTOETHMOIDECTOMY with osteoplastic flap (Anaes. 17718 = 10B + 8T) (Assist.) **Fee:** $789.50 **Benefit:** 75% = $592.15 85% = $738.60
41737	FRONTAL SINUS, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $376.25 **Benefit:** 75% = $282.20 85% = $325.35
41740	FRONTAL SINUS, catheterisation of (Anaes. 17707 = 5B + 2T) **Fee:** $45.75 **Benefit:** 75% = $34.35 85% = $38.90
41743	FRONTAL SINUS, trephine of (Anaes. 17707 = 5B + 2T) (Assist.) **Fee:** $262.70 **Benefit:** 75% = $197.05 85% = $223.30
41746	FRONTAL SINUS, radical obliteration of (Anaes. 17716 = 10B + 6T) (Assist.) **Fee:** $605.05 **Benefit:** 75% = $453.80 85% = $554.15

	ETHMOIDAL SINUSES, external operation on (Anaes. 17711 = 5B + 6T) (Assist.)		
41749	**Fee:** $472.20	**Benefit:** 75% = $354.15	85% = $421.30
	SPHENOIDAL SINUS, intranasal operation on (Anaes. 17709 = 5B + 4T) (Assist.)		
41752	**Fee:** $230.20	**Benefit:** 75% = $172.65	85% = $195.70
	EUSTACHIAN TUBE, catheterisation of (Anaes. 17708 = 5B + 3T)		
41755	**Fee:** $36.20	**Benefit:** 75% = $27.15	85% = $30.80
	DIVISION OF PHARYNGEAL ADHESIONS (Anaes. 17708 = 5B + 3T)		
41758	**Fee:** $91.50	**Benefit:** 75% = $68.65	85% = $77.80
	POSTNASAL SPACE, direct examination of, with or without biopsy (Anaes. 17707 = 5B + 2T)		
41761	**Fee:** $95.55	**Benefit:** 75% = $71.70	85% = $81.25
	NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX and LARYNX, one or more of these procedures (Anaes. 17707 = 5B + 2T)		
41764	**Fee:** $95.55	**Benefit:** 75% = $71.70	85% = $81.25
	NASOPHARYNGEAL ANGIOFIBROMA, transpalatal removal (Anaes. 17717 = 10B + 7T) (Assist.)		
41767	**Fee:** $573.75	**Benefit:** 75% = $430.35	85% = $522.85
	PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (Anaes. 17717 = 6B + 11T) (Assist.)		
41770	**Fee:** $545.95	**Benefit:** 75% = $409.50	85% = $495.05
	PHARYNGEAL POUCH, ENDOSCOPIC RESECTION OF (Dohlman's operation) (Anaes. 17714 = 5B + 9T) (Assist.)		
41773	**Fee:** $457.55	**Benefit:** 75% = $343.20	85% = $406.65
	CRICOPHARYNGEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes. 17711 = 6B + 5T) (Assist.)		
41776	**Fee:** $456.15	**Benefit:** 75% = $342.15	85% = $405.25
	PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes. 17719 = 10B + 9T) (Assist.)		
41779	**Fee:** $545.95	**Benefit:** 75% = $409.50	85% = $495.05
	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY (Anaes. 17717 = 10B + 7T) (Assist.)		
41782	**Fee:** $741.25	**Benefit:** 75% = $555.95	85% = $690.35
	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes. 17719 = 10B + 9T) (Assist.)		
41785	**Fee:** $919.60	**Benefit:** 75% = $689.70	85% = $868.70
	UVULOPALATOPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes. 17712 = 6B + 6T) (Assist.)		
41786	**Fee:** $573.75	**Benefit:** 75% = $430.35	85% = $522.85
	UVULECTOMY AND PARTIAL PALATECTOMY WITH LASER INCISION OF THE PALATE, with or without tonsillectomy, 1 or more stages, including any revision procedures within 12 months (Anaes. 17713 = 5B + 8T) (Assist.)		
41787	**Fee:** $442.70	**Benefit:** 75% = $332.05	85% = $391.80
	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person aged LESS THAN 12 YEARS (Anaes. 17708 = 5B + 3T)		
41788 G	**Fee:** $171.20	**Benefit:** 75% = $128.40	85% = $145.55
41789 S	**Fee:** $230.20	**Benefit:** 75% = $172.65	85% = $195.70
	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person 12 YEARS OF AGE OR OVER (Anaes. 17708 = 5B + 3T)		
41792 G	**Fee:** $215.45	**Benefit:** 75% = $161.60	85% = $183.15
41793 S	**Fee:** $289.20	**Benefit:** 75% = $216.90	85% = $245.85
	TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (Anaes. 17709 = 5B + 4T)		
41796 G	**Fee:** $88.55	**Benefit:** 75% = $66.45	85% = $75.30
41797 S	**Fee:** $112.15	**Benefit:** 75% = $84.15	85% = $95.35
	ADENOIDS, removal of (Anaes. 17707 = 5B + 2T)		
41800 G	**Fee:** $91.50	**Benefit:** 75% = $68.65	85% = $77.80
41801 S	**Fee:** $126.90	**Benefit:** 75% = $95.20	85% = $107.90
	LINGUAL TONSIL OR LATERAL PHARYNGEAL BANDS, removal of (Anaes. 17708 = 5B + 3T)		
41804	**Fee:** $70.05	**Benefit:** 75% = $52.55	85% = $59.55

41807	PERITONSILLAR ABSCESS (quinsy), incision of (Anaes. 17708 = 5B + 3T) **Fee:** $54.65 **Benefit:** 75% = $41.00 85% = $46.50
41810	UVULOTOMY or UVULECTOMY (Anaes. 17708 = 5B + 3T) **Fee:** $27.75 **Benefit:** 75% = $20.85 85% = $23.60
41813	VALLECULAR OR PHARYNGEAL CYSTS, removal of (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $277.45 **Benefit:** 75% = $208.10 85% = $235.85
41816	OESOPHAGOSCOPY (with rigid oesophagoscope) (Anaes. 17708 = 6B + 2T) **Fee:** $144.60 **Benefit:** 75% = $108.45 85% = $122.95
‡ 41819	DILATATION OF STRICTURE OF UPPER GASTRO-INTESTINAL TRACT using bougie or balloon over endoscopically inserted guidewire, including endoscopy with flexible or rigid endoscope (Anaes. 17708 = 6B + 2T) **Fee:** $271.70 **Benefit:** 75% = $203.80 85% = $230.95
† 41820	DILATATION OF STRICTURE OF UPPER GASTRO-INTESTINAL TRACT using bougie or balloon over endoscopically inserted guidewire, including endoscopy with flexible or rigid endoscope, where the use of imaging intensification is clinically indicated (Anaes. 17709 = 5B + 4T) **Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15
41822	OESOPHAGOSCOPY (with rigid oesophagoscope), with biopsy (Anaes. 17708 = 6B + 2T) **Fee:** $185.95 **Benefit:** 75% = $139.50 85% = $158.10
41825	OESOPHAGOSCOPY (with rigid oesophagoscope), with removal of foreign body (Anaes. 17709 = 6B + 3T) (Assist.) **Fee:** $277.45 **Benefit:** 75% = $208.10 85% = $235.85
41828	OESOPHAGEAL STRICTURE, dilatation of, without oesophagoscopy (Anaes. 17708 = 6B + 2T) **Fee:** $40.65 **Benefit:** 75% = $30.50 85% = $34.60
41831	OESOPHAGUS, endoscopic pneumatic dilatation of (Anaes. 17709 = 6B + 3T) (Assist.) **Fee:** $277.95 **Benefit:** 75% = $208.50 85% = $236.30
41832	OESOPHAGUS, balloon dilatation of, using interventional imaging techniques (Anaes. 17708 = 6B + 2T) **Fee:** $177.85 **Benefit:** 75% = $133.40 85% = $151.20
41834	LARYNGECTOMY (TOTAL) (Anaes. 17725 = 10B + 15T) (Assist.) **Fee:** $1,003.55 **Benefit:** 75% = $752.70 85% = $952.65
41837	VERTICAL HEMILARYNGECTOMY including tracheostomy (Anaes. 17722 = 10B + 12T) (Assist.) **Fee:** $962.30 **Benefit:** 75% = $721.75 85% = $911.40
41840	SUPRAGLOTTIC LARYNGECTOMY including tracheostomy (Anaes. 17726 = 10B + 16T) (Assist.) **Fee:** $1,183.25 **Benefit:** 75% = $887.45 85% = $1,132.35
41843	LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes. 17725 = 10B + 15T) (Assist.) **Fee:** $1,040.45 **Benefit:** 75% = $780.35 85% = $989.55
41846	LARYNX, direct examination of the supraglottic, glottic and subglottic regions, not being a service associated with any other procedure on the larynx or with the administration of a general anaesthetic (Anaes. 17708 = 6B + 2T) *(See para T8.45 of explanatory notes to this Category)* **Fee:** $144.60 **Benefit:** 75% = $108.45 85% = $122.95
41849	LARYNX, direct examination of, with biopsy (Anaes. 17708 = 6B + 2T) (Assist.) **Fee:** $212.45 **Benefit:** 75% = $159.35 85% = $180.60
41852	LARYNX, direct examination of, WITH REMOVAL OF TUMOUR (Anaes. 17709 = 6B + 3T) (Assist.) **Fee:** $230.20 **Benefit:** 75% = $172.65 85% = $195.70
41855	MICROLARYNGOSCOPY (Anaes. 17708 = 6B + 2T) (Assist.) **Fee:** $224.35 **Benefit:** 75% = $168.30 85% = $190.70
41858	MICROLARYNGOSCOPY with removal of juvenile papillomata (Anaes. 17709 = 6B + 3T) (Assist.) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $384.80 **Benefit:** 75% = $288.60 85% = $333.90

41861	MICROLARYNGOSCOPY with removal of papillomata by laser surgery (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $470.40 **Benefit:** 75% = $352.80 85% = $419.50
41864	MICROLARYNGOSCOPY WITH REMOVAL OF TUMOUR (Anaes. 17708 = 6B + 2T) (Assist.) **Fee:** $317.30 **Benefit:** 75% = $238.00 85% = $269.75
41867	MICROLARYNGOSCOPY with arytenoidectomy (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $477.50 **Benefit:** 75% = $358.15 85% = $426.60
41868	LARYNGEAL WEB, division of, using microlarygoscopic techniques (Anaes. 17711 = 6B + 5T) **Fee:** $302.60 **Benefit:** 75% = $226.95 85% = $257.25
41869	BOTULINUM TOXIN INJECTION INTO VOCAL CORDS, including associated consultation **Fee:** $207.85 **Benefit:** 75% = $155.90 85% = $176.70
41870	INJECTION OF VOCAL CORD BY TEFLON, FAT, COLLAGEN OR GELFOAM (Anaes. 17709 = 6B + 3T) (Assist.) **Fee:** $354.15 **Benefit:** 75% = $265.65 85% = $303.25
41873	LARYNX, FRACTURED, operation for (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $457.55 **Benefit:** 75% = $343.20 85% = $406.65
41876	LARYNX, external operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $457.55 **Benefit:** 75% = $343.20 85% = $406.65
41879	LARYNGOPLASTY or TRACHEOPLASTY, including tracheostomy (Anaes. 17718 = 6B + 12T) (Assist.) **Fee:** $741.25 **Benefit:** 75% = $555.95 85% = $690.35
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:** $197.85 **Benefit:** 75% = $148.40 85% = $168.20
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:** $312.75 **Benefit:** 75% = $234.60 85% = $265.85
41884	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes. 17708 = 6B + 2T) **Fee:** $70.85 **Benefit:** 75% = $53.15 85% = $60.25
41885	TRACHE-OESOPHAGEAL FISTULA, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $224.10 **Benefit:** 75% = $168.10 85% = $190.50
41886	TRACHEA, removal of foreign body in (Anaes. 17708 = 6B + 2T) **Fee:** $138.65 **Benefit:** 75% = $104.00 85% = $117.90
41889	BRONCHOSCOPY, as an independent procedure (Anaes. 17708 = 6B + 2T) **Fee:** $138.65 **Benefit:** 75% = $104.00 85% = $117.90
41892	BRONCHOSCOPY with 1 or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes. 17708 = 6B + 2T) **Fee:** $183.00 **Benefit:** 75% = $137.25 85% = $155.55
41895	BRONCHUS, removal of foreign body in (Anaes. 17709 = 6B + 3T) (Assist.) **Fee:** $286.30 **Benefit:** 75% = $214.75 85% = $243.40
41898	FIBREOPTIC BRONCHOSCOPY with 1 or more transbronchial lung biopsies, with or without bronchial or bronchoalveolar lavage, with or without the use of interventional imaging (Anaes. 17709 = 6B + 3T) (Assist.) **Fee:** $200.05 **Benefit:** 75% = $150.05 85% = $170.05
41901	ENDOSCOPIC LASER RESECTION OF ENDOBRONCHIAL TUMOURS for relief of obstruction including any associated endoscopic procedures (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $470.40 **Benefit:** 75% = $352.80 85% = $419.50
41904	BRONCHOSCOPY with dilatation of tracheal stricture (Anaes. 17708 = 6B + 2T) **Fee:** $191.90 **Benefit:** 75% = $143.95 85% = $163.15

41905	TRACHEA OR BRONCHUS, dilatation of stricture and endoscopic insertion of stent (Anaes. 17709 = 6B + 3T) (Assist.) **Fee:** $353.00	**Benefit:** 75% = $264.75	85% = $302.10
41907	NASAL SEPTUM BUTTON, insertion of (Anaes. 17707 = 5B + 2T) **Fee:** $95.55	**Benefit:** 75% = $71.70	85% = $81.25
41910	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $303.85	**Benefit:** 75% = $227.90	85% = $258.30
	SUBGROUP 9 - OPHTHALMOLOGY		
42503	OPHTHALMOLOGICAL EXAMINATION under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes. 17706 = 4B + 2T) **Fee:** $79.70	**Benefit:** 75% = $59.80	85% = $67.75
42506	EYE, ENUCLEATION OF, with or without sphere implant (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $374.70	**Benefit:** 75% = $281.05	85% = $323.80
42509	EYE, ENUCLEATION OF, with insertion of integrated implant (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $474.15	**Benefit:** 75% = $355.65	85% = $423.25
42510	EYE, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $546.55	**Benefit:** 75% = $409.95	85% = $495.65
42512	GLOBE, EVISCERATION OF (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $374.70	**Benefit:** 75% = $281.05	85% = $323.80
42515	GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $474.15	**Benefit:** 75% = $355.65	85% = $423.25
42518	ANOPHTHALMIC ORBIT, INSERTION OF CARTILAGE OR ARTIFICIAL IMPLANT as a delayed procedure, or REMOVAL OF IMPLANT FROM SOCKET, or PLACEMENT OF A MOTILITY INTEGRATING PEG by drilling into an existing orbital inplant (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $275.15	**Benefit:** 75% = $206.40	85% = $233.90
42521	ANOPHTHALMIC SOCKET, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Anaes. 17717 = 5B + 12T) (Assist.) **Fee:** $936.75	**Benefit:** 75% = $702.60	85% = $885.85
42524	ORBIT, SKIN GRAFT TO, as a delayed procedure (Anaes. 17708 = 5B + 3T) **Fee:** $159.30	**Benefit:** 75% = $119.50	85% = $135.45
42527	CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTING AND STENT MOULD (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $316.05	**Benefit:** 75% = $237.05	85% = $268.65
42530	ORBIT, EXPLORATION with or without biopsy, requiring REMOVAL OF BONE (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $491.85	**Benefit:** 75% = $368.90	85% = $440.95
42533	ORBIT, EXPLORATION OF, with drainage or biopsy not requiring removal of bone (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $316.05	**Benefit:** 75% = $237.05	85% = $268.65
42536	ORBIT, EXENTERATION OF, with or without skin graft and with or without temporalis muscle transplant (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $649.85	**Benefit:** 75% = $487.40	85% = $598.95
42539	ORBIT, EXPLORATION OF, with removal of tumour or foreign body, requiring removal of bone (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $925.05	**Benefit:** 75% = $693.80	85% = $874.15
42542	ORBIT, exploration of anterior aspect with removal of tumour or foreign body (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $392.30	**Benefit:** 75% = $294.25	85% = $341.40
42543	ORBIT, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $688.10	**Benefit:** 75% = $516.10	85% = $637.20

42545	ORBIT, decompression of, for dysthyroid eye disease, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, 1 eye (Anaes. 17717 = 5B + 12T) (Assist.) **Fee:** $995.25	**Benefit:** 75% = $746.45	85% = $944.35
42548	OPTIC NERVE MENINGES, incision of (Anaes. 17717 = 5B + 12T) (Assist.) **Fee:** $591.30	**Benefit:** 75% = $443.50	85% = $540.40
42551	EYEBALL, PERFORATING WOUND OF, not involving intraocular structures repair involving suture of cornea or sclera, or both, not being a service to which item 42632 applies (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $491.85	**Benefit:** 75% = $368.90	85% = $440.95
42554	EYEBALL, PERFORATING WOUND OF, with incarceration or prolapse of uveal tissue repair (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $573.75	**Benefit:** 75% = $430.35	85% = $522.85
42557	EYEBALL, PERFORATING WOUND OF, with incarceration of lens or vitreous repair (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $802.00	**Benefit:** 75% = $601.50	85% = $751.10
42560	INTRAOCULAR FOREIGN BODY, magnetic removal from anterior segment (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $316.05	**Benefit:** 75% = $237.05	85% = $268.65
42563	INTRAOCULAR FOREIGN BODY, nonmagnetic removal from anterior segment (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $404.00	**Benefit:** 75% = $303.00	85% = $353.10
42566	INTRAOCULAR FOREIGN BODY, magnetic removal from posterior segment (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $573.75	**Benefit:** 75% = $430.35	85% = $522.85
42569	INTRAOCULAR FOREIGN BODY, nonmagnetic removal from posterior segment (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $802.00	**Benefit:** 75% = $601.50	85% = $751.10
42572	ORBITAL ABSCESS OR CYST, drainage of (Anaes. 17707 = 5B + 2T) **Fee:** $91.30	**Benefit:** 75% = $68.50	85% = $77.65
42573	DERMOID, periorbital, excision of (Anaes. 17709 = 5B + 4T) **Fee:** $177.10	**Benefit:** 75% = $132.85	85% = $150.55
42574	DERMOID, orbital, excision of (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $376.25	**Benefit:** 75% = $282.20	85% = $325.35
42575	TARSAL CYST, extirpation of (Anaes. 17706 = 5B + 1T) **Fee:** $64.40	**Benefit:** 75% = $48.30	85% = $54.75
42578	TARSAL CARTILAGE, excision of (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $362.90	**Benefit:** 75% = $272.20	85% = $312.00
42581	ECTROPION OR ENTROPION, tarsal cauterisation of (Anaes. 17707 = 5B + 2T) **Fee:** $91.30	**Benefit:** 75% = $68.50	85% = $77.65
42584	TARSORRHAPHY (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $215.45	**Benefit:** 75% = $161.60	85% = $183.15
42587	TRICHIASIS, treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes. 17707 = 5B + 2T) **Fee:** $40.40	**Benefit:** 75% = $30.30	85% = $34.35
42590	CANTHOPLASTY, medial or lateral (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $263.40	**Benefit:** 75% = $197.55	85% = $223.90
42593	LACRIMAL GLAND, excision of palpebral lobe (Anaes. 17709 = 5B + 4T) **Fee:** $159.30	**Benefit:** 75% = $119.50	85% = $135.45
42596	LACRIMAL SAC, excision of, or operation on (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $392.30	**Benefit:** 75% = $294.25	85% = $341.40
42599	LACRIMAL CANALICULAR SYSTEM, establishment of patency by closed operation using silicone tubes or similar, 1 eye (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $491.85	**Benefit:** 75% = $368.90	85% = $440.95

42602	LACRIMAL CANALICULAR SYSTEM, establishment of patency by open operation, 1 eye (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $491.85 **Benefit:** 75% = $368.90 85% = $440.95
42605	LACRIMAL CANALICULUS, immediate repair of (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $362.90 **Benefit:** 75% = $272.20 85% = $312.00
42608	LACRIMAL DRAINAGE by insertion of glass tube, as an independent procedure (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $234.15 **Benefit:** 75% = $175.65 85% = $199.05
42610	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (Anaes. 17706 = 5B + 1T) **Fee:** $74.90 **Benefit:** 75% = $56.20 85% = $63.70
42611	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (Anaes. 17707 = 5B + 2T) **Fee:** $112.40 **Benefit:** 75% = $84.30 85% = $95.55
42614	NASOLACRIMAL TUBE (unilateral), removal or 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 aftercare) **Fee:** $37.55 **Benefit:** 75% = $28.20 85% = $31.95
42615	NASOLACRIMAL TUBE (bilateral), removal or 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 aftercare) **Fee:** $56.20 **Benefit:** 75% = $42.15 85% = $47.80
42617	PUNCTUM SNIP operation (Anaes. 17706 = 5B + 1T) **Fee:** $106.60 **Benefit:** 75% = $79.95 85% = $90.65
42620	PUNCTUM, occlusion of, by use of a plug (Anaes. 17706 = 5B + 1T) **Fee:** $41.05 **Benefit:** 75% = $30.80 85% = $34.90
42621	PUNCTUM, temporary occlusion of, by use of electrical cautery (Anaes. 17706 = 5B + 1T) **Fee:** $41.05 **Benefit:** 75% = $30.80 85% = $34.90
42622	PUNCTUM, permanent occlusion of, by use of electrical cautery (Anaes. 17706 = 5B + 1T) **Fee:** $64.40 **Benefit:** 75% = $48.30 85% = $54.75
42623	DACRYOCYSTORHINOSTOMY (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $544.55 **Benefit:** 75% = $408.45 85% = $493.65
42626	DACRYOCYSTORHINOSTOMY where a previous dacryocystorhinostomy has been performed (Anaes. 17717 = 5B + 12T) (Assist.) **Fee:** $878.20 **Benefit:** 75% = $658.65 85% = $827.30
42629	CONJUNCTIVORHINOSTOMY including dacryocystorhinostomy and fashioning of conjunctival flaps (Anaes. 17716 = 5B + 11T) (Assist.) **Fee:** $661.55 **Benefit:** 75% = $496.20 85% = $610.65
42632	CONJUNCTIVAL PERITOMY OR REPAIR OF CORNEAL LACERATION by conjunctival flap (Anaes. 17707 = 5B + 2T) **Fee:** $91.30 **Benefit:** 75% = $68.50 85% = $77.65
42635	CORNEAL PERFORATIONS, sealing of, with tissue adhesive (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $234.15 **Benefit:** 75% = $175.65 85% = $199.05
42638	CONJUNCTIVAL GRAFT OVER CORNEA (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $292.70 **Benefit:** 75% = $219.55 85% = $248.80
42641	AUTOCONJUNCTIVAL TRANSPLANT, or mucous membrane graft (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $380.50 **Benefit:** 75% = $285.40 85% = $329.60
42644	CORNEA OR SCLERA, removal of imbedded foreign body from (excluding aftercare) (Anaes. 17710 = 5B + 5T) **Fee:** $56.15 **Benefit:** 75% = $42.15 85% = $47.75
42647	CORNEAL SCARS, removal of, by partial keratectomy, not being a service associated with a service to which item 42686 applies (Anaes. 17709 = 5B + 4T) **Fee:** $159.30 **Benefit:** 75% = $119.50 85% = $135.45

42650	CORNEA, epithelial debridement for corneal ulcer or corneal erosion (excluding aftercare) (Anaes. 17709 = 5B + 4T) **Fee:** $56.15	**Benefit:** 75% = $42.15	85% = $47.75
42651	CORNEA, epithelial debridement for eliminating band keratopathy (Anaes. 17709 = 5B + 4T) **Fee:** $125.15	**Benefit:** 75% = $93.90	85% = $106.40
42653	CORNEA, transplantation of, full thickness (Anaes. 17713 = 8B + 5T) (Assist.) **Fee:** $1,042.10	**Benefit:** 75% = $781.60	85% = $991.20
42656	CORNEA, transplantation of, where there have been 2 previous graft operations (Anaes. 17714 = 8B + 6T) (Assist.) **Fee:** $1,299.70	**Benefit:** 75% = $974.80	85% = $1,248.80
42659	CORNEA, transplantation of, superficial or lamellar (Anaes. 17712 = 8B + 4T) (Assist.) **Fee:** $702.50	**Benefit:** 75% = $526.90	85% = $651.60
42662	SCLERA, transplantation of, full thickness, including collection of donor material (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $702.50	**Benefit:** 75% = $526.90	85% = $651.60
42665	SCLERA, transplantation of, superficial or lamellar, including collection of donor material (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $468.35	**Benefit:** 75% = $351.30	85% = $417.45
42667	RUNNING CORNEAL SUTURE, manipulation of, performed within 4 months of corneal grafting, to reduce astigmatism where a reduction of 2 dioptres of astigmatism is obtained, including any associated consultation **Fee:** $110.50	**Benefit:** 75% = $82.90	85% = $93.95
42668	CORNEAL SUTURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes. 17707 = 5B + 2T) **Fee:** $58.60	**Benefit:** 75% = $43.95	85% = $49.85
42671	REFRACTIVE KERATOPLASTY with penetrating incisions (excluding radial keratotomy) following corneal grafting or intraocular operation INCLUDING ANY MEASUREMENTS AND CALCULATIONS associated with the procedure (Anaes. 17710 = 5B + 5T) (Assist.) *(See para T8.47 of explanatory notes to this Category)* **Fee:** $702.50	**Benefit:** 75% = $526.90	85% = $651.60
42674	CORNEAL INCISIONS, non penetrating, for the correction of astigmatism following surgery of anterior chamber or corneal grafting, and including associated ultrasound pachymetry of corneal thickness, with or without compression sutures (Anaes. 17710 = 5B + 5T) **Fee:** $351.30	**Benefit:** 75% = $263.50	85% = $300.40
42676	CONJUNCTIVA, biopsy of, as an independent procedure **Fee:** $90.10	**Benefit:** 75% = $67.60	85% = $76.60
42677	CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at which treatment is given including any associated consultation (Anaes. 17706 = 5B + 1T) **Fee:** $47.45	**Benefit:** 75% = $35.60	85% = $40.35
42680	CONJUNCTIVA, cryotherapy to, for melanotic lesions or similar using CO^2 or N^20 (Anaes. 17707 = 5B + 2T) **Fee:** $234.15	**Benefit:** 75% = $175.65	85% = $199.05
42683	CONJUNCTIVAL CYSTS, removal of, requiring admission to hospital or approved day-hospital facility (Anaes. 17707 = 5B + 2T) **Fee:** $93.65	**Benefit:** 75% = $70.25	85% = $79.65
42686	PTERYGIUM, removal of (Anaes. 17707 = 5B + 2T) **Fee:** $213.10	**Benefit:** 75% = $159.85	85% = $181.15
42689	PINGUECULA, removal of, not being a service associated with the fitting of contact lenses (Anaes. 17707 = 5B + 2T) **Fee:** $91.30	**Benefit:** 75% = $68.50	85% = $77.65
42692	LIMBIC TUMOUR, removal of, excluding Pterygium (Anaes. 17708 = 5B + 3T) (Assist.) **Fee:** $215.45	**Benefit:** 75% = $161.60	85% = $183.15
42695	LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $351.30	**Benefit:** 75% = $263.50	85% = $300.40

‡ 42698	LENS EXTRACTION, excluding surgery performed for the correction of refractive error only (Anaes. 17710 = 6B + 4T) **Fee:** $548.00 **Benefit:** 75% = $411.00 85% = $497.10
‡ 42701	ARTIFICIAL LENS, insertion of, excluding surgery performed for the correction of refractive error only (Anaes. 17710 = 6B + 4T) **Fee:** $305.55 **Benefit:** 75% = $229.20 85% = $259.75
‡ 42702	LENS EXTRACTION AND INSERTION OF ARTIFICIAL LENS, excluding surgery performed for the correction of refractive error only (Anaes. 17711 = 6B + 5T) **Fee:** $700.80 **Benefit:** 75% = $525.60 85% = $649.90
42703	ARTIFICIAL LENS, insertion of, into the posterior chamber and suture to the iris and sclera (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $445.35 **Benefit:** 75% = $334.05 85% = $394.45
42704	ARTIFICIAL LENS, REMOVAL or REPOSITIONING of by open operation, not being a service associated with a service to which item 42701 applies (Anaes. 17709 = 6B + 3T) **Fee:** $362.90 **Benefit:** 75% = $272.20 85% = $312.00
42707	ARTIFICIAL LENS, REMOVAL of and REPLACEMENT with a different lens (Anaes. 17710 = 6B + 4T) **Fee:** $620.55 **Benefit:** 75% = $465.45 85% = $569.65
42710	ARTIFICIAL LENS, removal of, and replacement with a lens inserted into the posterior chamber and sutured to the iris or sclera (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $702.50 **Benefit:** 75% = $526.90 85% = $651.60
42713	INTRAOCULAR LENSES, repositioning of, by the use of a McCannell suture or similar (Anaes. 17710 = 6B + 4T) (Assist.) **Fee:** $292.70 **Benefit:** 75% = $219.55 85% = $248.80
42716	CATARACT, JUVENILE, removal of, including subsequent needlings (Anaes. 17710 = 6B + 4T) (Assist.) **Fee:** $930.85 **Benefit:** 75% = $698.15 85% = $879.95
42719	CAPSULECTOMY OR REMOVAL OF VITREOUS via the anterior chamber by any method, not being a service associated with a service to which item 42698, 42702 or 42716 applies (Anaes. 17712 = 8B + 4T) (Assist.) **Fee:** $404.00 **Benefit:** 75% = $303.00 85% = $353.10
42722	CAPSULECTOMY by posterior chamber sclerotomy OR REMOVAL OF VITREOUS or VITREOUS BANDS from the anterior chamber by posterior chamber sclerotomy, by cutting and suction and replacement by saline, Hartmann's or similar solution, not being a service associated with a service to which item 42698, 42702 or 42716 applies - 1 or both procedures (Anaes. 17714 = 8B + 6T) (Assist.) **Fee:** $441.95 **Benefit:** 75% = $331.50 85% = $391.05
42725	VITRECTOMY by posterior chamber sclerotomy including the removal of vitreous, division of bands or removal of preretinal membranes by cutting and suction and replacement by saline, Hartmann's or similar solution (Anaes. 17718 = 10B + 8T) (Assist.) **Fee:** $1,042.10 **Benefit:** 75% = $781.60 85% = $991.20
42728	CRYOTHERAPY OF RETINA or other intraocular structures with an internal probe, being a service associated with a service to which item 42725 applies (Anaes. 17709 = 5B + 4T) **Fee:** $175.70 **Benefit:** 75% = $131.80 85% = $149.35
42731	CAPSULECTOMY or LENSECTOMY by posterior chamber sclerotomy in conjunction with the removal of vitreous or division of vitreous bands or removal of preretinal membrane from the posterior chamber by cutting and suction and replacement by saline, Hartmann's or similar solution, not being a service associated with any other intraocular operation (Anaes. 17718 = 10B + 8T) (Assist.) *(See para T8.48 of explanatory notes to this Category)* **Fee:** $1,182.55 **Benefit:** 75% = $886.95 85% = $1,131.65
42734	CAPSULOTOMY, other than by laser (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $234.15 **Benefit:** 75% = $175.65 85% = $199.05
42737	NEEDLING OF POSTERIOR CAPSULE (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $234.15 **Benefit:** 75% = $175.65 85% = $199.05
42740	PARACENTESIS OF ANTERIOR OR POSTERIOR CHAMBER OR BOTH, for the injection of therapeutic substances, or the removal of aqueous or vitreous for diagnostic purposes, 1 or more of (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $234.15 **Benefit:** 75% = $175.65 85% = $199.05

42743	ANTERIOR CHAMBER, IRRIGATION OF BLOOD FROM, as an independent procedure (Anaes. 17708 = 5B + 3T) (Assist.) **Fee:** $491.85	**Benefit:** 75% = $368.90	85% = $440.95
42746	GLAUCOMA, filtering operation for (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $743.50	**Benefit:** 75% = $557.65	85% = $692.60
42749	GLAUCOMA, filtering operation for, where previous filtering operation has been performed (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $930.85	**Benefit:** 75% = $698.15	85% = $879.95
42752	GLAUCOMA, insertion of Molteno valve for, 1 or more stages (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $1,042.10	**Benefit:** 75% = $781.60	85% = $991.20
42755	GLAUCOMA, removal of Molteno valve (Anaes. 17709 = 5B + 4T) **Fee:** $128.85	**Benefit:** 75% = $96.65	85% = $109.55
42758	GONIOTOMY (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $544.55	**Benefit:** 75% = $408.45	85% = $493.65
42761	DIVISION OF ANTERIOR OR POSTERIOR SYNECHIAE, as an independent procedure, other than by laser (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $404.00	**Benefit:** 75% = $303.00	85% = $353.10
42764	IRIDECTOMY (including excision of tumour of iris) OR IRIDOTOMY, as an independent procedure, other than by laser (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $404.00	**Benefit:** 75% = $303.00	85% = $353.10
42767	TUMOUR, INVOLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $848.85	**Benefit:** 75% = $636.65	85% = $797.95
42770	CYCLODESTRUCTIVE procedures for the treatment of intractable glaucoma, treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $229.55	**Benefit:** 75% = $172.20	85% = $195.15
42773	DETACHED RETINA, diathermy or cryotherapy for, not being a service associated with a service to which item 42776 applies (Anaes. 17710 = 6B + 4T) (Assist.) **Fee:** $702.50	**Benefit:** 75% = $526.90	85% = $651.60
42776	DETACHED RETINA, buckling or resection operation for (Anaes. 17713 = 6B + 7T) (Assist.) **Fee:** $1,042.10	**Benefit:** 75% = $781.60	85% = $991.20
42779	DETACHED RETINA, revision operation for (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $1,299.70	**Benefit:** 75% = $974.80	85% = $1,248.80
42782	LASER TRABECULOPLASTY - each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes. 17707 = 5B + 2T) (Assist.) *(See para T8.49 of explanatory notes to this Category)* **Fee:** $351.30	**Benefit:** 75% = $263.50	85% = $300.40
42783	LASER TRABECULOPLASTY - each treatment to 1 eye - ***where it can be demonstrated that a 5th or subsequent treatment to that eye (including any treatments to which item 42782 applies) is indicated in a 2 year period*** *(Anaes. 17707 = 5B + 2T) (Assist.)* *(See para T8.49 of explanatory notes to this Category)* **Fee:** $351.30	**Benefit:** 75% = $263.50	85% = $300.40
42785	LASER IRIDOTOMY - each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes. 17707 = 5B + 2T) (Assist.) *(See para T8.50 of explanatory notes to this Category)* **Fee:** $275.15	**Benefit:** 75% = $206.40	85% = $233.90
42786	LASER IRIDOTOMY - each treatment to 1 eye - ***where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42785 applies) is indicated in a 2 year period*** *(Anaes. 17707 = 5B + 2T) (Assist.)* *(See para T8.50 of explanatory notes to this Category)* **Fee:** $275.15	**Benefit:** 75% = $206.40	85% = $233.90

42788	LASER CAPSULOTOMY - each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes. 17707 = 5B + 2T) (Assist.) *(See para T8.51 of explanatory notes to this Category)* **Fee:** $275.15	**Benefit:** 75% = $206.40	85% = $233.90
42789	LASER CAPSULOTOMY - each treatment to 1 eye - ***where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42788 applies) is indicated in a 2 year period*** *(Anaes. 17707 = 5B + 2T) (Assist.)* *(See para T8.51 of explanatory notes to this Category)* **Fee:** $275.15	**Benefit:** 75% = $206.40	85% = $233.90
42791	LASER VITREOLYSIS OR CORTICOLYSIS OF LENS MATERIAL OR FIBRINOLYSIS -each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes. 17707 = 5B + 2T) (Assist.) *(See para T8.52 of explanatory notes to this Category)* **Fee:** $275.15	**Benefit:** 75% = $206.40	85% = $233.90
42792	LASER VITREOLYSIS OR CORTICOLYSIS OF LENS MATERIAL OR FIBRINOLYSIS - each treatment to 1 eye - ***where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42791 applies) is indicated in a 2 year period*** *(Anaes. 17707 = 5B + 2T) (Assist.)* *(See para T8.52 of explanatory notes to this Category)* **Fee:** $275.15	**Benefit:** 75% = $206.40	85% = $233.90
42794	DIVISION OF SUTURE BY LASER following trabeculoplasty, each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes. 17707 = 5B + 2T) *(See para T8.53 of explanatory notes to this Category)* **Fee:** $52.65	**Benefit:** 75% = $39.50	85% = $44.80
42797	LASER COAGULATION OF CORNEAL OR SCLERAL BLOOD VESSELS - each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes. 17707 = 5B + 2T) *(See para T8.54 of explanatory notes to this Category)* **Fee:** $52.65	**Benefit:** 75% = $39.50	85% = $44.80
42806	IRIS TUMOUR, laser photocoagulation of (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $275.15	**Benefit:** 75% = $206.40	85% = $233.90
42807	PHOTOMYDRIASIS, laser **Fee:** $277.00	**Benefit:** 75% = $207.75	85% = $235.45
42808	PHOTOIRIDOSYNERESIS, laser **Fee:** $277.00	**Benefit:** 75% = $207.75	85% = $235.45
42809	RETINA, photocoagulation of (Anaes. 17710 = 6B + 4T) (Assist.) **Fee:** $351.30	**Benefit:** 75% = $263.50	85% = $300.40
42810	PHOTOTHERAPEUTIC KERATECTOMY, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes. 17711 = 5B + 6T) **Fee:** $442.00	**Benefit:** 75% = $331.50	85% = $391.10
42812	DETACHED RETINA, removal of encircling silicone band from (Anaes. 17710 = 6B + 4T) **Fee:** $128.85	**Benefit:** 75% = $96.65	85% = $109.55
42815	POSTERIOR CHAMBER, removal of silicone oil from (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $491.85	**Benefit:** 75% = $368.90	85% = $440.95
42818	RETINA, CRYOTHERAPY TO, as an independent procedure, with external probe (Anaes. 17709 = 6B + 3T) **Fee:** $456.55	**Benefit:** 75% = $342.45	85% = $405.65
42821	RETROBULBAR TRANSILLUMINATION, as an independent procedure (Anaes. 17705 = 4B + 1T) **Fee:** $70.25	**Benefit:** 75% = $52.70	85% = $59.75
42824	RETROBULBAR INJECTION OF ALCOHOL OR OTHER DRUG, as an independent procedure **Fee:** $54.45	**Benefit:** 75% = $40.85	85% = $46.30
42827	BOTULINUS TOXIN, injection of, for blepharospasm, including all such injections on any 1 day (Anaes. 17706 = 5B + 1T) **Fee:** $35.10	**Benefit:** 75% = $26.35	85% = $29.85

42830	BOTULINUS TOXIN, injection of, for strabismus including all such injections on any 1 day and associated electromyography (Anaes. 17707 = 5B + 2T) **Fee:** $121.80 **Benefit:** 75% = $91.35 85% = $103.55
42833	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $456.55 **Benefit:** 75% = $342.45 85% = $405.65
42836	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES where there have been 2 or more previous squint operations on the eye or eyes (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $567.85 **Benefit:** 75% = $425.90 85% = $516.95
42839	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 OR MORE MUSCLES (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $544.55 **Benefit:** 75% = $408.45 85% = $493.65
42842	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 OR MORE MUSCLES where there have been 2 or more previous squint operations on the eye or eyes (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $679.15 **Benefit:** 75% = $509.40 85% = $628.25
42845	READJUSTMENT OF ADJUSTABLE SUTURES, 1 or both eyes, as an independent procedure following an operation for correction of squint (Anaes. 17707 = 5B + 2T) *(See para T8.55 of explanatory notes to this Category)* **Fee:** $147.45 **Benefit:** 75% = $110.60 85% = $125.35
42848	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $544.55 **Benefit:** 75% = $408.45 85% = $493.65
42851	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) where there have been 2 or more previous squint operations on the eye or eyes (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $679.15 **Benefit:** 75% = $509.40 85% = $628.25
42854	RUPTURED MEDIAL PALPEBRAL LIGAMENT or ruptured EXTRAOCULAR MUSCLE, repair of (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $316.05 **Benefit:** 75% = $237.05 85% = $268.65
42857	RESUTURING OF WOUND FOLLOWING INTRAOCULAR PROCEDURES with or without excision of prolapsed iris (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $316.05 **Benefit:** 75% = $237.05 85% = $268.65
42860	EYELID (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $702.50 **Benefit:** 75% = $526.90 85% = $651.60
42863	EYELID, recession of (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $603.00 **Benefit:** 75% = $452.25 85% = $552.10
42866	ENTROPION or TARSAL ECTROPION, repair of, by tightening, shortening or repair of inferior retractors by open operation across the entire width of the eyelid (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $585.45 **Benefit:** 75% = $439.10 85% = $534.55
42869	EYELID closure in facial nerve paralysis, insertion of foreign implant for (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $427.40 **Benefit:** 75% = $320.55 85% = $376.50
42872	EYEBROW, elevation of, for paretic states (Anaes. 17710 = 5B + 5T) **Fee:** $187.35 **Benefit:** 75% = $140.55 85% = $159.25
	SUBGROUP 10 - OPERATIONS FOR OSTEOMYELITIS
	OPERATIONS FOR ACUTE OSTEOMYELITIS
43500	OPERATION ON PHALANX (Anaes. 17706 = 3B + 3T) **Fee:** $96.05 **Benefit:** 75% = $72.05 85% = $81.65
43503	OPERATION ON STERNUM, CLAVICLE, RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, TARSUS, SKULL, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE (Anaes. 17710 = 5B + 5T) **Fee:** $159.40 **Benefit:** 75% = $119.55 85% = $135.50

43506	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $277.45 **Benefit:** 75% = $208.10 85% = $235.85
43509	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes. 17715 = 8B + 7T) (Assist.) **Fee:** $277.45 **Benefit:** 75% = $208.10 85% = $235.85
	OPERATIONS FOR CHRONIC OSTEOMYELITIS
43512	OPERATION ON SCAPULA, STERNUM, CLAVICLE, RIB, ULNA, RADIUS, METACARPUS, CARPUS, PHALANX, TIBIA, FIBULA, METATARSUS, TARSUS, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE or ANY COMBINATION OF ADJOINING BONES (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $277.45 **Benefit:** 75% = $208.10 85% = $235.85
43515	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $277.45 **Benefit:** 75% = $208.10 85% = $235.85
43518	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes. 17715 = 8B + 7T) (Assist.) **Fee:** $457.55 **Benefit:** 75% = $343.20 85% = $406.65
43521	OPERATION ON SKULL (Anaes. 17719 = 12B + 7T) (Assist.) **Fee:** $361.60 **Benefit:** 75% = $271.20 85% = $310.70
43524	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 43515, 43518 or 43521 (Anaes. 17715 = 8B + 7T) (Assist.) **Fee:** $457.55 **Benefit:** 75% = $343.20 85% = $406.65
	SUBGROUP 11 - PAEDIATRIC
	SURGERY IN THE NEONATE OR YOUNG CHILD
43801	INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $745.30 **Benefit:** 75% = $559.00 85% = $694.40
43804	INTESTINAL MALROTATION with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Anaes. 17717 = 7B + 10T) (Assist.) **Fee:** $793.55 **Benefit:** 75% = $595.20 85% = $742.65
43807	DUODENAL ATRESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes. 17719 = 7B + 12T) (Assist.) **Fee:** $865.75 **Benefit:** 75% = $649.35 85% = $814.85
43810	JEJUNAL ATRESIA, bowel resection and anastomosis for, with or without tapering (Anaes. 17719 = 7B + 12T) (Assist.) **Fee:** $1,010.10 **Benefit:** 75% = $757.60 85% = $959.20
43813	MECONIUM ILEUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intesinal perforation with or without meconium peritonitis (Anaes. 17720 = 8B + 12T) (Assist.) **Fee:** $1,010.10 **Benefit:** 75% = $757.60 85% = $959.20
43816	ILEAL ATRESIA, COLONIC ATRESIA OR MECONIUM ILEUS not being a service associated with a service to which item 43813 applies, laparotomy for (Anaes. 17719 = 8B + 11T) (Assist.) **Fee:** $937.90 **Benefit:** 75% = $703.45 85% = $887.00
43819	HIRSCHSPRUNG'S DISEASE, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes. 17716 = 7B + 9T) (Assist.) **Fee:** $757.55 **Benefit:** 75% = $568.20 85% = $706.65
43822	ANORECTAL MALFORMATION, laparotomy and colostomy for (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $757.55 **Benefit:** 75% = $568.20 85% = $706.65
43825	NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes. 17718 = 8B + 10T) (Assist.) **Fee:** $865.75 **Benefit:** 75% = $649.35 85% = $814.85
43828	ACUTE NEONATAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes. 17720 = 8B + 12T) (Assist.) **Fee:** $956.45 **Benefit:** 75% = $717.35 85% = $905.55

43831	ACUTE NEONATAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, laparotomy for (Anaes. 17714 = 8B + 6T) (Assist.) **Fee:** $745.30	**Benefit:** 75% = $559.00	85% = $694.40
43834	BOWEL RESECTION for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Anaes. 17719 = 7B + 12T) (Assist.) **Fee:** $865.75	**Benefit:** 75% = $649.35	85% = $814.85
43837	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $1,082.15	**Benefit:** 75% = $811.65	85% = $1,031.25
43840	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, diagnosed after the first day of life and before 20 days of age (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $937.90	**Benefit:** 75% = $703.45	85% = $887.00
43843	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, not being a service to which item 43846 applies (Anaes. 17728 = 16B + 12T) (Assist.) **Fee:** $1,442.85	**Benefit:** 75% = $1,082.15	85% = $1,391.95
43846	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, in infant of birth weight less than 1500 grams (Anaes. 17728 = 16B + 12T) (Assist.) **Fee:** $1,551.05	**Benefit:** 75% = $1,163.30	85% = $1,500.15
43849	OESOPHAGEAL ATRESIA, gastrostomy for (Anaes. 17714 = 8B + 6T) (Assist.) **Fee:** $396.75	**Benefit:** 75% = $297.60	85% = $345.85
43852	OESOPHAGEAL ATRESIA, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes. 17726 = 16B + 10T) (Assist.) **Fee:** $1,262.50	**Benefit:** 75% = $946.90	85% = $1,211.60
43855	OESOPHAGEAL ATRESIA, delayed primary anastomosis for (Anaes. 17728 = 16B + 12T) (Assist.) **Fee:** $1,334.70	**Benefit:** 75% = $1,001.05	85% = $1,283.80
43858	OESOPHAGEAL ATRESIA, cervical oesophagostomy for (Anaes. 17722 = 16B + 6T) (Assist.) **Fee:** $468.90	**Benefit:** 75% = $351.70	85% = $418.00
43861	CONGENITAL CYSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR EMPHYSEMA, thoracotomy and lung resection for (Anaes. 17724 = 14B + 10T) (Assist.) **Fee:** $1,298.60	**Benefit:** 75% = $973.95	85% = $1,247.70
43864	GASTROSCHISIS, operation for (Anaes. 17718 = 8B + 10T) (Assist.) **Fee:** $973.90	**Benefit:** 75% = $730.45	85% = $923.00
43867	GASTROSCHISIS, secondary operation for, with removal of silo and closure of abdominal wall (Anaes. 17716 = 8B + 8T) (Assist.) **Fee:** $541.10	**Benefit:** 75% = $405.85	85% = $490.20
43870	EXOMPHALOS containing small bowel only, operation for (Anaes. 17716 = 8B + 8T) (Assist.) **Fee:** $757.55	**Benefit:** 75% = $568.20	85% = $706.65
43873	EXOMPHALOS containing small bowel and other viscera, operation for (Anaes. 17720 = 8B + 12T) (Assist.) **Fee:** $1,010.10	**Benefit:** 75% = $757.60	85% = $959.20
43876	SACROCOCCYGEAL TERATOMA, excision of, by posterior approach (Anaes. 17721 = 11B + 10T) (Assist.) **Fee:** $865.75	**Benefit:** 75% = $649.35	85% = $814.85
43879	SACROCOCCYGEAL TERATOMA, excision of, by combined posterior and abdominal approach (Anaes. 17723 = 11B + 12T) (Assist.) **Fee:** $1,010.10	**Benefit:** 75% = $757.60	85% = $959.20
43882	CLOACAL EXSTROPHY, operation for (Anaes. 17726 = 10B + 16T) (Assist.) **Fee:** $1,298.60	**Benefit:** 75% = $973.95	85% = $1,247.70

	THORACIC SURGERY
43900	TRACHEO-OESOPHAGEAL FISTULA without atresia, division and repair of (Anaes. 17726 = 16B + 10T) (Assist.) **Fee:** $865.75 **Benefit:** 75% = $649.35 85% = $814.85
43903	OESOPHAGEAL ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes. 17732 = 16B + 16T) (Assist.) **Fee:** $1,442.85 **Benefit:** 75% = $1,082.15 85% = $1,391.95
43906	OESOPHAGUS, resection of congenital, anastomic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Anaes. 17728 = 16B + 12T) (Assist.) **Fee:** $1,262.50 **Benefit:** 75% = $946.90 85% = $1,211.60
43909	TRACHEOMALACIA, aortopexy for (Anaes. 17726 = 16B + 10T) (Assist.) **Fee:** $1,262.50 **Benefit:** 75% = $946.90 85% = $1,211.60
43912	THORACOTOMY and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Anaes. 17725 = 13B + 12T) (Assist.) **Fee:** $1,192.70 **Benefit:** 75% = $894.55 85% = $1,141.80
43915	EVENTRATION, plication of diaphragm for (Anaes. 17723 = 13B + 10T) (Assist.) **Fee:** $901.80 **Benefit:** 75% = $676.35 85% = $850.90
	ABDOMINAL SURGERY
43930	HYPERTROPHIC PYLORIC STENOSIS, pyloromyotomy for (Anaes. 17712 = 8B + 4T) (Assist.) **Fee:** $346.80 **Benefit:** 75% = $260.10 85% = $295.90
43933	IDIOPATHIC INTUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $405.90 **Benefit:** 75% = $304.45 85% = $355.00
43936	INTUSSUSCEPTION, laparotomy and resection with anastomosis (Anaes. 17717 = 7B + 10T) (Assist.) **Fee:** $757.55 **Benefit:** 75% = $568.20 85% = $706.65
43939	VENTRAL HERNIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $577.15 **Benefit:** 75% = $432.90 85% = $526.25
43942	ABDOMINAL WALL VITELLO INTESTINAL REMNANT, excision of (Anaes. 17706 = 4B + 2T) **Fee:** $180.40 **Benefit:** 75% = $135.30 85% = $153.35
43945	PATENT VITELLO INTESTINAL DUCT, excision of (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $757.55 **Benefit:** 75% = $568.20 85% = $706.65
43948	UMBILICAL GRANULOMA, excision of, under general anaesthesia (Anaes. 17705 = 3B + 2T) **Fee:** $108.25 **Benefit:** 75% = $81.20 85% = $92.05
43951	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Anaes. 17720 = 7B + 13T) (Assist.) **Fee:** $678.35 **Benefit:** 75% = $508.80 85% = $627.45
43954	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes. 17720 = 7B + 13T) (Assist.) **Fee:** $829.70 **Benefit:** 75% = $622.30 85% = $778.80
43957	GASTRO-OESOPHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Anaes. 17721 = 7B + 14T) (Assist.) **Fee:** $901.80 **Benefit:** 75% = $676.35 85% = $850.90
43960	ANORECTAL MALFORMATION, perineal anoplasty of (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $317.30 **Benefit:** 75% = $238.00 85% = $269.75
43963	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of (Anaes. 17724 = 8B + 16T) (Assist.) **Fee:** $1,262.50 **Benefit:** 75% = $946.90 85% = $1,211.60
43966	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes. 17726 = 8B + 18T) (Assist.) **Fee:** $1,442.85 **Benefit:** 75% = $1,082.15 85% = $1,391.95

	PERSISTENT CLOACA, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Anaes. 17734 = 10B + 24T) (Assist.)		
43969	**Fee:** $1,984.00	**Benefit:** 75% = $1,488.00	85% = $1,933.10
	CHOLEDOCHAL CYST, resection of, with 1 duct anastomosis (Anaes. 17720 = 8B + 12T) (Assist.)		
43972	**Fee:** $1,442.85	**Benefit:** 75% = $1,082.15	85% = $1,391.95
	CHOLEDOCHAL CYST, resection of, with 2 duct anastomoses (Anaes. 17722 = 8B + 14T) (Assist.)		
43975	**Fee:** $1,695.40	**Benefit:** 75% = $1,271.55	85% = $1,644.50
	BILIARY ATRESIA, portoenterostomy for (Anaes. 17724 = 8B + 16T) (Assist.)		
43978	**Fee:** $1,442.85	**Benefit:** 75% = $1,082.15	85% = $1,391.95
	NEPHROBLASTOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes. 17713 = 7B + 6T) (Assist.)		
43981	**Fee:** $396.75	**Benefit:** 75% = $297.60	85% = $345.85
	NEPHROBLASTOMA, radical nephrectomy for (Anaes. 17719 = 7B + 12T) (Assist.)		
43984	**Fee:** $1,010.10	**Benefit:** 75% = $757.60	85% = $959.20
	NEUROBLASTOMA, radical excision of (Anaes. 17721 = 7B + 14T) (Assist.)		
43987	**Fee:** $1,118.30	**Benefit:** 75% = $838.75	85% = $1,067.40
	HIRSCHSPRUNG'S DISEASE, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends to sigmoid colon (Anaes. 17728 = 10B + 18T) (Assist.)		
43990	**Fee:** $1,370.75	**Benefit:** 75% = $1,028.10	85% = $1,319.85
	HIRSCHSPRUNG'S DISEASE, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends into descending or transverse colon with or without resiting of stoma (Anaes. 17730 = 10B + 20T) (Assist.)		
43993	**Fee:** $1,479.00	**Benefit:** 75% = $1,109.25	85% = $1,428.10
	HIRSCHPRUNG'S DISEASE, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolic anastomosis (Anaes. 17730 = 10B + 20T) (Assist.)		
43996	**Fee:** $1,659.35	**Benefit:** 75% = $1,244.55	85% = $1,608.45
	HIRSCHSPRUNG'S DISEASE, anal sphincterotomy as an independent procedure for (Anaes. 17706 = 4B + 2T) (Assist.)		
43999	**Fee:** $207.55	**Benefit:** 75% = $155.70	85% = $176.45
	RECTUM, examination of, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes. 17707 = 4B + 3T) (Assist.)		
44102	**Fee:** $200.05	**Benefit:** 75% = $150.05	85% = $170.05
	RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, under general anaesthesia (Anaes. 17706 = 4B + 2T)		
44105	**Fee:** $35.15	**Benefit:** 75% = $26.40	85% = $29.90
	INGUINAL HERNIA repair at age less than 3 months (Anaes. 17710 = 5B + 5T) (Assist.)		
44108	**Fee:** $382.65	**Benefit:** 75% = $287.00	85% = $331.75
	OBSTRUCTED OR STRANGULATED INGUINAL HERNIA, repair of, at age less than 3 months, including orchidopexy when performed (Anaes. 17711 = 5B + 6T) (Assist.)		
44111	**Fee:** $448.15	**Benefit:** 75% = $336.15	85% = $397.25
	INGUINAL HERNIA repair at age less than 3 months when orchidopexy also required (Anaes. 17711 = 5B + 6T) (Assist.)		
44114	**Fee:** $448.15	**Benefit:** 75% = $336.15	85% = $397.25
	MISCELLANEOUS SURGERY		
	LYMPHADENECTOMY, for atypical mycobacterial infection or other granulomatous disease (Anaes. 17711 = 6B + 5T) (Assist.)		
44130	**Fee:** $360.75	**Benefit:** 75% = $270.60	85% = $309.85
	TORTICOLLIS, open division of sternomastoid muscle for (Anaes. 17708 = 5B + 3T) (Assist.)		
44133	**Fee:** $286.30	**Benefit:** 75% = $214.75	85% = $243.40
	INGROWN TOE NAIL, operation for, under general anaesthesia (Anaes. 17706 = 3B + 3T)		
44136	**Fee:** $131.95	**Benefit:** 75% = $99.00	85% = $112.20

	SUBGROUP 12 - AMPUTATIONS
44325	HAND, MIDCARPAL OR TRANSMETACARPAL, amputation of (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $230.20 **Benefit:** 75% = $172.65 85% = $195.70
44328	HAND, FOREARM OR THROUGH ARM, amputation of (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $277.45 **Benefit:** 75% = $208.10 85% = $235.85
44331	AMPUTATION AT SHOULDER (Anaes. 17717 = 9B + 8T) (Assist.) **Fee:** $457.55 **Benefit:** 75% = $343.20 85% = $406.65
44334	INTERSCAPULOTHORACIC AMPUTATION (Anaes. 17725 = 15B + 10T) (Assist.) **Fee:** $929.80 **Benefit:** 75% = $697.35 85% = $878.90
44338	1 DIGIT of foot, amputation of (Anaes. 17705 = 3B + 2T) **Fee:** $112.15 **Benefit:** 75% = $84.15 85% = $95.35
44342	2 DIGITS of 1 foot, amputation of (Anaes. 17706 = 3B + 3T) **Fee:** $171.20 **Benefit:** 75% = $128.40 85% = $145.55
44346	3 DIGITS of 1 foot, amputation of (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $197.75 **Benefit:** 75% = $148.35 85% = $168.10
44350	4 DIGITS of 1 foot, amputation of (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $224.35 **Benefit:** 75% = $168.30 85% = $190.70
44354	5 DIGITS of 1 foot, amputation of (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $256.80 **Benefit:** 75% = $192.60 85% = $218.30
44358	TOE, including metatarsal or part of metatarsal each toe , amputation of (Anaes. 17707 = 3B + 4T) **Fee:** $143.15 **Benefit:** 75% = $107.40 85% = $121.70
44359	ONE OR MORE TOES OF ONE FOOT, amputation of, including if performed, excision of 1 or more metatarsal bones of the foot, performed for diabetic or other microvascular disease, excluding aftercare (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $205.45 **Benefit:** 75% = $154.10 85% = $174.65
44361	FOOT AT ANKLE (Syme, Pirogoff types), amputation of (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $277.45 **Benefit:** 75% = $208.10 85% = $235.85
44364	FOOT, MIDTARSAL OR TRANSMETATARSAL, amputation of (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $230.20 **Benefit:** 75% = $172.65 85% = $195.70
44367	AMPUTATION THROUGH THIGH, AT KNEE OR BELOW KNEE (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $406.30 **Benefit:** 75% = $304.75 85% = $355.40
44370	AMPUTATION AT HIP (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $560.75 **Benefit:** 75% = $420.60 85% = $509.85
44373	HINDQUARTER, amputation of (Anaes. 17727 = 15B + 12T) (Assist.) **Fee:** $1,151.05 **Benefit:** 75% = $863.30 85% = $1,100.15
44376	AMPUTATION STUMP, reamputation of, to provide adequate skin and muscle cover (Assist.) **Derived Fee:** 75% of the original amputation fee

SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY

METICULOUS REPAIR DESIGNED TO OBTAIN MAXIMUM FUNCTIONAL RESULTS INCLUDING THE PREPARATION OF THE DEFECT REQUIRING REPAIR

(Note: See Explanatory notes to this Category for definition of "Local skin flap")

GENERAL

45000	SINGLE STAGE LOCAL MUSCLE FLAP REPAIR, on eyelid, nose, lip, neck, hand, thumb, finger or genitals (Anaes. 17708 = 5B + 3T) **Fee:** $421.50	**Benefit:** 75% = $316.15	85% = $370.60
45003	SINGLE STAGE LOCAL MYOCUTANEOUS FLAP REPAIR to 1 defect, simple and small (Anaes. 17710 = 3B + 7T) **Fee:** $468.35	**Benefit:** 75% = $351.30	85% = $417.45
45006	SINGLE STAGE LARGE MYOCUTANEOUS FLAP REPAIR to 1 defect, (pectoralis major, latissimus dorsi, or similar large muscle) (Anaes. 17717 = 5B + 12T) (Assist.) **Fee:** $807.90	**Benefit:** 75% = $605.95	85% = $757.00
45009	SINGLE STAGE LOCAL muscle flap repair to 1 defect, simple and small (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $295.15	**Benefit:** 75% = $221.40	85% = $250.90
45012	SINGLE STAGE LARGE MUSCLE FLAP REPAIR to 1 defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle) (Anaes. 17716 = 3B + 13T) (Assist.) **Fee:** $494.35	**Benefit:** 75% = $370.80	85% = $443.45
45015	MUSCLE OR MYOCUTANEOUS FLAP, delay of (Anaes. 17708 = 3B + 5T) **Fee:** $234.15	**Benefit:** 75% = $175.65	85% = $199.05
45018	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $368.80	**Benefit:** 75% = $276.60	85% = $317.90
45019	FULL FACE CHEMICAL PEEL **for severely sun-damaged skin, *where it can be demonstrated that the damage affects 75% of the facial skin surface area involving photodamage (dermatoheliosis) typically consisting of solar keratoses, solar lentigines, freckling, yellowing and leathering of the skin***, where at least medium depth peeling agents are used, performed in the operating theatre of a hospital or approved day-hospital facility by a specialist in the practice of his or her specialty - ***1 session only in a 12 month period*** (Anaes. 17708 = 5B + 3T) *(See para T8.56 of explanatory notes to this Category)* **Fee:** $308.80	**Benefit:** 75% = $231.60	85% = $262.50
45020	FULL FACE CHEMICAL PEEL **for severe chloasma or melasma refractory to all other treatments, *where it can be demonstrated that the chloasma or melasma affects 75% of the facial skin surface area involving diffuse pigmentation visible at a distance of 4 metres***, *where at least medium depth peeling agents are used*, performed in the operating theatre of a hospital or approved day-hospital facility by a specialist in the practice of his or her specialty - ***1 session only in a 12 month period*** (Anaes. 17708 = 5B + 3T) *(See para T8.56 of explanatory notes to this Category)* **Fee:** $308.80	**Benefit:** 75% = $231.60	85% = $262.50
45021	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes. 17705 = 3B + 2T) *(See para T8.57 of explanatory notes to this Category)* **Fee:** $138.15	**Benefit:** 75% = $103.65	85% = $117.45
45024	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes. 17706 = 3B + 3T) *(See para T8.57 of explanatory notes to this Category)* **Fee:** $310.25	**Benefit:** 75% = $232.70	85% = $263.75
45025	CARBON DIOXIDE LASER OR ERBIUM LASER resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes. 17705 = 3B + 2T) *(See para T8.57 of explanatory notes to this Category)* **Fee:** $138.15	**Benefit:** 75% = $103.65	85% = $117.45

45026	CARBON DIOXIDE LASER OR ERBIUM LASER resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes. 17706 = 3B + 3T) *(See para T8.57 of explanatory notes to this Category)* **Fee:** $310.25	**Benefit:** 75% = $232.70	85% = $263.75
45027	ANGIOMA, cauterisation of or injection into, where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17706 = 3B + 3T) **Fee:** $93.65	**Benefit:** 75% = $70.25	85% = $79.65
45030	ANGIOMA (haemangioma or lymphangioma or both) of skin and subcutaneous tissue (excluding facial muscle or breast) or mucous surface, small, excision and suture of (Anaes. 17706 = 3B + 3T) **Fee:** $100.65	**Benefit:** 75% = $75.50	85% = $85.60
45033	ANGIOMA, (haemangioma or lymphangioma or both), large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes. 17710 = 5B + 5T) **Fee:** $187.35	**Benefit:** 75% = $140.55	85% = $159.25
45035	ANGIOMA (haemangioma or lymphangioma or both), large and deep, involving muscles or nerves, excision of (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $546.55	**Benefit:** 75% = $409.95	85% = $495.65
45036	ANGIOMA (haemangioma or lymphangioma or both) of neck, deep, excision of (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $878.20	**Benefit:** 75% = $658.65	85% = $827.30
45039	ARTERIOVENOUS MALFORMATION (3 centimetres or less) of superficial tissue, excision of (Anaes. 17707 = 3B + 4T) **Fee:** $187.35	**Benefit:** 75% = $140.55	85% = $159.25
45042	ARTERIOVENOUS MALFORMATION, (greater than 3 centimetres), excision of (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $240.05	**Benefit:** 75% = $180.05	85% = $204.05
45045	ARTERIOVENOUS MALFORMATION on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes. 17711 = 5B + 6T) **Fee:** $240.05	**Benefit:** 75% = $180.05	85% = $204.05
45048	LYMPHOEDEMATOUS tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $603.00	**Benefit:** 75% = $452.25	85% = $552.10
45051	CONTOUR RECONSTRUCTION for pathological deformity, insertion of foreign implant (non biological but excluding injection of liquid or semisolid material) by open operation (Anaes. 17711 = 5B + 6T) (Assist.) *(See para T8.58 of explanatory notes to this Category)* **Fee:** $368.90	**Benefit:** 75% = $276.70	85% = $318.00
45054	LIMB OR CHEST, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Anaes. 17708 = 4B + 4T) (Assist.) *(See para T8.59 of explanatory notes to this Category)* **Fee:** $191.55	**Benefit:** 75% = $143.70	85% = $162.85
	SKIN FLAP SURGERY *(Note: See Explanatory notes to this Category for definition of "Local skin flap")*		
45200	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, simple and small, excluding flap for male pattern baldness (Anaes. 17706 = 3B + 3T) **Fee:** $221.40	**Benefit:** 75% = $166.05	85% = $188.20
45203	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, complicated or large, excluding flap for male pattern baldness (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $316.05	**Benefit:** 75% = $237.05	85% = $268.65
45206	SINGLE STAGE LOCAL FLAP where indicated to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals (Anaes. 17711 = 5B + 6T) **Fee:** $298.60	**Benefit:** 75% = $223.95	85% = $253.85
45209	DIRECT FLAP REPAIR (cross arm, abdominal or similar), first stage (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $368.90	**Benefit:** 75% = $276.70	85% = $318.00

45212	DIRECT FLAP REPAIR (cross arm, abdominal or similar), second stage (Anaes. 17708 = 3B + 5T) **Fee:** $183.00	**Benefit:** 75% = $137.25	85% = $155.55
45215	DIRECT FLAP REPAIR, cross leg, first stage (Anaes. 17712 = 3B + 9T) (Assist.) **Fee:** $789.50	**Benefit:** 75% = $592.15	85% = $738.60
45218	DIRECT FLAP REPAIR, cross leg, second stage (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $354.15	**Benefit:** 75% = $265.65	85% = $303.25
45221	DIRECT FLAP REPAIR, small (cross finger or similar), first stage (Anaes. 17706 = 3B + 3T) **Fee:** $203.60	**Benefit:** 75% = $152.70	85% = $173.10
45224	DIRECT FLAP REPAIR, small (cross finger or similar), second stage (Anaes. 17706 = 3B + 3T) **Fee:** $91.50	**Benefit:** 75% = $68.65	85% = $77.80
45227	INDIRECT FLAP OR TUBED PEDICLE, formation of (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $346.80	**Benefit:** 75% = $260.10	85% = $295.90
45230	DIRECT OR INDIRECT FLAP OR TUBED PEDICLE, delay of (Anaes. 17707 = 3B + 4T) **Fee:** $173.35	**Benefit:** 75% = $130.05	85% = $147.35
45233	INDIRECT FLAP OR TUBED PEDICLE, preparation of intermediate or final site and attachment to the site (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $368.90	**Benefit:** 75% = $276.70	85% = $318.00
45236	INDIRECT FLAP OR TUBED PEDICLE, spreading of pedicle, as a separate procedure (Anaes. 17708 = 3B + 5T) **Fee:** $289.20	**Benefit:** 75% = $216.90	85% = $245.85
45239	DIRECT, INDIRECT OR LOCAL FLAP, revision of (Anaes. 17707 = 3B + 4T) **Fee:** $203.60	**Benefit:** 75% = $152.70	85% = $173.10
	FREE GRAFTS		
45400	FREE GRAFTING (split skin) of a granulating area, small (Anaes. 17706 = 3B + 3T) **Fee:** $159.40	**Benefit:** 75% = $119.55	85% = $135.50
45403	FREE GRAFTING (split skin) of a granulating area, extensive (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $317.30	**Benefit:** 75% = $238.00	85% = $269.75
45406	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving not more than 3 per cent of total body surface (Anaes. 17707 = 3B + 4T) (Assist.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $351.30	**Benefit:** 75% = $263.50	85% = $300.40
45409	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 3 per cent or more but less than 6 per cent of total body surface (Anaes. 17709 = 3B + 6T) (Assist.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $468.35	**Benefit:** 75% = $351.30	85% = $417.45
45412	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 6 per cent or more but less than 9 per cent of total body surface (Anaes. 17711 = 3B + 8T) (Assist.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $644.05	**Benefit:** 75% = $483.05	85% = $593.15
45415	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 9 per cent or more but less than 12 per cent of total body surface (Anaes. 17713 = 3B + 10T) (Assist.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $702.50	**Benefit:** 75% = $526.90	85% = $651.60
45418	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 12 per cent or more but less than 15 per cent of total body surface (Anaes. 17715 = 3B + 12T) (Assist.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $761.05	**Benefit:** 75% = $570.80	85% = $710.15
45439	FREE GRAFTING (split skin) to 1 defect, including elective dissection, small (Anaes. 17706 = 3B + 3T) **Fee:** $221.40	**Benefit:** 75% = $166.05	85% = $188.20

45442	FREE GRAFTING (split skin) to 1 defect, including elective dissection, extensive (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $456.55 **Benefit:** 75% = $342.45 85% = $405.65
45445	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of, and removal of mould) (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $433.35 **Benefit:** 75% = $325.05 85% = $382.45
45448	FREE GRAFTING (split skin) to 1 defect, including elective dissection on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, not being a service to which item 45442 or 45445 applies (Anaes. 17709 = 5B + 4T) **Fee:** $292.70 **Benefit:** 75% = $219.55 85% = $248.80
45451	FREE GRAFTING (full thickness), to 1 defect, excluding grafts for male pattern baldness (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $368.90 **Benefit:** 75% = $276.70 85% = $318.00
45460	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **one surgeon** (Anaes. 17719 = 5B + 14T) (Assist.) **Fee:** $975.80 **Benefit:** 75% = $731.85 85% = $924.90
45461	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $695.40 **Benefit:** 75% = $521.55 85% = $644.50
45462	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **conjoint surgery, co- surgeon** (Assist.) **Fee:** $524.85 **Benefit:** 75% = $393.65 85% = $473.95
45464	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **one surgeon** (Anaes. 17721 = 5B + 16T) (Assist.) **Fee:** $1,489.40 **Benefit:** 75% = $1,117.05 85% = $1,438.50
45465	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes. 17717 = 5B + 12T) (Assist.) **Fee:** $1,061.10 **Benefit:** 75% = $795.85 85% = $1,010.20
45466	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $800.20 **Benefit:** 75% = $600.15 85% = $749.30
45468	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***30 percent or more but less than 40 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes. 17724 = 10B + 14T) (Assist.) **Fee:** $1,426.75 **Benefit:** 75% = $1,070.10 85% = $1,375.85
45469	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***30 percent or more but less than 40 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $1,076.45 **Benefit:** 75% = $807.35 85% = $1,025.55
45471	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***40 percent or more but less than 50 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes. 17728 = 12B + 16T) (Assist.) **Fee:** $1,793.45 **Benefit:** 75% = $1,345.10 85% = $1,742.55
45472	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***40 percent or more but less than 50 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $1,352.80 **Benefit:** 75% = $1,014.60 85% = $1,301.90
45474	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***50 percent or more but less than 60 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes. 17734 = 14B + 20T) (Assist.) **Fee:** $2,159.15 **Benefit:** 75% = $1,619.40 85% = $2,108.25
45475	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***50 percent or more but less than 60 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $1,629.10 **Benefit:** 75% = $1,221.85 85% = $1,578.20
45477	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***60 percent or more but less than 70 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes. 17738 = 16B + 22T) (Assist.) **Fee:** $2,524.80 **Benefit:** 75% = $1,893.60 85% = $2,473.90

45478	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***60 percent or more but less than 70 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $1,904.40	**Benefit:** 75% = $1,428.30	85% = $1,853.50
45480	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***70 percent or more but less than 80 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes. 17742 = 18B + 24T) (Assist.) **Fee:** $2,890.45	**Benefit:** 75% = $2,167.85	85% = $2,839.55
45481	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***70 percent or more but less than 80 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $2,180.70	**Benefit:** 75% = $1,635.55	85% = $2,129.80
45483	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***80 percent or more*** of total body surface - **conjoint surgery, principal surgeon** (Anaes. 17748 = 20B + 28T) (Assist.) **Fee:** $3,293.15	**Benefit:** 75% = $2,469.90	85% = $3,242.25
45484	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***80 percent or more*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $2,484.75	**Benefit:** 75% = $1,863.60	85% = $2,433.85
45485	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - upper eyelid, nose, lip, ear or palm of the hand (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $410.85	**Benefit:** 75% = $308.15	85% = $359.95
45486	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - forehead, cheek, anterior aspect of the neck, chin, plantar aspect of the foot, heel or genitalia (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $351.30	**Benefit:** 75% = $263.50	85% = $300.40
45487	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of toe (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $316.05	**Benefit:** 75% = $237.05	85% = $268.65
45488	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the hand (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $351.30	**Benefit:** 75% = $263.50	85% = $300.40
45489	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the hand (Anaes. 17712 = 3B + 9T) (Assist.) **Fee:** $526.95	**Benefit:** 75% = $395.25	85% = $476.05
45490	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the hand (Anaes. 17715 = 3B + 12T) (Assist.) **Fee:** $702.60	**Benefit:** 75% = $526.95	85% = $651.70
45491	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the hand (Anaes. 17718 = 3B + 15T) (Assist.) **Fee:** $878.20	**Benefit:** 75% = $658.65	85% = $827.30
45492	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the hand (Anaes. 17721 = 3B + 18T) (Assist.) **Fee:** $1,053.90	**Benefit:** 75% = $790.45	85% = $1,003.00
45493	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - portion of digit of hand (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $316.05	**Benefit:** 75% = $237.05	85% = $268.65
45494	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of face (excluding ears) (Anaes. 17723 = 7B + 16T) (Assist.) **Fee:** $1,275.80	**Benefit:** 75% = $956.85	85% = $1,224.90
	OTHER GRAFTS AND MISCELLANEOUS PROCEDURES		
45496	FLAP, free tissue transfer using microvascular techniques - ***revision of***, by open operation (Anaes. 17713 = 5B + 8T) **Fee:** $323.85	**Benefit:** 75% = $242.90	85% = $275.30
45497	FLAP, free tissue transfer using microvascular techniques - ***complete revision of***, by liposuction (Anaes. 17709 = 5B + 4T) **Fee:** $253.00	**Benefit:** 75% = $189.75	85% = $215.05

45498	FLAP, free tissue transfer using microvascular techniques - ***staged revision of***, by liposuction - first stage (Anaes. 17708 = 5B + 3T) **Fee:** $203.60	**Benefit:** 75% = $152.70	85% = $173.10
45499	FLAP, free tissue transfer using microvascular techniques - ***staged revision of***, by liposuction - second stage (Anaes. 17708 = 5B + 3T) **Fee:** $151.80	**Benefit:** 75% = $113.85	85% = $129.05
45500	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $848.85	**Benefit:** 75% = $636.65	85% = $797.95
45501	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit (Anaes. 17743 = 10B + 33T) (Assist.) **Fee:** $1,381.75	**Benefit:** 75% = $1,036.35	85% = $1,330.85
45502	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of limb or digit (Anaes. 17743 = 10B + 33T) (Assist.) **Fee:** $1,381.75	**Benefit:** 75% = $1,036.35	85% = $1,330.85
45503	MICRO-ARTERIAL OR MICRO-VENOUS GRAFT using microsurgical techniques (Anaes. 17726 = 8B + 18T) (Assist.) **Fee:** $1,580.75	**Benefit:** 75% = $1,185.60	85% = $1,529.85
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:** $1,381.75	**Benefit:** 75% = $1,036.35	85% = $1,330.85
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:** $1,381.75	**Benefit:** 75% = $1,036.35	85% = $1,330.85
45506	SCAR, of face or neck, not more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her specialty (Anaes. 17708 = 5B + 3T) **Fee:** $171.20	**Benefit:** 75% = $128.40	85% = $145.55
45512	SCAR, of face or neck, more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her specialty (Anaes. 17709 = 5B + 4T) **Fee:** $230.20	**Benefit:** 75% = $172.65	85% = $195.70
45515	SCAR, other than on face or neck, not more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her specialty (Anaes. 17708 = 3B + 5T) **Fee:** $145.20	**Benefit:** 75% = $108.90	85% = $123.45
45518	SCAR, other than on face or neck, more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her speciality (Anaes. 17708 = 3B + 5T) **Fee:** $175.70	**Benefit:** 75% = $131.80	85% = $149.35
45519	EXTENSIVE BURN SCARS OF SKIN (more than 1 percent of body surface area), excision of, for correction of scar contracture (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $334.00	**Benefit:** 75% = $250.50	85% = $283.90
45520	REDUCTION MAMMAPLASTY (unilateral) with surgical repositioning of nipple (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $701.05	**Benefit:** 75% = $525.80	85% = $650.15
45522	REDUCTION MAMMAPLASTY (unilateral) without surgical repositioning of nipple (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $491.85	**Benefit:** 75% = $368.90	85% = $440.95
45524	MAMMAPLASTY, AUGMENTATION, for significant breast asymmetry where the augmentation is limited to 1 breast (Anaes. 17711 = 5B + 6T) (Assist.) *(See para T8.62 of explanatory notes to this Category)* **Fee:** $577.40	**Benefit:** 75% = $433.05	85% = $526.50
45527	MAMMAPLASTY, AUGMENTATION, (unilateral), following mastectomy (Anaes. 17711 = 5B + 6T) (Assist.) *(See para T8.62 of explanatory notes to this Category)* **Fee:** $577.40	**Benefit:** 75% = $433.05	85% = $526.50

45528	MAMMAPLASTY, AUGMENTATION, bilateral, not being a service to which Item 45524 or 45527 applies, ***where it can be demonstrated that surgery is indicated because of disease, trauma or congenital malformation*** (Anaes. 17713 = 5B + 8T) (Assist.) *(See para T8.62 of explanatory notes to this Category)* **Fee:** $866.05	**Benefit:** 75% = $649.55	85% = $815.15
45530	BREAST RECONSTRUCTION (unilateral) using a latissimus dorsi or other large muscle or myocutaneous flap, including repair of secondary skin defect, if required, excluding repair of muscular aponeurotic layer (Anaes. 17721 = 5B + 16T) (Assist.) *(See para T8.63 of explanatory notes to this Category)* **Fee:** $855.90	**Benefit:** 75% = $641.95	85% = $805.00
45533	BREAST RECONSTRUCTION using breast sharing technique (first stage) including breast reduction, transfer of complex skin and breast tissue flap, split skin graft to pedicle of flap or other similar procedure (Anaes. 17716 = 5B + 11T) (Assist.) **Fee:** $969.35	**Benefit:** 75% = $727.05	85% = $918.45
45536	BREAST RECONSTRUCTION using breast sharing technique (second stage) including division of pedicle, insetting of breast flap, with closure of donor site or other similar procedure (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $356.45	**Benefit:** 75% = $267.35	85% = $305.55
45539	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $834.00	**Benefit:** 75% = $625.50	85% = $783.10
45542	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion removal of tissue expansion unit and insertion of permanent prosthesis (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $477.50	**Benefit:** 75% = $358.15	85% = $426.60
45543	BREAST PTOSIS, correction of (unilateral), to match the position of the contralateral breast (Anaes. 17713 = 5B + 8T) (Assist.) *(See para T8.64 of explanatory notes to this Category)* **Fee:** $596.35	**Benefit:** 75% = $447.30	85% = $545.45
45544	BREAST PTOSIS, correction of (unilateral), following pregnancy and lactation, when performed within 6 years of the most recent pregnancy, and where it can be demonstrated that the nipple is inferior to the infra-mammary groove (Anaes. 17713 = 5B + 8T) (Assist.) *(See para T8.64 of explanatory notes to this Category)* **Fee:** $596.35	**Benefit:** 75% = $447.30	85% = $545.45
45545	NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes. 17710 = 5B + 5T) (Assist.) *(See para T8.65 of explanatory notes to this Category)* **Fee:** $484.70	**Benefit:** 75% = $363.55	85% = $433.80
45546	NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple *(See para T8.65 of explanatory notes to this Category)* **Fee:** $154.10	**Benefit:** 75% = $115.60	85% = $131.00
45548	BREAST PROSTHESIS, removal of, as an independent procedure (Anaes. 17708 = 5B + 3T) **Fee:** $215.45	**Benefit:** 75% = $161.60	85% = $183.15
45551	BREAST PROSTHESIS, removal of, with complete excision of fibrous capsule (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $345.40	**Benefit:** 75% = $259.05	85% = $294.50
45552	BREAST PROSTHESIS, removal of, with complete excision of fibrous capsule and replacement of prosthesis (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $497.25	**Benefit:** 75% = $372.95	85% = $446.35
45554	BREAST PROSTHESIS, replacement of, following medical complications (such as rupture, migration of prosthetic material, or capsule formation), where new pocket is formed, including excision of fibrous capsule (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $544.55	**Benefit:** 75% = $408.45	85% = $493.65
45555	SILICONE BREAST PROSTHESIS, removal of and replacement with prosthesis other than silicone gel prosthesis (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $497.25	**Benefit:** 75% = $372.95	85% = $446.35
45560	HAIR TRANSPLANTATION for the treatment of alopecia of congenital or traumatic origin or due to disease, excluding male pattern baldness, not being a service to which another item in this Group applies (Anaes. 17712 = 5B + 7T) **Fee:** $368.80	**Benefit:** 75% = $276.60	85% = $317.90

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:** $855.90	**Benefit:** 75% = $641.95	85% = $805.00
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:** $855.90	**Benefit:** 75% = $641.95	85% = $805.00
45564	FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, principal specialist surgeon (Anaes. 17752 = 10B + 42T) (Assist.) **Fee:** $1,982.40	**Benefit:** 75% = $1,486.80	85% = $1,931.50
45565	FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, conjoint specialist surgeon (Assist.) **Fee:** $1,486.85	**Benefit:** 75% = $1,115.15	85% = $1,435.95
45566	TISSUE EXPANSION not being a service to which item 45539 or 45542 applies insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $834.00	**Benefit:** 75% = $625.50	85% = $783.10
45572	INTRA OPERATIVE TISSUE EXPANSION performed during an operation when combined with a service to which another item in Group T8 applies including expansion injections and excluding treatment of male pattern baldness (Anaes. 17709 = 3B + 6T) **Fee:** $227.15	**Benefit:** 75% = $170.40	85% = $193.10
45575	FACIAL NERVE PARALYSIS, free fascia graft for (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $560.75	**Benefit:** 75% = $420.60	85% = $509.85
45578	FACIAL NERVE PARALYSIS, muscle transfer for (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $649.40	**Benefit:** 75% = $487.05	85% = $598.50
45581	FACIAL NERVE PALSY, excision of tissue for (Anaes. 17709 = 5B + 4T) **Fee:** $215.45	**Benefit:** 75% = $161.60	85% = $183.15
45584	LIPOSUCTION (suction assisted lipolysis) to 1 regional area (thigh, buttock, or similar), for treatment of post-traumatic pseudolipoma (Anaes. 17713 = 5B + 8T) *(See para T8.66 of explanatory notes to this Category)* **Fee:** $491.85	**Benefit:** 75% = $368.90	85% = $440.95

45585	LIPOSUCTION (suction assisted lipolysis) to 1 regional area, not being a service to which item 45584 applies, ***where it can be demonstrated that the treatment is for pathological lipodystrophy of hips, buttocks, thighs and lower legs (including knees), gynaecomastia, lymphoedema or similar conditions*** (Anaes. 17713 = 5B + 8T) *(See para T8.66 of explanatory notes to this Category)* **Fee:** $491.85 **Benefit:** 75% = $368.90 85% = $440.95
45587	MELOPLASTY for correction of facial asymmetry due to soft tissue abnormality where the meloplasty is limited to 1 side of the face (Anaes. 17714 = 5B + 9T) (Assist.) *(See para T8.67 of explanatory notes to this Category)* **Fee:** $693.60 **Benefit:** 75% = $520.20 85% = $642.70
45588	MELOPLASTY, bilateral, not being a service to which Item 45587 applies, ***where it can be demonstrated that surgery is indicated because of disease, trauma or congenital conditions*** *(Anaes. 17717 = 5B + 12T) (Assist.)* *(See para T8.67 of explanatory notes to this Category)* **Fee:** $1,040.40 **Benefit:** 75% = $780.30 85% = $989.50
45590	ORBITAL CAVITY, reconstruction of a wall or floor, with or without foreign implant (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $376.25 **Benefit:** 75% = $282.20 85% = $325.35
45593	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $441.95 **Benefit:** 75% = $331.50 85% = $391.05
45596	MAXILLA, total resection of (Anaes. 17726 = 10B + 16T) (Assist.) **Fee:** $701.05 **Benefit:** 75% = $525.80 85% = $650.15
45597	MAXILLA, total resection of both maxillae (Anaes. 17735 = 10B + 25T) (Assist.) **Fee:** $938.40 **Benefit:** 75% = $703.80 85% = $887.50
45599	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes. 17735 = 10B + 25T) (Assist.) **Fee:** $729.20 **Benefit:** 75% = $546.90 85% = $678.30
45602	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $544.55 **Benefit:** 75% = $408.45 85% = $493.65
45605	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $457.55 **Benefit:** 75% = $343.20 85% = $406.65
45608	MANDIBLE, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Anaes. 17722 = 10B + 12T) (Assist.) **Fee:** $644.05 **Benefit:** 75% = $483.05 85% = $593.15
45611	MANDIBLE, condylectomy (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $368.90 **Benefit:** 75% = $276.70 85% = $318.00
45614	EYELID, WHOLE THICKNESS RECONSTRUCTION OF other than by direct suture only (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $457.55 **Benefit:** 75% = $343.20 85% = $406.65
45617	UPPER EYELID, REDUCTION OF, for skin redundancy obscuring vision (as evidenced by upper eyelid skin resting on lashes on straight ahead gaze), herniation of orbital fat in exophthalmos, facial nerve palsy or posttraumatic scarring, or the restoration of symmetry of contralateral upper eyelid in respect of 1 of these conditions (Anaes. 17708 = 5B + 3T) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $183.00 **Benefit:** 75% = $137.25 85% = $155.55
45620	LOWER EYELID, REDUCTION OF, for herniation of orbital fat in exophthalmos, facial nerve palsy or posttraumatic scarring, or, in respect of 1 of these conditions, the restoration of symmetry of the contralateral lower eyelid (Anaes. 17709 = 5B + 4T) *(See para T8.68 of explanatory notes to this Category)* **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $215.75
45623	PTOSIS of eyelid (unilateral), correction of (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $563.00 **Benefit:** 75% = $422.25 85% = $512.10

45624	PTOSIS of eyelid, correction of, where previous ptosis surgery has been performed on that side (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $729.80	**Benefit:** 75% = $547.35	85% = $678.90
45625	PTOSIS of eyelid, correction of eyelid height by revision of levator sutures within one week of primary repair by levator resection or advancement, performed in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17707 = 5B + 2T) **Fee:** $146.00	**Benefit:** 75% = $109.50	85% = $124.10
45626	ECTROPION OR ENTROPION, correction of (unilateral) (Anaes. 17709 = 5B + 4T) **Fee:** $253.80	**Benefit:** 75% = $190.35	85% = $215.75
45629	SYMBLEPHARON, grafting for (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $368.90	**Benefit:** 75% = $276.70	85% = $318.00
45632	RHINOPLASTY, correction of lateral or alar cartilages (Anaes. 17710 = 5B + 5T) **Fee:** $398.50	**Benefit:** 75% = $298.90	85% = $347.60
45635	RHINOPLASTY, correction of bony vault only (Anaes. 17710 = 5B + 5T) **Fee:** $457.55	**Benefit:** 75% = $343.20	85% = $406.65
45638	RHINOPLASTY, TOTAL, including correction of all bony and cartilaginous elements of the external nose, for correction of post-traumatic deformity or nasal obstruction, or both (Anaes. 17711 = 5B + 6T) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $789.50	**Benefit:** 75% = $592.15	85% = $738.60
45639	RHINOPLASTY, TOTAL, including correction of all bony and cartilaginous elements of the external nose, where it can be demonstrated that there is a need for correction of significant developmental deformity (Anaes. 17711 = 5B + 6T) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $789.50	**Benefit:** 75% = $592.15	85% = $738.60
45641	RHINOPLASTY involving nasal or septal cartilage graft, or nasal bone graft, or nasal bone and nasal cartilage graft (Anaes. 17713 = 5B + 8T) **Fee:** $843.05	**Benefit:** 75% = $632.30	85% = $792.15
45644	RHINOPLASTY involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $996.10	**Benefit:** 75% = $747.10	85% = $945.20
45645	CHOANAL ATRESIA, repair of by puncture and dilatation (Anaes. 17711 = 5B + 6T) **Fee:** $174.10	**Benefit:** 75% = $130.60	85% = $148.00
45646	CHOANAL ATRESIA - correction by open operation with bone removal (Anaes. 17716 = 5B + 11T) (Assist.) **Fee:** $701.05	**Benefit:** 75% = $525.80	85% = $650.15
45647	FACE, contour restoration of 1 region, using autogenous bone or cartilage graft (not being a service to which item 45644 applies) (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $996.10	**Benefit:** 75% = $747.10	85% = $945.20
45650	RHINOPLASTY, secondary revision of (Anaes. 17710 = 5B + 5T) **Fee:** $115.10	**Benefit:** 75% = $86.35	85% = $97.85
45652	RHINOPHYMA, carbon dioxide laser excision-ablation of (Anaes. 17710 = 5B + 5T) **Fee:** $277.45	**Benefit:** 75% = $208.10	85% = $235.85
45653	RHINOPHYMA, shaving of (Anaes. 17710 = 5B + 5T) **Fee:** $277.45	**Benefit:** 75% = $208.10	85% = $235.85
45656	COMPOSITE GRAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $391.05	**Benefit:** 75% = $293.30	85% = $340.15
45659	LOP EAR, BAT EAR OR SIMILAR DEFORMITY, correction of (Anaes. 17709 = 5B + 4T) **Fee:** $405.80	**Benefit:** 75% = $304.35	85% = $354.90

† 45660	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, using multiple costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - performed by a specialist in the practice of his or her specialty (Anaes. 17743 = 13B + 30T) (Assist.) **Fee:** $2,241.25 **Benefit:** 75% = $1,680.95 85% = $2,188.75
† 45661	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, elevation of costal cartilage framework using cartilage previously stored in abdominal wall, including the use of local skin and fascia flaps and full thickness skin graft to cover cartilage (second stage) - performed by a specialist in the practice of his or her specialty (Anaes. 17728 = 10B + 18T) (Assist.) **Fee:** $996.10 **Benefit:** 75% = $747.10 85% = $945.20
45662	CONGENITAL ATRESIA, reconstruction of external auditory canal (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $545.95 **Benefit:** 75% = $409.50 85% = $495.05
45665	LIP, EYELID OR EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures (Anaes. 17707 = 5B + 2T) **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $215.75
45668	VERMILIONECTOMY, by surgical excision (Anaes. 17709 = 5B + 4T) **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $215.75
45669	VERMILIONECTOMY, using carbon dioxide laser excision-ablation (Anaes. 17709 = 5B + 4T) *(See para T8.70 of explanatory notes to this Category)* **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $215.75
45671	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $649.40 **Benefit:** 75% = $487.05 85% = $598.50
45674	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes. 17707 = 5B + 2T) **Fee:** $188.90 **Benefit:** 75% = $141.70 85% = $160.60
45675	MACROCHEILIA or macroglossia, operation for (Anaes. 17716 = 5B + 11T) (Assist.) **Fee:** $376.25 **Benefit:** 75% = $282.20 85% = $325.35
45676	MACROSTOMIA, operation for (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $447.90 **Benefit:** 75% = $335.95 85% = $397.00
45677	CLEFT LIP, unilateral primary repair, 1 stage, without anterior palate repair (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $421.50 **Benefit:** 75% = $316.15 85% = $370.60
45680	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes. 17716 = 7B + 9T) (Assist.) **Fee:** $526.95 **Benefit:** 75% = $395.25 85% = $476.05
45683	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $585.45 **Benefit:** 75% = $439.10 85% = $534.55
45686	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes. 17718 = 7B + 11T) (Assist.) **Fee:** $690.90 **Benefit:** 75% = $518.20 85% = $640.00
45689	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $203.75 **Benefit:** 75% = $152.85 85% = $173.20
45692	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes. 17711 = 6B + 5T) **Fee:** $234.15 **Benefit:** 75% = $175.65 85% = $199.05
45695	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes. 17713 = 6B + 7T) (Assist.) **Fee:** $380.50 **Benefit:** 75% = $285.40 85% = $329.60
45698	CLEFT LIP, primary columella lengthening procedure, bilateral (Anaes. 17711 = 6B + 5T) **Fee:** $357.15 **Benefit:** 75% = $267.90 85% = $306.25
45701	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $644.05 **Benefit:** 75% = $483.05 85% = $593.15
45704	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes. 17708 = 6B + 2T) **Fee:** $234.15 **Benefit:** 75% = $175.65 85% = $199.05

45707	CLEFT PALATE, primary repair (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $608.80 **Benefit:** 75% = $456.60 85% = $557.90
45710	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes. 17714 = 7B + 7T) **Fee:** $380.50 **Benefit:** 75% = $285.40 85% = $329.60
45713	CLEFT PALATE, secondary repair, lengthening procedure (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $433.35 **Benefit:** 75% = $325.05 85% = $382.45
45714	ORO-NASAL FISTULA, plastic closure of, including services to which item 45200, 45203 or 45239 applies (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $608.80 **Benefit:** 75% = $456.60 85% = $557.90
45716	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes. 17711 = 5B + 6T) **Fee:** $608.80 **Benefit:** 75% = $456.60 85% = $557.90
45720	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17718 = 10B + 8T) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $752.70 **Benefit:** 75% = $564.55 85% = $701.80
‡ 45723	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes. 17720 = 10B + 10T) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $848.85 **Benefit:** 75% = $636.65 85% = $797.95
45726	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17725 = 10B + 15T) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $959.25 **Benefit:** 75% = $719.45 85% = $908.35
‡ 45729	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes. 17729 = 10B + 19T) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $1,077.20 **Benefit:** 75% = $807.90 85% = $1,026.30
45731	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17729 = 10B + 19T) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $1,092.05 **Benefit:** 75% = $819.05 85% = $1,041.15
‡ 45732	MANDIBLE OR MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes. 17732 = 10B + 22T) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $1,229.50 **Benefit:** 75% = $922.15 85% = $1,178.60
45735	MANDIBLE AND MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17726 = 10B + 16T) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $1,254.30 **Benefit:** 75% = $940.75 85% = $1,203.40
‡ 45738	MANDIBLE AND MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes. 17732 = 10B + 22T) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $1,410.95 **Benefit:** 75% = $1,058.25 85% = $1,360.05
45741	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17753 = 10B + 43T) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $1,379.80 **Benefit:** 75% = $1,034.85 85% = $1,328.90

‡ 45744	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes. 17758 = 10B + 48T) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $1,551.40	**Benefit:** 75% = $1,163.55	85% = $1,500.50
45747	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty (when performed) and transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17758 = 10B + 48T) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $1,505.30	**Benefit:** 75% = $1,129.00	85% = $1,454.40
‡ 45752	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes. 17771 = 10B + 61T) (Assist.) *(See para T8.71 of explanatory notes to this Category)* **Fee:** $1,686.10	**Benefit:** 75% = $1,264.60	85% = $1,635.20
45753	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III(Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17758 = 10B + 48T) (Assist.) **Fee:** $1,696.20	**Benefit:** 75% = $1,272.15	85% = $1,645.30
‡ 45754	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes. 17764 = 10B + 54T) (Assist.) **Fee:** $2,033.20	**Benefit:** 75% = $1,524.90	85% = $1,982.30
45755	TEMPOROMANDIBULAR MENISCECTOMY (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $286.30	**Benefit:** 75% = $214.75	85% = $243.40
45758	TEMPORO-MANDIBULAR JOINT, arthroplasty (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $512.35	**Benefit:** 75% = $384.30	85% = $461.45
45761	GENIOPLASTY, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17713 = 5B + 8T) (Assist.) *(See para T8.72 of explanatory notes to this Category)* **Fee:** $582.85	**Benefit:** 75% = $437.15	85% = $531.95
45767	HYPERTELORISM, correction of, intracranial (Anaes. 17760 = 12B + 48T) (Assist.) **Fee:** $1,955.40	**Benefit:** 75% = $1,466.55	85% = $1,904.50
45770	HYPERTELORISM, correction of, subcranial (Anaes. 17730 = 10B + 20T) (Assist.) **Fee:** $1,497.85	**Benefit:** 75% = $1,123.40	85% = $1,446.95
45773	TREACHER COLLINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone grafts (Anaes. 17735 = 10B + 25T) (Assist.) **Fee:** $1,365.10	**Benefit:** 75% = $1,023.85	85% = $1,314.20
45776	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, intracranial (Anaes. 17745 = 12B + 33T) (Assist.) **Fee:** $1,365.10	**Benefit:** 75% = $1,023.85	85% = $1,314.20
45779	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes. 17725 = 12B + 13T) (Assist.) **Fee:** $1,003.55	**Benefit:** 75% = $752.70	85% = $952.65
45782	FRONTOORBITAL ADVANCEMENT, UNILATERAL (Anaes. 17726 = 12B + 14T) (Assist.) **Fee:** $767.40	**Benefit:** 75% = $575.55	85% = $716.50
45785	CRANIAL VAULT RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar condition (bilateral frontoorbital advancement) (Anaes. 17751 = 12B + 39T) (Assist.) **Fee:** $1,298.65	**Benefit:** 75% = $974.00	85% = $1,247.75

45788	GLENOID FOSSA, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, (Obwegeser technique) (Anaes. 17724 = 10B + 14T) (Assist.) **Fee:** $1,283.85 **Benefit:** 75% = $962.90 85% = $1,232.95
45791	ABSENT CONDYLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF, not including harvesting of graft material (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $693.60 **Benefit:** 75% = $520.20 85% = $642.70
45794	OSSEO-INTEGRATION PROCEDURE - extra-oral, implantation of titanium fixture (Anaes. 17713 = 5B + 8T) **Fee:** $392.30 **Benefit:** 75% = $294.25 85% = $341.40
45797	OSSEO-INTEGRATION PROCEDURE, fixation of transcutaneous abutment (Anaes. 17709 = 5B + 4T) **Fee:** $145.20 **Benefit:** 75% = $108.90 85% = $123.45
	SUBGROUP 14 - HAND SURGERY
	Note: Items 46300 to 46534 are restricted to surgery on the hand/s.
46300	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrodesis of (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $263.45 **Benefit:** 75% = $197.60 85% = $223.95
46303	CARPOMETACARPAL JOINT, arthrodesis of (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $292.80 **Benefit:** 75% = $219.60 85% = $248.90
46306	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, interposition arthroplasty of and including tendon transfers or realignment on the 1 ray (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $409.90 **Benefit:** 75% = $307.45 85% = $359.00
46307	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT - volar plate arthroplasty for traumatic deformity including tendon transfers or realignment on the 1 ray (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $409.90 **Benefit:** 75% = $307.45 85% = $359.00
46309	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 1 joint (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $409.90 **Benefit:** 75% = $307.45 85% = $359.00
46312	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 2 joints (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $527.05 **Benefit:** 75% = $395.30 85% = $476.15
46315	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 3 joints (Anaes. 17712 = 3B + 9T) (Assist.) **Fee:** $702.65 **Benefit:** 75% = $527.00 85% = $651.75
46318	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 4 joints (Anaes. 17713 = 3B + 10T) (Assist.) **Fee:** $878.40 **Benefit:** 75% = $658.80 85% = $827.50
46321	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 5 or more joints (Anaes. 17715 = 3B + 12T) (Assist.) **Fee:** $1,054.10 **Benefit:** 75% = $790.60 85% = $1,003.20
46324	CARPAL BONE REPLACEMENT ARTHROPLASTY including associated tendon transfer or realignment when performed (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $628.60 **Benefit:** 75% = $471.45 85% = $577.70
46325	CARPAL BONE REPLACEMENT OR RESECTION ARTHROPLASTY using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed (Anaes. 17713 = 3B + 10T) (Assist.) **Fee:** $655.90 **Benefit:** 75% = $491.95 85% = $605.00
46327	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of (Anaes. 17706 = 3B + 3T) **Fee:** $158.20 **Benefit:** 75% = $118.65 85% = $134.50
46330	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of, with ligamentous or capsular repair (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $269.45 **Benefit:** 75% = $202.10 85% = $229.05

46333	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of, using free tissue graft or implant (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $439.15	**Benefit:** 75% = $329.40	85% = $388.25
46336	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, capsulectomy or debridement of, not being a service associated with any procedure related to that joint (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $205.00	**Benefit:** 75% = $153.75	85% = $174.25
46339	EXTENSOR TENDONS or FLEXOR TENDONS of hand or wrist, synovectomy of (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $363.00	**Benefit:** 75% = $272.25	85% = $312.10
46342	DISTAL RADIOULNAR JOINT or CARPOMETACARPAL JOINT OR JOINTS, synovectomy of (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $363.00	**Benefit:** 75% = $272.25	85% = $312.10
46345	DISTAL RADIOULNAR JOINT, reconstruction or stabilisation of, including fusion, or ligamentous arthroplasty and excision of distal ulna, when performed (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $439.15	**Benefit:** 75% = $329.40	85% = $388.25
46348	DIGIT, synovectomy of flexor tendon or tendons - 1 digit (Anaes. 17706 = 3B + 3T) **Fee:** $190.30	**Benefit:** 75% = $142.75	85% = $161.80
46351	DIGIT, synovectomy of flexor tendon or tendons - 2 digits (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $284.00	**Benefit:** 75% = $213.00	85% = $241.40
46354	DIGIT, synovectomy of flexor tendon or tendons - 3 digits (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $380.60	**Benefit:** 75% = $285.45	85% = $329.70
46357	DIGIT, synovectomy of flexor tendon or tendons - 4 digits (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $474.30	**Benefit:** 75% = $355.75	85% = $423.40
46360	DIGIT, synovectomy of flexor tendon or tendons - 5 digits (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $570.90	**Benefit:** 75% = $428.20	85% = $520.00
46363	TENDON SHEATH OF HAND OR WRIST, open operation on, for STENOSING TENOVAGINITIS (Anaes. 17705 = 3B + 2T) **Fee:** $164.00	**Benefit:** 75% = $123.00	85% = $139.40
46366	DUPUYTREN'S CONTRACTURE, subcutaneous fasciotomy for - each band (Anaes. 17706 = 3B + 3T) **Fee:** $99.55	**Benefit:** 75% = $74.70	85% = $84.65
46369	DUPUYTREN'S CONTRACTURE, palmar fasciectomy for - 1 hand (Anaes. 17707 = 3B + 4T) **Fee:** $164.00	**Benefit:** 75% = $123.00	85% = $139.40
46372	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $333.15	**Benefit:** 75% = $249.90	85% = $283.20
46375	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - 1 hand (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $395.30	**Benefit:** 75% = $296.50	85% = $344.40
46378	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - 1 hand (Anaes. 17713 = 3B + 10T) (Assist.) **Fee:** $527.05	**Benefit:** 75% = $395.30	85% = $476.15
46381	INTER-PHALANGEAL JOINT, joint capsule release when performed in conjunction with operation for Dupuytren's Contracture - each procedure (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $234.20	**Benefit:** 75% = $175.65	85% = $199.10
46384	Z PLASTY (or similar local flap procedure) when performed in conjunction with operation for Dupuytren's Contracture - 1 such procedure (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $234.20	**Benefit:** 75% = $175.65	85% = $199.10
46387	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - operation for recurrence in that ray (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $483.10	**Benefit:** 75% = $362.35	85% = $432.20

46390	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - operation for recurrence in those rays (Anaes. 17712 = 3B + 9T) (Assist.) **Fee:** $644.20 **Benefit:** 75% = $483.15 85% = $593.30
46393	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - operation for recurrence in those rays (Anaes. 17714 = 3B + 11T) (Assist.) **Fee:** $746.60 **Benefit:** 75% = $559.95 85% = $695.70
46396	PHALANX OR METACARPAL OF THE HAND, osteotomy or osteectomy of (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $256.60 **Benefit:** 75% = $192.45 85% = $218.15
46399	PHALANX OR METACARPAL OF THE HAND, osteotomy of, with internal fixation (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $403.15 **Benefit:** 75% = $302.40 85% = $352.25
46402	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), including obtaining of graft material (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $403.15 **Benefit:** 75% = $302.40 85% = $352.25
46405	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), involving internal fixation and including obtaining of graft material (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $491.95 **Benefit:** 75% = $369.00 85% = $441.05
46408	TENDON, reconstruction of, by tendon graft (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $538.75 **Benefit:** 75% = $404.10 85% = $487.85
46411	FLEXOR TENDON PULLEY, reconstruction of, by graft (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $316.15 **Benefit:** 75% = $237.15 85% = $268.75
46414	ARTIFICIAL TENDON PROSTHESIS, INSERTION OF, in preparation for tendon grafting (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $409.80 **Benefit:** 75% = $307.35 85% = $358.90
46417	TENDON transfer for restoration of hand function, each transfer (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $380.60 **Benefit:** 75% = $285.45 85% = $329.70
46420	EXTENSOR TENDON OF HAND OR WRIST, primary repair of, each tendon (Anaes. 17707 = 3B + 4T) **Fee:** $159.30 **Benefit:** 75% = $119.50 85% = $135.45
46423	EXTENSOR TENDON OF HAND OR WRIST, secondary repair of, each tendon (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $254.70 **Benefit:** 75% = $191.05 85% = $216.50
46426	FLEXOR TENDON OF HAND OR WRIST, primary repair of, proximal to A1 pulley, each tendon (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $263.45 **Benefit:** 75% = $197.60 85% = $223.95
46429	FLEXOR TENDON OF HAND OR WRIST, secondary repair of, proximal to A1 pulley, each tendon (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $322.05 **Benefit:** 75% = $241.55 85% = $273.75
46432	FLEXOR TENDON OF HAND, primary repair of, distal to A1 pulley, each tendon (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $300.50
46435	FLEXOR TENDON OF HAND, secondary repair of, distal to A1 pulley, each tendon (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $409.90 **Benefit:** 75% = $307.45 85% = $359.00
46438	MALLET FINGER, closed pin fixation of (Anaes. 17706 = 3B + 3T) **Fee:** $105.40 **Benefit:** 75% = $79.05 85% = $89.60
46441	MALLET FINGER, open repair of, including pin fixation when performed (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $254.70 **Benefit:** 75% = $191.05 85% = $216.50
46442	MALLET FINGER with intra articular fracture involving more than one third of base of terminal phalanx - open reduction (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $218.65 **Benefit:** 75% = $164.00 85% = $185.90
46444	BOUTONNIERE DEFORMITY without joint contracture, reconstruction of (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $380.60 **Benefit:** 75% = $285.45 85% = $329.70

46447	BOUTONNIERE DEFORMITY with joint contracture, reconstruction of (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $474.30 **Benefit:** 75% = $355.75 85% = $423.40
46450	EXTENSOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes. 17708 = 3B + 5T) **Fee:** $175.70 **Benefit:** 75% = $131.80 85% = $149.35
46453	FLEXOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $292.80 **Benefit:** 75% = $219.60 85% = $248.90
46456	FINGER, percutaneous tenotomy of (Anaes. 17704 = 3B + 1T) **Fee:** $76.10 **Benefit:** 75% = $57.10 85% = $64.70
46459	OPERATION for OSTEOMYELITIS on distal phalanx (Anaes. 17706 = 3B + 3T) **Fee:** $146.45 **Benefit:** 75% = $109.85 85% = $124.50
46462	OPERATION for OSTEOMYELITIS on middle or proximal phalanx, metacarpal or carpus (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $234.20 **Benefit:** 75% = $175.65 85% = $199.10
46464	AMPUTATION of a supernumerary complete digit (Anaes. 17706 = 3B + 3T) **Fee:** $175.70 **Benefit:** 75% = $131.80 85% = $149.35
46465	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes. 17705 = 3B + 2T) **Fee:** $175.70 **Benefit:** 75% = $131.80 85% = $149.35
46468	AMPUTATION of 2 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $307.45 **Benefit:** 75% = $230.60 85% = $261.35
46471	AMPUTATION of 3 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $439.15 **Benefit:** 75% = $329.40 85% = $388.25
46474	AMPUTATION of 4 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $570.90 **Benefit:** 75% = $428.20 85% = $520.00
46477	AMPUTATION of 5 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $702.65 **Benefit:** 75% = $527.00 85% = $651.75
46480	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover, including metacarpal (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $292.80 **Benefit:** 75% = $219.60 85% = $248.90
46483	REVISION of AMPUTATION STUMP to provide adequate soft tissue cover (Anaes. 17705 = 3B + 2T) (Assist.) **Fee:** $234.20 **Benefit:** 75% = $175.65 85% = $199.10
46486	NAIL BED, accurate reconstruction of nail bed laceration using magnification, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17708 = 3B + 5T) **Fee:** $175.70 **Benefit:** 75% = $131.80 85% = $149.35
46489	NAIL BED, secondary exploration and accurate repair of nail bed deformity using magnification, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $205.00 **Benefit:** 75% = $153.75 85% = $174.25
46492	CONTRACTURE OF DIGITS OF HAND, flexor or extensor, correction of, involving tissues deeper than skin and subcutaneous tissue (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $281.10 **Benefit:** 75% = $210.85 85% = $238.95
46494	GANGLION OF HAND, excision of, not being a service associated with a service to which another item in this Group applies (Anaes. 17706 = 4B + 2T) **Fee:** $171.20 **Benefit:** 75% = $128.40 85% = $145.55
46495	GANGLION OR MUCOUS CYST OF DISTAL DIGIT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes. 17705 = 3B + 2T) **Fee:** $158.20 **Benefit:** 75% = $118.65 85% = $134.50

46498	GANGLION OF FLEXOR TENDON SHEATH, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes. 17705 = 3B + 2T) **Fee:** $171.20	**Benefit:** 75% = $128.40	85% = $145.55
46500	GANGLION OF DORSAL WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $205.00	**Benefit:** 75% = $153.75	85% = $174.25
46501	GANGLION OF VOLAR WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $256.25	**Benefit:** 75% = $192.20	85% = $217.85
46502	RECURRENT GANGLION OF DORSAL WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $235.80	**Benefit:** 75% = $176.85	85% = $200.45
46503	RECURRENT GANGLION OF VOLAR WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $294.60	**Benefit:** 75% = $220.95	85% = $250.45
46504	NEUROVASCULAR ISLAND FLAP, for pulp innervation (Anaes. 17719 = 8B + 11T) (Assist.) **Fee:** $860.80	**Benefit:** 75% = $645.60	85% = $809.90
46507	DIGIT OR RAY, transposition or transfer of, on vascular pedicle, complete procedure (Anaes. 17722 = 8B + 14T) (Assist.) **Fee:** $1,001.30	**Benefit:** 75% = $751.00	85% = $950.40
46510	MACRODACTYLY, surgical reduction of enlarged elements - each digit (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $273.30	**Benefit:** 75% = $205.00	85% = $232.35
46513	DIGITAL NAIL OF FINGER OR THUMB, removal of, not being a service to which item 46516 applies (Anaes. 17704 = 3B + 1T) **Fee:** $44.00	**Benefit:** 75% = $33.00	85% = $37.40
46516	DIGITAL NAIL OF FINGER OR THUMB, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17704 = 3B + 1T) **Fee:** $87.90	**Benefit:** 75% = $65.95	85% = $74.75
46519	MIDDLE PALMAR, THENAR OR HYPOTHENAR SPACES OF HAND, drainage of (excluding aftercare) (Anaes. 17705 = 3B + 2T) **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50
46522	FLEXOR TENDON SHEATH OF FINGER OR THUMB, open operation and drainage for infection (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $327.90	**Benefit:** 75% = $245.95	85% = $278.75
46525	PULP SPACE INFECTION, PARONYCHIA OF HAND, incision for, when performed in an operating theatre of a hospital or approved day-hospital facility, not being a service to which another item in this Group applies (excluding after-care) (Anaes. 17704 = 3B + 1T) **Fee:** $44.00	**Benefit:** 75% = $33.00	85% = $37.40
46528	INGROWING NAIL OF FINGER OR THUMB, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed (Anaes. 17705 = 3B + 2T) **Fee:** $131.95	**Benefit:** 75% = $99.00	85% = $112.20
46531	INGROWING NAIL OF FINGER OR THUMB, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes. 17705 = 3B + 2T) **Fee:** $66.25	**Benefit:** 75% = $49.70	85% = $56.35
46534	NAIL PLATE INJURY OR DEFORMITY, radical excision of nail germinal matrix (Anaes. 17706 = 3B + 3T) **Fee:** $183.30	**Benefit:** 75% = $137.50	85% = $155.85

SUBGROUP 15 - ORTHOPAEDIC

TREATMENT OF DISLOCATIONS

(Note: See paragraph T8.73 of explanatory notes to this Category)

47000	MANDIBLE, treatment of dislocation of, by closed reduction (Anaes. 17706 = 5B + 1T) **Fee:** $55.00	**Benefit:** 75% = $41.25	85% = $46.75
47003	CLAVICLE, treatment of dislocation of, by closed reduction (Anaes. 17706 = 4B + 2T) **Fee:** $65.95	**Benefit:** 75% = $49.50	85% = $56.10
47006	CLAVICLE, treatment of dislocation of, by open reduction (Anaes. 17709 = 5B + 4T) **Fee:** $132.60	**Benefit:** 75% = $99.45	85% = $112.75
47009	SHOULDER, treatment of dislocation of, requiring general anaesthesia, not being a service to which item 47012 applies (Anaes. 17706 = 4B + 2T) **Fee:** $131.95	**Benefit:** 75% = $99.00	85% = $112.20
47012	SHOULDER, treatment of dislocation of, requiring general anaesthesia, open reduction (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $263.90	**Benefit:** 75% = $197.95	85% = $224.35
47015	SHOULDER, treatment of dislocation of, not requiring general anaesthesia **Fee:** $65.95	**Benefit:** 75% = $49.50	85% = $56.10
47018	ELBOW, treatment of dislocation of, by closed reduction (Anaes. 17705 = 3B + 2T) **Fee:** $153.85	**Benefit:** 75% = $115.40	85% = $130.80
47021	ELBOW, treatment of dislocation of, by open reduction (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $205.25	**Benefit:** 75% = $153.95	85% = $174.50
47024	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not being a service associated with fracture or dislocation in the same region (Anaes. 17705 = 3B + 2T) **Fee:** $153.85	**Benefit:** 75% = $115.40	85% = $130.80
47027	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by open reduction, not being a service associated with fracture or dislocation in the same region (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $205.25	**Benefit:** 75% = $153.95	85% = $174.50
47030	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by closed reduction (Anaes. 17705 = 3B + 2T) **Fee:** $153.85	**Benefit:** 75% = $115.40	85% = $130.80
47033	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by open reduction (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $205.25	**Benefit:** 75% = $153.95	85% = $174.50
47036	INTERPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes. 17704 = 3B + 1T) **Fee:** $65.95	**Benefit:** 75% = $49.50	85% = $56.10
47039	INTERPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes. 17706 = 3B + 3T) **Fee:** $87.90	**Benefit:** 75% = $65.95	85% = $74.75
47042	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes. 17704 = 3B + 1T) **Fee:** $87.90	**Benefit:** 75% = $65.95	85% = $74.75
47045	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes. 17706 = 3B + 3T) **Fee:** $117.30	**Benefit:** 75% = $88.00	85% = $99.75
47048	HIP, treatment of dislocation of, by closed reduction (Anaes. 17706 = 4B + 2T) **Fee:** $252.90	**Benefit:** 75% = $189.70	85% = $215.00
47051	HIP, treatment of dislocation of, by open reduction (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $337.10	**Benefit:** 75% = $252.85	85% = $286.55
47054	KNEE, treatment of dislocation of, by closed reduction (Anaes. 17705 = 3B + 2T) (Assist.) **Fee:** $252.90	**Benefit:** 75% = $189.70	85% = $215.00

47057	PATELLA, treatment of dislocation of, by closed reduction (Anaes. 17704 = 3B + 1T) **Fee:** $98.90	**Benefit:** 75% = $74.20	85% = $84.10
47060	PATELLA, treatment of dislocation of, by open reduction (Anaes. 17708 = 4B + 4T) **Fee:** $131.95	**Benefit:** 75% = $99.00	85% = $112.20
47063	ANKLE or TARSUS, treatment of dislocation of, by closed reduction (Anaes. 17705 = 3B + 2T) **Fee:** $197.90	**Benefit:** 75% = $148.45	85% = $168.25
47066	ANKLE or TARSUS, treatment of dislocation of, by open reduction (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $263.90	**Benefit:** 75% = $197.95	85% = $224.35
47069	TOE, treatment of dislocation of, by closed reduction (Anaes. 17704 = 3B + 1T) **Fee:** $55.00	**Benefit:** 75% = $41.25	85% = $46.75
47072	TOE, treatment of dislocation of, by open reduction (Anaes. 17706 = 3B + 3T) **Fee:** $73.20	**Benefit:** 75% = $54.90	85% = $62.25
	TREATMENT OF FRACTURES *(Note: See paragraph T8.73 of explanatory notes to this Category)*		
47300	DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by closed reduction, including percutaneous fixation where used (Anaes. 17705 = 3B + 2T) **Fee:** $65.95	**Benefit:** 75% = $49.50	85% = $56.10
47303	DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by closed reduction (Anaes. 17705 = 3B + 2T) **Fee:** $76.95	**Benefit:** 75% = $57.75	85% = $65.45
47306	DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by open reduction (Anaes. 17707 = 3B + 4T) **Fee:** $87.90	**Benefit:** 75% = $65.95	85% = $74.75
47309	DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by open reduction (Anaes. 17707 = 3B + 4T) **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50
47312	MIDDLE PHALANX of FINGER, treatment of fracture of, by closed reduction (Anaes. 17705 = 3B + 2T) **Fee:** $98.90	**Benefit:** 75% = $74.20	85% = $84.10
47315	MIDDLE PHALANX of FINGER, treatment of intra-articular fracture of, by closed reduction (Anaes. 17705 = 3B + 2T) **Fee:** $113.60	**Benefit:** 75% = $85.20	85% = $96.60
47318	MIDDLE PHALANX OF FINGER, treatment of fracture of, by open reduction (Anaes. 17707 = 3B + 4T) **Fee:** $131.95	**Benefit:** 75% = $99.00	85% = $112.20
47321	MIDDLE PHALANX OF FINGER, treatment of intra-articular fracture of, by open reduction (Anaes. 17707 = 3B + 4T) **Fee:** $164.85	**Benefit:** 75% = $123.65	85% = $140.15
47324	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by closed reduction (Anaes. 17705 = 3B + 2T) **Fee:** $131.95	**Benefit:** 75% = $99.00	85% = $112.20
47327	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by closed reduction (Anaes. 17705 = 3B + 2T) **Fee:** $153.85	**Benefit:** 75% = $115.40	85% = $130.80
47330	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by open reduction (Anaes. 17707 = 3B + 4T) **Fee:** $175.95	**Benefit:** 75% = $132.00	85% = $149.60
47333	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by open operation (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $219.80	**Benefit:** 75% = $164.85	85% = $186.85
47336	METACARPAL, treatment of fracture of, by closed reduction (Anaes. 17705 = 3B + 2T) **Fee:** $131.95	**Benefit:** 75% = $99.00	85% = $112.20

47339	METACARPAL, treatment of intra-articular fracture of, by closed reduction (Anaes. 17705 = 3B + 2T) **Fee:** $153.85 **Benefit:** 75% = $115.40 85% = $130.80
47342	METACARPAL, treatment of fracture of, by open reduction (Anaes. 17707 = 3B + 4T) **Fee:** $175.95 **Benefit:** 75% = $132.00 85% = $149.60
47345	METACARPAL, treatment of intra-articular fracture of, by open reduction (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $219.80 **Benefit:** 75% = $164.85 85% = $186.85
47348	CARPUS (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies (Anaes. 17705 = 3B + 2T) **Fee:** $73.20 **Benefit:** 75% = $54.90 85% = $62.25
47351	CARPUS (excluding scaphoid), treatment of fracture of, by open reduction (Anaes. 17709 = 3B + 6T) **Fee:** $183.30 **Benefit:** 75% = $137.50 85% = $155.85
47354	CARPAL SCAPHOID, treatment of fracture of, not being a service to which item 47357 applies (Anaes. 17705 = 3B + 2T) **Fee:** $131.95 **Benefit:** 75% = $99.00 85% = $112.20
47357	CARPAL SCAPHOID, treatment of fracture of, by open reduction (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $293.20 **Benefit:** 75% = $219.90 85% = $249.25
47360	RADIUS OR ULNA, distal end of, treatment of fracture of, by cast immobilisation, not being a service to which item 47363 or 47366 applies (Anaes. 17705 = 3B + 2T) **Fee:** $102.65 **Benefit:** 75% = $77.00 85% = $87.30
47363	RADIUS OR ULNA, distal end of, treatment of fracture of, by closed reduction (Anaes. 17705 = 3B + 2T) **Fee:** $153.85 **Benefit:** 75% = $115.40 85% = $130.80
47366	RADIUS OR ULNA, distal end of, treatment of fracture of, by open reduction (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $205.25 **Benefit:** 75% = $153.95 85% = $174.50
47369	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by cast immobilisation, not being a service to which item 47372 or 47375 applies (Anaes. 17705 = 3B + 2T) **Fee:** $131.95 **Benefit:** 75% = $99.00 85% = $112.20
47372	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes. 17705 = 3B + 2T) **Fee:** $219.80 **Benefit:** 75% = $164.85 85% = $186.85
47375	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $293.20 **Benefit:** 75% = $219.90 85% = $249.25
47378	RADIUS OR ULNA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47381, 47384, 47385 or 47386 applies (Anaes. 17705 = 3B + 2T) **Fee:** $131.95 **Benefit:** 75% = $99.00 85% = $112.20
47381	RADIUS OR ULNA, shaft of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17705 = 3B + 2T) **Fee:** $197.90 **Benefit:** 75% = $148.45 85% = $168.25
47384	RADIUS OR ULNA, shaft of, treatment of fracture of, by open reduction (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $263.90 **Benefit:** 75% = $197.95 85% = $224.35
47385	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $227.20 **Benefit:** 75% = $170.40 85% = $193.15
47386	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by open reduction or internal fixation (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $366.45 **Benefit:** 75% = $274.85 85% = $315.55
47387	RADIUS AND ULNA, shafts of, treatment of fracture of, by cast immobilisation, not being a service to which item 47390 or 47393 applies (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $212.50 **Benefit:** 75% = $159.40 85% = $180.65

47390	RADIUS AND ULNA, shafts of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17706 = 3B + 3T) **Fee:** $318.85	**Benefit:** 75% = $239.15	85% = $271.05
47393	RADIUS AND ULNA, shafts of, treatment of fracture of, by open reduction (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $425.10	**Benefit:** 75% = $318.85	85% = $374.20
47396	OLECRANON, treatment of fracture of, not being a service to which item 47399 applies (Anaes. 17706 = 3B + 3T) **Fee:** $146.60	**Benefit:** 75% = $109.95	85% = $124.65
47399	OLECRANON, treatment of fracture of, by open reduction (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $293.20	**Benefit:** 75% = $219.90	85% = $249.25
47402	OLECRANON, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $219.80	**Benefit:** 75% = $164.85	85% = $186.85
47405	RADIUS, treatment of fracture of head or neck of, closed management of (Anaes. 17706 = 3B + 3T) **Fee:** $146.60	**Benefit:** 75% = $109.95	85% = $124.65
47408	RADIUS, treatment of fracture of head or neck of, open management of, including internal fixation and excision where performed (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $293.20	**Benefit:** 75% = $219.90	85% = $249.25
47411	HUMERUS, treatment of fracture of tuberosity of, not being a service to which item 47417 applies (Anaes. 17705 = 3B + 2T) **Fee:** $87.90	**Benefit:** 75% = $65.95	85% = $74.75
47414	HUMERUS, treatment of fracture of tuberosity of, by open reduction (Anaes. 17710 = 4B + 6T) **Fee:** $175.95	**Benefit:** 75% = $132.00	85% = $149.60
47417	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed reduction (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $205.25	**Benefit:** 75% = $153.95	85% = $174.50
47420	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by open reduction (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $403.15	**Benefit:** 75% = $302.40	85% = $352.25
47423	HUMERUS, proximal, treatment of fracture of, not being a service to which item 47426, 47429 or 47432 applies (Anaes. 17706 = 3B + 3T) **Fee:** $168.50	**Benefit:** 75% = $126.40	85% = $143.25
47426	HUMERUS, proximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17706 = 3B + 3T) **Fee:** $252.90	**Benefit:** 75% = $189.70	85% = $215.00
47429	HUMERUS, proximal, treatment of fracture of, by open reduction (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $337.10	**Benefit:** 75% = $252.85	85% = $286.55
47432	HUMERUS, proximal, treatment of intra-articular fracture of, by open reduction (Anaes. 17714 = 4B + 10T) (Assist.) **Fee:** $421.45	**Benefit:** 75% = $316.10	85% = $370.55
47435	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $322.50	**Benefit:** 75% = $241.90	85% = $274.15
47438	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $513.15	**Benefit:** 75% = $384.90	85% = $462.25
47441	HUMERUS, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $641.35	**Benefit:** 75% = $481.05	85% = $590.45
47444	HUMERUS, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies (Anaes. 17706 = 3B + 3T) **Fee:** $175.95	**Benefit:** 75% = $132.00	85% = $149.60

47447	HUMERUS, shaft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17706 = 3B + 3T) **Fee:** $263.90 **Benefit:** 75% = $197.95 85% = $224.35
47450	HUMERUS, shaft of, treatment of fracture of, by internal or external fixation (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $351.80 **Benefit:** 75% = $263.85 85% = $300.90
47451	HUMERUS, shaft of, treatment of fracture of, by intramedullary fixation (Anaes. 17714 = 4B + 10T) (Assist.) **Fee:** $424.15 **Benefit:** 75% = $318.15 85% = $373.25
47453	HUMERUS, distal, (supracondylar or condylar), treatment of fracture of, not being a service to which item 47456 or 47459 applies (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $205.25 **Benefit:** 75% = $153.95 85% = $174.50
47456	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17706 = 3B + 3T) **Fee:** $307.95 **Benefit:** 75% = $231.00 85% = $261.80
47459	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $410.45 **Benefit:** 75% = $307.85 85% = $359.55
47462	CLAVICLE, treatment of fracture of, not being a service to which item 47465 applies (Anaes. 17706 = 4B + 2T) **Fee:** $87.90 **Benefit:** 75% = $65.95 85% = $74.75
47465	CLAVICLE, treatment of fracture of, by open reduction (Anaes. 17710 = 5B + 5T) **Fee:** $175.95 **Benefit:** 75% = $132.00 85% = $149.60
47466	STERNUM, treatment of fracture of, not being a service to which item 47467 applies (Anaes. 17707 = 5B + 2T) **Fee:** $87.90 **Benefit:** 75% = $65.95 85% = $74.75
47467	STERNUM, treatment of fracture of, by open reduction (Anaes. 17711 = 5B + 6T) **Fee:** $175.95 **Benefit:** 75% = $132.00 85% = $149.60
47468	SCAPULA, neck or glenoid region of, treatment of fracture of, by open reduction (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $337.10 **Benefit:** 75% = $252.85 85% = $286.55
47471	RIBS (1 or more), treatment of fracture of - each attendance **Fee:** $33.40 **Benefit:** 75% = $25.05 85% = $28.40
47474	PELVIC RING, treatment of fracture of, not involving disruption of pelvic ring or acetabulum **Fee:** $146.60 **Benefit:** 75% = $109.95 85% = $124.65
47477	PELVIC RING, treatment of fracture of, with disruption of pelvic ring or acetabulum **Fee:** $183.30 **Benefit:** 75% = $137.50 85% = $155.85
47480	PELVIC RING, treatment of fracture of, requiring traction (Anaes. 17708 = 6B + 2T) (Assist.) **Fee:** $366.45 **Benefit:** 75% = $274.85 85% = $315.55
47483	PELVIC RING, treatment of fracture of, requiring control by external fixation (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $439.75 **Benefit:** 75% = $329.85 85% = $388.85
47486	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of anterior segment, including diastasis of pubic symphysis (Anaes. 17722 = 8B + 14T) (Assist.) **Fee:** $732.95 **Benefit:** 75% = $549.75 85% = $682.05
47489	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of posterior segment (including sacro-iliac joint), with or without fixation of anterior segment (Anaes. 17726 = 8B + 18T) (Assist.) **Fee:** $1,099.45 **Benefit:** 75% = $824.60 85% = $1,048.55
47492	ACETABULUM, treatment of fracture of, and associated dislocation of hip (Anaes. 17708 = 6B + 2T) **Fee:** $183.30 **Benefit:** 75% = $137.50 85% = $155.85
47495	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring traction (Anaes. 17709 = 6B + 3T) (Assist.) **Fee:** $366.45 **Benefit:** 75% = $274.85 85% = $315.55

47498	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, with or without traction (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $549.70	**Benefit:** 75% = $412.30	85% = $498.80
47501	ACETABULUM, treatment of single column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair (Anaes. 17720 = 6B + 14T) (Assist.) **Fee:** $732.95	**Benefit:** 75% = $549.75	85% = $682.05
47504	ACETABULUM, treatment of T-shape fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair (Anaes. 17724 = 6B + 18T) (Assist.) **Fee:** $1,099.45	**Benefit:** 75% = $824.60	85% = $1,048.55
47507	ACETABULUM, treatment of transverse fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair (Anaes. 17724 = 6B + 18T) (Assist.) **Fee:** $1,099.45	**Benefit:** 75% = $824.60	85% = $1,048.55
47510	ACETABULUM, treatment of double column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair (Anaes. 17724 = 6B + 18T) (Assist.) **Fee:** $1,099.45	**Benefit:** 75% = $824.60	85% = $1,048.55
47513	SACRO-ILIAC JOINT DISRUPTION, treatment of, requiring internal fixation, being a service associated with a service to which items 47501 to 47510 apply (Anaes. 17718 = 8B + 10T) (Assist.) **Fee:** $293.20	**Benefit:** 75% = $219.90	85% = $249.25
47516	FEMUR, treatment of fracture of, by closed reduction or traction (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $337.10	**Benefit:** 75% = $252.85	85% = $286.55
47519	FEMUR, treatment of trochanteric or subcapital fracture of, by internal fixation (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $674.35	**Benefit:** 75% = $505.80	85% = $623.45
47522	FEMUR, treatment of subcapital fracture of, by hemi-arthroplasty (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $586.40	**Benefit:** 75% = $439.80	85% = $535.50
47525	FEMUR, treatment of fracture of, for slipped capital femoral epiphysis (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $674.35	**Benefit:** 75% = $505.80	85% = $623.45
47528	FEMUR, treatment of fracture of, by internal fixation or external fixation (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $586.40	**Benefit:** 75% = $439.80	85% = $535.50
47531	FEMUR, treatment of fracture of shaft, by intramedullary fixation and cross fixation (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $747.60	**Benefit:** 75% = $560.70	85% = $696.70
47534	FEMUR, condylar region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring internal fixation, with or without internal fixation of 1 or more osteochondral fragments (Anaes. 17717 = 5B + 12T) (Assist.) **Fee:** $842.90	**Benefit:** 75% = $632.20	85% = $792.00
47537	FEMUR, condylar region of, treatment of fracture of, requiring internal fixation of 1 or more osteochondral fragments, not being a service associated with a service to which item 47534 applies (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $337.10	**Benefit:** 75% = $252.85	85% = $286.55
47540	HIP SPICA OR SHOULDER SPICA, application of, as an independent procedure (Anaes. 17708 = 4B + 4T) **Fee:** $168.50	**Benefit:** 75% = $126.40	85% = $143.25
47543	TIBIA, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies (Anaes. 17706 = 3B + 3T) **Fee:** $175.95	**Benefit:** 75% = $132.00	85% = $149.60
47546	TIBIA, plateau of, treatment of medial or lateral fracture of, by closed reduction (Anaes. 17706 = 3B + 3T) **Fee:** $263.90	**Benefit:** 75% = $197.95	85% = $224.35
47549	TIBIA, plateau of, treatment of medial or lateral fracture of, by open reduction (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $351.80	**Benefit:** 75% = $263.85	85% = $300.90
47552	TIBIA, plateau of, treatment of both medial and lateral fractures of, not being a service to which item 47555 or 47558 applies (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $293.20	**Benefit:** 75% = $219.90	85% = $249.25

47555	TIBIA, plateau of, treatment of both medial and lateral fractures of, by closed reduction (Anaes. 17707 = 3B + 4T) **Fee:** $439.75 **Benefit:** 75% = $329.85 85% = $388.85
47558	TIBIA, plateau of, treatment of both medial and lateral fractures of, by open reduction (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $586.40 **Benefit:** 75% = $439.80 85% = $535.50
47561	TIBIA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47564, 47567, 47570 or 47573 applies (Anaes. 17706 = 3B + 3T) **Fee:** $212.50 **Benefit:** 75% = $159.40 85% = $180.65
47564	TIBIA, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes. 17705 = 3B + 2T) **Fee:** $318.85 **Benefit:** 75% = $239.15 85% = $271.05
47565	TIBIA, shaft of, treatment of fracture of, by internal fixation or external fixation (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $554.60 **Benefit:** 75% = $415.95 85% = $503.70
47566	TIBIA, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $707.00 **Benefit:** 75% = $530.25 85% = $656.10
47567	TIBIA, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $370.10 **Benefit:** 75% = $277.60 85% = $319.20
47570	TIBIA, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $425.10 **Benefit:** 75% = $318.85 85% = $374.20
47573	TIBIA, shaft of, treatment of intra-articular fracture of, by open reduction, with or without treatment of fibula fracture (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $531.35 **Benefit:** 75% = $398.55 85% = $480.45
47576	FIBULA, treatment of fracture of (Anaes. 17705 = 3B + 2T) **Fee:** $87.90 **Benefit:** 75% = $65.95 85% = $74.75
47579	PATELLA, treatment of fracture of, not being a service to which item 47582 or 47585 applies (Anaes. 17705 = 3B + 2T) **Fee:** $124.65 **Benefit:** 75% = $93.50 85% = $106.00
47582	PATELLA, treatment of fracture of, by excision of patella or pole with reattachment of tendon (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $256.60 **Benefit:** 75% = $192.45 85% = $218.15
47585	PATELLA, treatment of fracture of, by internal fixation (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $329.85 **Benefit:** 75% = $247.40 85% = $280.40
47588	KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes. 17717 = 5B + 12T) (Assist.) **Fee:** $1,026.10 **Benefit:** 75% = $769.60 85% = $975.20
47591	KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar and tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes. 17720 = 5B + 15T) (Assist.) **Fee:** $1,246.15 **Benefit:** 75% = $934.65 85% = $1,195.25
47594	ANKLE JOINT, treatment of fracture of, not being a service to which item 47597 applies (Anaes. 17705 = 3B + 2T) **Fee:** $168.50 **Benefit:** 75% = $126.40 85% = $143.25
47597	ANKLE JOINT, treatment of fracture of, by closed reduction (Anaes. 17705 = 3B + 2T) **Fee:** $252.90 **Benefit:** 75% = $189.70 85% = $215.00
47600	ANKLE JOINT, treatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $337.10 **Benefit:** 75% = $252.85 85% = $286.55
47603	ANKLE JOINT, treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or diastasis (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $439.75 **Benefit:** 75% = $329.85 85% = $388.85

47606	CALCANEUM OR TALUS, treatment of fracture of, not being a service to which item 47609, 47612, 47615 or 47618 applies, with or without dislocation (Anaes. 17706 = 3B + 3T) **Fee:** $183.30	**Benefit:** 75% = $137.50	85% = $155.85
47609	CALCANEUM OR TALUS, treatment of fracture of, by closed reduction, with or without dislocation (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $274.85	**Benefit:** 75% = $206.15	85% = $233.65
47612	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $318.85	**Benefit:** 75% = $239.15	85% = $271.05
47615	CALCANEUM OR TALUS, treatment of fracture of, by open reduction, with or without dislocation (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $366.45	**Benefit:** 75% = $274.85	85% = $315.55
47618	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by open reduction, with or without dislocation (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $458.15	**Benefit:** 75% = $343.65	85% = $407.25
47621	TARSO-METATARSAL, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes. 17705 = 3B + 2T) (Assist.) **Fee:** $318.85	**Benefit:** 75% = $239.15	85% = $271.05
47624	TARSO-METATARSAL, treatment of fracture of, by open reduction, with or without dislocation (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $439.75	**Benefit:** 75% = $329.85	85% = $388.85
47627	TARSUS (excluding calcaneum or talus), treatment of fracture of (Anaes. 17705 = 3B + 2T) **Fee:** $124.65	**Benefit:** 75% = $93.50	85% = $106.00
47630	TARSUS (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $263.90	**Benefit:** 75% = $197.95	85% = $224.35
47633	METATARSAL, 1 of, treatment of fracture of (Anaes. 17705 = 3B + 2T) **Fee:** $87.90	**Benefit:** 75% = $65.95	85% = $74.75
47636	METATARSAL, 1 of, treatment of fracture of, by closed reduction (Anaes. 17705 = 3B + 2T) **Fee:** $131.95	**Benefit:** 75% = $99.00	85% = $112.20
47639	METATARSAL, 1 of, treatment of fracture of, by open reduction (Anaes. 17707 = 3B + 4T) **Fee:** $175.95	**Benefit:** 75% = $132.00	85% = $149.60
47642	METATARSALS, 2 of, treatment of fracture of (Anaes. 17705 = 3B + 2T) **Fee:** $117.30	**Benefit:** 75% = $88.00	85% = $99.75
47645	METATARSALS, 2 of, treatment of fracture of, by closed reduction (Anaes. 17705 = 3B + 2T) **Fee:** $175.95	**Benefit:** 75% = $132.00	85% = $149.60
47648	METATARSALS, 2 of, treatment of fracture of, by open reduction (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $234.45	**Benefit:** 75% = $175.85	85% = $199.30
47651	METATARSALS, 3 or more of, treatment of fracture of (Anaes. 17705 = 3B + 2T) **Fee:** $183.30	**Benefit:** 75% = $137.50	85% = $155.85
47654	METATARSALS, 3 or more of, treatment of fracture of, by closed reduction (Anaes. 17705 = 3B + 2T) (Assist.) **Fee:** $274.85	**Benefit:** 75% = $206.15	85% = $233.65
47657	METATARSALS, 3 or more of, treatment of fracture of, by open reduction (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $366.45	**Benefit:** 75% = $274.85	85% = $315.55
47663	PHALANX OF GREAT TOE, treatment of fracture of, by closed reduction (Anaes. 17705 = 3B + 2T) **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50
47666	PHALANX OF GREAT TOE, treatment of fracture of, by open reduction (Anaes. 17707 = 3B + 4T) **Fee:** $183.30	**Benefit:** 75% = $137.50	85% = $155.85

47672	PHALANX OF TOE (other than great toe), 1 of, treatment of fracture of, by open reduction (Anaes. 17706 = 3B + 3T) **Fee:** $87.90	**Benefit:** 75% = $65.95	85% = $74.75
47678	PHALANX OF TOE (other than great toe), more than 1 of, treatment of fracture of, by open reduction (Anaes. 17709 = 3B + 6T) **Fee:** $131.95	**Benefit:** 75% = $99.00	85% = $112.20
47681	SPINE (excluding sacrum), treatment of fracture of transverse process, vertebral body, or posterior elements - each attendance **Fee:** $33.40	**Benefit:** 75% = $25.05	85% = $28.40
47684	SPINE, treatment of fracture, dislocation or fracture-dislocation, without spinal cord involvement, including immobilisation by calipers (Anaes. 17714 = 10B + 4T) (Assist.) **Fee:** $586.40	**Benefit:** 75% = $439.80	85% = $535.50
47687	SPINE, treatment of fracture, dislocation or fracture-dislocation, with spinal cord involvement, including immobilisation by calipers, and including up to 14 days post-operative care (Assist.) **Fee:** $1,026.10	**Benefit:** 75% = $769.60	85% = $975.20
47690	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, including immobilisation by calipers, requiring reduction by closed manipulation (Anaes. 17714 = 10B + 4T) (Assist.) **Fee:** $806.25	**Benefit:** 75% = $604.70	85% = $755.35
47693	SPINE, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, including immobilisation by calipers, requiring reduction by closed manipulation, including up to 14 days post-operative care (Assist.) **Fee:** $1,026.10	**Benefit:** 75% = $769.60	85% = $975.20
47696	SPINE, reduction of fracture or dislocation of, without cord involvement, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17714 = 10B + 4T) (Assist.) **Fee:** $293.20	**Benefit:** 75% = $219.90	85% = $249.25
47699	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, requiring open reduction with or without internal fixation (Anaes. 17722 = 10B + 12T) (Assist.) **Fee:** $1,172.75	**Benefit:** 75% = $879.60	85% = $1,121.85
47702	SPINE, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, requiring open reduction with or without internal fixation, including up to 14 days post-operative care (Anaes. 17722 = 10B + 12T) (Assist.) **Fee:** $1,466.00	**Benefit:** 75% = $1,099.50	85% = $1,415.10
47703	SKULL, treatment of fracture of, each attendance **Fee:** $33.40	**Benefit:** 75% = $25.05	85% = $28.40
47705	SKULL CALIPERS, insertion of, as an independent procedure (Anaes. 17708 = 5B + 3T) (Assist.) **Fee:** $219.80	**Benefit:** 75% = $164.85	85% = $186.85
47708	PLASTER JACKET, application of, as an independent procedure (Anaes. 17707 = 3B + 4T) **Fee:** $168.50	**Benefit:** 75% = $126.40	85% = $143.25
47711	HALO, application of, as an independent procedure (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $249.25	**Benefit:** 75% = $186.95	85% = $211.90
47714	HALO, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes. 17709 = 5B + 4T) **Fee:** $186.90	**Benefit:** 75% = $140.20	85% = $158.90
47717	HALO-THORACIC TRACTION - application of both halo and thoracic jacket (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $329.85	**Benefit:** 75% = $247.40	85% = $280.40
47720	HALO-FEMORAL TRACTION, as an independent procedure (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $329.85	**Benefit:** 75% = $247.40	85% = $280.40
47723	HALO-FEMORAL TRACTION, in conjunction with a major spine operation (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $329.85	**Benefit:** 75% = $247.40	85% = $280.40
47726	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - small quantity (Anaes. 17707 = 5B + 2T) **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50

47729	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - large quantity (Anaes. 17708 = 5B + 3T) **Fee:** $183.30	**Benefit:** 75% = $137.50	85% = $155.85
47732	VASCULARISED PEDICLE BONE GRAFT, harvesting of, in conjunction with another service (Anaes. 17710 = 6B + 4T) (Assist.) **Fee:** $293.20	**Benefit:** 75% = $219.90	85% = $249.25
47735	NASAL BONES, treatment of fracture of, not being a service to which item 47738 or 47741 applies - each attendance **Fee:** $33.40	**Benefit:** 75% = $25.05	85% = $28.40
47738	NASAL BONES, treatment of fracture of, by reduction (Anaes. 17707 = 5B + 2T) **Fee:** $183.30	**Benefit:** 75% = $137.50	85% = $155.85
47741	NASAL BONES, treatment of fracture of, by open reduction involving osteotomies (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $373.90	**Benefit:** 75% = $280.45	85% = $323.00
47753	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $316.60	**Benefit:** 75% = $237.45	85% = $269.15
47756	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $316.60	**Benefit:** 75% = $237.45	85% = $269.15
47762	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes. 17707 = 5B + 2T) **Fee:** $185.95	**Benefit:** 75% = $139.50	85% = $158.10
47765	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $305.25	**Benefit:** 75% = $228.95	85% = $259.50
47768	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $373.90	**Benefit:** 75% = $280.45	85% = $323.00
47771	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $429.60	**Benefit:** 75% = $322.20	85% = $378.70
47774	MAXILLA, treatment of fracture of, requiring open operation (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $339.20	**Benefit:** 75% = $254.40	85% = $288.35
47777	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $339.20	**Benefit:** 75% = $254.40	85% = $288.35
47780	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $440.90	**Benefit:** 75% = $330.70	85% = $390.00
47783	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $440.90	**Benefit:** 75% = $330.70	85% = $390.00
47786	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $559.60	**Benefit:** 75% = $419.70	85% = $508.70
47789	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $559.60	**Benefit:** 75% = $419.70	85% = $508.70
	GENERAL		
47900	BONE CYST, injection into or aspiration of (Anaes. 17706 = 4B + 2T) **Fee:** $131.95	**Benefit:** 75% = $99.00	85% = $112.20

47903	EPICONDYLITIS, open operation for (Anaes. 17706 = 4B + 2T) **Fee:** $183.30	**Benefit:** 75% = $137.50	85% = $155.85
47904	DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies (Anaes. 17704 = 3B + 1T) **Fee:** $44.00	**Benefit:** 75% = $33.00	85% = $37.40
47906	DIGITAL NAIL OF TOE, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17704 = 3B + 1T) **Fee:** $87.90	**Benefit:** 75% = $65.95	85% = $74.75
47912	PULP SPACE INFECTION, PARONYCHIA of FOOT, incision for, not being a service to which another item in this Group applies (excluding aftercare) (Anaes. 17705 = 3B + 2T) **Fee:** $44.00	**Benefit:** 75% = $33.00	85% = $37.40
47915	INGROWING NAIL OF TOE, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed (Anaes. 17705 = 3B + 2T) **Fee:** $131.95	**Benefit:** 75% = $99.00	85% = $112.20
47916	INGROWING NAIL OF TOE, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes. 17705 = 3B + 2T) **Fee:** $66.25	**Benefit:** 75% = $49.70	85% = $56.35
47918	INGROWING TOENAIL, radical excision of nailbed (Anaes. 17705 = 3B + 2T) **Fee:** $183.30	**Benefit:** 75% = $137.50	85% = $155.85
47920	BONE GROWTH STIMULATOR, insertion of (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $296.45	**Benefit:** 75% = $222.35	85% = $252.00
47921	ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes. 17706 = 4B + 2T) **Fee:** $87.90	**Benefit:** 75% = $65.95	85% = $74.75
47924	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of requiring incision and suture, not being a service to which item 47927 or 47930 applies - per bone (Anaes. 17706 = 4B + 2T) **Fee:** $29.30	**Benefit:** 75% = $22.00	85% = $24.95
47927	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital or approved day-hospital facility - per bone (Anaes. 17706 = 4B + 2T) **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50
47930	PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all of which were inserted for internal fixation purposes, removal of, not being a service associated with a service to which item 47924 or 47927 applies - per bone (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $205.25	**Benefit:** 75% = $153.95	85% = $174.50
47933	EXOSTOSIS OF SMALL BONE, excision of, including simple removal of bunion and any associated bursa (Anaes. 17706 = 4B + 2T) **Fee:** $161.20	**Benefit:** 75% = $120.90	85% = $137.05
47936	EXOSTOSIS OF LARGE BONE, excision of (Anaes. 17706 = 4B + 2T) (Assist.) **Fee:** $197.90	**Benefit:** 75% = $148.45	85% = $168.25
47948	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17706 = 4B + 2T) **Fee:** $124.65	**Benefit:** 75% = $93.50	85% = $106.00
47951	EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes. 17706 = 4B + 2T) **Fee:** $146.60	**Benefit:** 75% = $109.95	85% = $124.65
47954	TENDON, repair of, not being a service to which another item in this Group applies (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $293.20	**Benefit:** 75% = $219.90	85% = $249.25
47957	TENDON, large, lengthening of, not being a service to which another item in this Group applies (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $219.80	**Benefit:** 75% = $164.85	85% = $186.85

47960	TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies (Anaes. 17704 = 3B + 1T) **Fee:** $102.65 **Benefit:** 75% = $77.00 85% = $87.30
47963	TENOTOMY, OPEN, with or without tenoplasty, not being a service to which another item in this Group applies (Anaes. 17706 = 4B + 2T) **Fee:** $168.50 **Benefit:** 75% = $126.40 85% = $143.25
47966	TENDON OR LIGAMENT, TRANSFER, not being a service to which another item in this Group applies (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $337.10 **Benefit:** 75% = $252.85 85% = $286.55
47969	TENOSYNOVECTOMY, not being a service to which another item in this Group applies (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $205.25 **Benefit:** 75% = $153.95 85% = $174.50
47972	TENDON SHEATH, open operation for teno-vaginitis, not being a service to which another item in this Group applies (Anaes. 17707 = 4B + 3T) **Fee:** $164.00 **Benefit:** 75% = $123.00 85% = $139.40
47975	FOREARM OR CALF, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $287.35 **Benefit:** 75% = $215.55 85% = $244.25
47978	FOREARM OR CALF, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (Anaes. 17708 = 3B + 5T) **Fee:** $174.55 **Benefit:** 75% = $130.95 85% = $148.40
47981	FOREARM, CALF OR INTEROSSEOUS MUSCLE SPACE OF HAND, decompression fasciotomy of, not being a service to which another item applies (Anaes. 17706 = 3B + 3T) **Fee:** $117.15 **Benefit:** 75% = $87.90 85% = $99.60
47982	FORAGE (Drill decompression), of NECK OR HEAD of FEMUR, or BOTH (Anaes. 17710 = 6B + 4T) (Assist.) **Fee:** $284.10 **Benefit:** 75% = $213.10 85% = $241.50
	BONE GRAFTS
48200	FEMUR, bone graft to (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $586.40 **Benefit:** 75% = $439.80 85% = $535.50
48203	FEMUR, bone graft to, with internal fixation (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $711.00 **Benefit:** 75% = $533.25 85% = $660.10
48206	TIBIA, bone graft to (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $440.20 **Benefit:** 75% = $330.15 85% = $389.30
48209	TIBIA, bone graft to, with internal fixation (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $564.35 **Benefit:** 75% = $423.30 85% = $513.45
48212	HUMERUS, bone graft to (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $440.20 **Benefit:** 75% = $330.15 85% = $389.30
48215	HUMERUS, bone graft to, with internal fixation (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $564.35 **Benefit:** 75% = $423.30 85% = $513.45
48218	RADIUS AND ULNA, bone graft to (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $440.20 **Benefit:** 75% = $330.15 85% = $389.30
48221	RADIUS AND ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes. 17712 = 3B + 9T) (Assist.) **Fee:** $586.40 **Benefit:** 75% = $439.80 85% = $535.50
48224	RADIUS OR ULNA, bone graft to (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $293.20 **Benefit:** 75% = $219.90 85% = $249.25
48227	RADIUS OR ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $381.15 **Benefit:** 75% = $285.90 85% = $330.25
48230	SCAPHOID, bone graft to, for non-union (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $329.85 **Benefit:** 75% = $247.40 85% = $280.40

48233	SCAPHOID, bone graft to, for non-union, with internal fixation (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $476.45	**Benefit:** 75% = $357.35	85% = $425.55
48236	SCAPHOID, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $623.05	**Benefit:** 75% = $467.30	85% = $572.15
48239	BONE GRAFT, not being a service to which another item in this Group applies (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $344.50	**Benefit:** 75% = $258.40	85% = $293.60
48242	BONE GRAFT, with internal fixation, not being a service to which another item in this Group applies (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $476.45	**Benefit:** 75% = $357.35	85% = $425.55
	OSTEOTOMY OR OSTEECTOMY		
48400	PHALANX, METATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or osteectomy of, excluding services to which item 49848 or 49851 applies (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $256.60	**Benefit:** 75% = $192.45	85% = $218.15
48403	PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $403.15	**Benefit:** 75% = $302.40	85% = $352.25
48406	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $256.60	**Benefit:** 75% = $192.45	85% = $218.15
48409	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than Acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, with internal fixation (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $403.15	**Benefit:** 75% = $302.40	85% = $352.25
48412	HUMERUS, osteotomy or osteectomy of (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $491.00	**Benefit:** 75% = $368.25	85% = $440.10
48415	HUMERUS, osteotomy or osteectomy of, with internal fixation (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $623.05	**Benefit:** 75% = $467.30	85% = $572.15
48418	TIBIA, osteotomy or osteectomy of (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $491.00	**Benefit:** 75% = $368.25	85% = $440.10
48421	TIBIA, osteotomy or osteectomy of, with internal fixation (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $623.05	**Benefit:** 75% = $467.30	85% = $572.15
48424	FEMUR OR PELVIS, osteotomy or osteectomy of (Anaes. 17715 = 6B + 9T) (Assist.) **Fee:** $586.40	**Benefit:** 75% = $439.80	85% = $535.50
48427	FEMUR OR PELVIS, osteotomy or osteectomy of, with internal fixation (Anaes. 17717 = 6B + 11T) (Assist.) **Fee:** $711.00	**Benefit:** 75% = $533.25	85% = $660.10
	EPIPHYSIODESIS		
48500	FEMUR, epiphysiodesis of (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $256.60	**Benefit:** 75% = $192.45	85% = $218.15
48503	TIBIA AND FIBULA, epiphysiodesis of (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $256.60	**Benefit:** 75% = $192.45	85% = $218.15
48506	FEMUR, TIBIA AND FIBULA, epiphysiodesis of (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $381.15	**Benefit:** 75% = $285.90	85% = $330.25
48509	EPIPHYSIODESIS, staple arrest of hemiepiphysis (Anaes. 17709 = 4B + 5T) **Fee:** $183.30	**Benefit:** 75% = $137.50	85% = $155.85
48512	EPIPHYSIOLYSIS, operation to prevent closure of plate (Anaes. 17716 = 4B + 12T) (Assist.) **Fee:** $696.25	**Benefit:** 75% = $522.20	85% = $645.35

	SPINE
48600	SPINE, MANIPULATION OF, performed in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17704 = 3B + 1T) **Fee:** $73.20 **Benefit:** 75% = $54.90 85% = $62.25
48603	SPINE, manipulation of, under epidural anaesthesia, with or without steroid injection, where the manipulation and the administration of the epidural anaesthetic are performed by the same medical practitioner in the operating theatre of a hospital or approved day-hospital facility, not being a service associated with a service to which item 48600 or 50115 applies (Anaes. 17707 = 5B + 2T) **Fee:** $110.00 **Benefit:** 75% = $82.50 85% = $93.50
48606	SCOLIOSIS or KYPHOSIS, spinal fusion for (without instrumentation) (Anaes. 17732 = 13B + 19T) (Assist.) **Fee:** $1,026.10 **Benefit:** 75% = $769.60 85% = $975.20
48609	SCOLIOSIS or KYPHOSIS, spinal fusion for, using Harrington or other nonsegmental fixation (Anaes. 17732 = 13B + 19T) (Assist.) **Fee:** $1,282.70 **Benefit:** 75% = $962.05 85% = $1,231.80
48612	SCOLIOSIS, spinal fusion for, using segmental instrumentation (C D, Zielke, Luque, or similar) (Anaes. 17738 = 13B + 25T) (Assist.) **Fee:** $1,905.75 **Benefit:** 75% = $1,429.35 85% = $1,854.85
48613	SCOLIOSIS OR KYPHOSIS, spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes. 17743 = 13B + 30T) (Assist.) **Fee:** $2,710.75 **Benefit:** 75% = $2,033.10 85% = $2,659.85
48615	SCOLIOSIS, re-exploration for, involving adjustment or removal of instrumentation or simple bone grafting procedure (Anaes. 17723 = 13B + 10T) (Assist.) **Fee:** $344.50 **Benefit:** 75% = $258.40 85% = $293.60
48618	SCOLIOSIS, revision of failed scoliosis surgery, involving more than 1 of multiple osteotomy, fusion or instrumentation (Anaes. 17734 = 13B + 21T) (Assist.) **Fee:** $1,905.75 **Benefit:** 75% = $1,429.35 85% = $1,854.85
48621	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke, or similar) - not more than 4 levels (Anaes. 17734 = 13B + 21T) (Assist.) **Fee:** $1,246.15 **Benefit:** 75% = $934.65 85% = $1,195.25
48624	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes. 17738 = 13B + 25T) (Assist.) **Fee:** $1,539.30 **Benefit:** 75% = $1,154.50 85% = $1,488.40
48627	SCOLIOSIS, spinal fusion for, combined with segmental instrumentation (C D, Zielke or similar) down to and including pelvis (Anaes. 17738 = 13B + 25T) (Assist.) **Fee:** $1,979.00 **Benefit:** 75% = $1,484.25 85% = $1,928.10
48630	SCOLIOSIS, requiring anterior decompression of spinal cord with resection of vertebrae including bone graft and instrumentation in the presence of spinal cord involvement (Anaes. 17738 = 13B + 25T) (Assist.) **Fee:** $2,198.85 **Benefit:** 75% = $1,649.15 85% = $2,147.95
48632	SCOLIOSIS, congenital, vertebral resection and fusion for (Anaes. 17738 = 13B + 25T) (Assist.) **Fee:** $1,215.50 **Benefit:** 75% = $911.65 85% = $1,164.60
48636	PERCUTANEOUS LUMBAR DISCECTOMY, 1 or more levels (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $630.25 **Benefit:** 75% = $472.70 85% = $579.35
48639	VERTEBRAL BODY, total or subtotal excision of, including bone grafting or other form of fixation (Anaes. 17733 = 10B + 23T) (Assist.) **Fee:** $1,062.80 **Benefit:** 75% = $797.10 85% = $1,011.90
48640	VERTEBRAL BODY, disease of, excision and spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes. 17743 = 13B + 30T) (Assist.) **Fee:** $2,710.75 **Benefit:** 75% = $2,033.10 85% = $2,659.85

48642	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - 1 or 2 levels (Anaes. 17721 = 10B + 11T) (Assist.) **Fee:** $623.05	**Benefit:** 75% = $467.30	85% = $572.15
48645	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - more than 2 levels (Anaes. 17723 = 10B + 13T) (Assist.) **Fee:** $842.90	**Benefit:** 75% = $632.20	85% = $792.00
48648	SPINE, bone graft to, (postero-lateral fusion) - 1 or 2 levels (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $842.90	**Benefit:** 75% = $632.20	85% = $792.00
48651	SPINE, bone graft to, (postero-lateral fusion) - more than 2 levels (Anaes. 17722 = 10B + 12T) (Assist.) **Fee:** $1,172.75	**Benefit:** 75% = $879.60	85% = $1,121.85
48654	SPINAL FUSION (posterior interbody), with laminectomy, 1 level (Anaes. 17722 = 10B + 12T) (Assist.) **Fee:** $842.90	**Benefit:** 75% = $632.20	85% = $792.00
48657	SPINAL FUSION (posterior interbody), with laminectomy, more than 1 level (Anaes. 17725 = 10B + 15T) (Assist.) **Fee:** $1,172.75	**Benefit:** 75% = $879.60	85% = $1,121.85
48660	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (Anaes. 17724 = 12B + 12T) (Assist.) **Fee:** $842.90	**Benefit:** 75% = $632.20	85% = $792.00
48663	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - principal surgeon (Anaes. 17724 = 12B + 12T) (Assist.) **Fee:** $630.25	**Benefit:** 75% = $472.70	85% = $579.35
48666	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - assisting surgeon (Assist.) **Fee:** $381.15	**Benefit:** 75% = $285.90	85% = $330.25
48669	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (Anaes. 17726 = 12B + 14T) (Assist.) **Fee:** $1,136.10	**Benefit:** 75% = $852.10	85% = $1,085.20
48672	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - principal surgeon (Anaes. 17726 = 12B + 14T) (Assist.) **Fee:** $850.35	**Benefit:** 75% = $637.80	85% = $799.45
48675	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - assisting surgeon (Assist.) **Fee:** $513.15	**Benefit:** 75% = $384.90	85% = $462.25
48678	SPINE, simple internal fixation of, involving 1 or more of facetal screw, wire loop or similar, being a service associated with a service to which items 48642 to 48675 apply (Anaes. 17721 = 10B + 11T) (Assist.) *(See para T8.74 of explanatory notes to this Category)* **Fee:** $440.20	**Benefit:** 75% = $330.15	85% = $389.30
48681	SPINE, non-segmental internal fixation of (Harrington or similar), other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies (Anaes. 17721 = 10B + 11T) (Assist.) *(See para T8.74 of explanatory notes to this Category)* **Fee:** $732.95	**Benefit:** 75% = $549.75	85% = $682.05
48684	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies - 1 or 2 levels (Anaes. 17721 = 10B + 11T) (Assist.) *(See para T8.74 of explanatory notes to this Category)* **Fee:** $732.95	**Benefit:** 75% = $549.75	85% = $682.05
48687	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - 3 or 4 levels (Anaes. 17725 = 10B + 15T) (Assist.) *(See para T8.74 of explanatory notes to this Category)* **Fee:** $1,026.10	**Benefit:** 75% = $769.60	85% = $975.20
48690	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - more than 4 levels (Anaes. 17727 = 10B + 17T) (Assist.) *(See para T8.74 of explanatory notes to this Category)* **Fee:** $1,172.75	**Benefit:** 75% = $879.60	85% = $1,121.85

SHOULDER

48900	SHOULDER, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $219.80 **Benefit:** 75% = $164.85 85% = $186.85
48903	SHOULDER, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $439.75 **Benefit:** 75% = $329.85 85% = $388.85
48906	SHOULDER, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both - not being a service associated with a service to which item 48900 applies (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $439.75 **Benefit:** 75% = $329.85 85% = $388.85
48909	SHOULDER, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, not being a service associated with a service to which item 48903 applies (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $586.40 **Benefit:** 75% = $439.80 85% = $535.50
48912	SHOULDER, arthrotomy of (Anaes. 17708 = 5B + 3T) (Assist.) **Fee:** $256.60 **Benefit:** 75% = $192.45 85% = $218.15
48915	SHOULDER, hemi-arthroplasty of (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $586.40 **Benefit:** 75% = $439.80 85% = $535.50
48918	SHOULDER, total replacement arthroplasty of, including any associated rotator cuff repair (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $1,172.75 **Benefit:** 75% = $879.60 85% = $1,121.85
48921	SHOULDER, total replacement arthroplasty, revision of (Anaes. 17722 = 10B + 12T) (Assist.) **Fee:** $1,209.40 **Benefit:** 75% = $907.05 85% = $1,158.50
48924	SHOULDER, total replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or both (Anaes. 17724 = 10B + 14T) (Assist.) **Fee:** $1,392.70 **Benefit:** 75% = $1,044.55 85% = $1,341.80
48927	SHOULDER prosthesis, removal of (Anaes. 17715 = 9B + 6T) (Assist.) **Fee:** $285.80 **Benefit:** 75% = $214.35 85% = $242.95
48930	SHOULDER, stabilisation procedure for recurrent anterior or posterior dislocation (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $586.40 **Benefit:** 75% = $439.80 85% = $535.50
48933	SHOULDER, stabilisation procedure for multi-directional instability, including anterior or posterior (or both) repair when performed (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $769.65 **Benefit:** 75% = $577.25 85% = $718.75
48936	SHOULDER, synovectomy of, as an independent procedure (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $586.40 **Benefit:** 75% = $439.80 85% = $535.50
48939	SHOULDER, arthrodesis of (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $842.90 **Benefit:** 75% = $632.20 85% = $792.00
48942	SHOULDER, arthrodesis of, including removal of prosthesis, requiring bone grafting or internal fixation (Anaes. 17725 = 9B + 16T) (Assist.) **Fee:** $1,099.45 **Benefit:** 75% = $824.60 85% = $1,048.55
48945	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes. 17708 = 5B + 3T) (Assist.) **Fee:** $212.50 **Benefit:** 75% = $159.40 85% = $180.65
48948	SHOULDER, arthroscopic surgery of, involving any 1 or more of: removal of loose bodies; decompression of calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $476.45 **Benefit:** 75% = $357.35 85% = $425.55
48951	SHOULDER, arthroscopic division of coraco-acromial ligament including acromioplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $696.25 **Benefit:** 75% = $522.20 85% = $645.35

48954	SHOULDER, arthroscopic total synovectomy of, including release of contracture when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $732.95	**Benefit:** 75% = $549.75	85% = $682.05
48957	SHOULDER, arthroscopic stabilisation of, for recurrent instability including labral repair or reattachment when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $842.90	**Benefit:** 75% = $632.20	85% = $792.00
48960	SHOULDER, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed - not being a service associated with any other procedure of the shoulder region (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $732.95	**Benefit:** 75% = $549.75	85% = $682.05
	ELBOW		
49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $256.60	**Benefit:** 75% = $192.45	85% = $218.15
49103	ELBOW, ligamentous stabilisation of (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $549.70	**Benefit:** 75% = $412.30	85% = $498.80
49106	ELBOW, arthrodesis of (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $732.95	**Benefit:** 75% = $549.75	85% = $682.05
49109	ELBOW, total synovectomy of (Anaes. 17711 = 4B + 7T) (Assist.) **Fee:** $549.70	**Benefit:** 75% = $412.30	85% = $498.80
49112	ELBOW, silastic or other replacement of radial head (Anaes. 17713 = 4B + 9T) (Assist.) **Fee:** $549.70	**Benefit:** 75% = $412.30	85% = $498.80
49115	ELBOW, total joint replacement of (Anaes. 17721 = 7B + 14T) (Assist.) **Fee:** $879.55	**Benefit:** 75% = $659.70	85% = $828.65
49118	ELBOW, diagnostic arthroscopy of, including biopsy (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $212.50	**Benefit:** 75% = $159.40	85% = $180.65
49121	ELBOW, arthroscopic surgery involving any 1 or more of: drilling of defect, removal of loose body; release of contracture or adhesions; chondroplasty; or osteoplasty - not being a service associated with any other arthroscopic procedure of the elbow (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $476.45	**Benefit:** 75% = $357.35	85% = $425.55
	WRIST		
49200	WRIST, arthrodesis of, including bone graft, with or without internal fixation of the radiocarpal joint (Anaes. 17709 = 3B + 6T) (Assist.) *(See para T8.75 of explanatory notes to this Category)* **Fee:** $637.60	**Benefit:** 75% = $478.20	85% = $586.70
49203	WRIST, limited arthrodesis of the intercarpal joint, including bone graft (Anaes. 17709 = 3B + 6T) (Assist.) *(See para T8.75 of explanatory notes to this Category)* **Fee:** $476.45	**Benefit:** 75% = $357.35	85% = $425.55
49206	WRIST, proximal carpectomy of, including styloidectomy when performed (Anaes. 17709 = 3B + 6T) (Assist.) *(See para T8.75 of explanatory notes to this Category)* **Fee:** $439.75	**Benefit:** 75% = $329.85	85% = $388.85
49209	WRIST, total replacement arthroplasty of (Anaes. 17721 = 7B + 14T) (Assist.) *(See para T8.75 of explanatory notes to this Category)* **Fee:** $586.40	**Benefit:** 75% = $439.80	85% = $535.50
49212	WRIST, arthrotomy of (Anaes. 17707 = 3B + 4T) *(See para T8.75 of explanatory notes to this Category)* **Fee:** $183.30	**Benefit:** 75% = $137.50	85% = $155.85

	WRIST, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy (Anaes. 17712 = 3B + 9T) (Assist.) *(See para T8.75 of explanatory notes to this Category)*		
49215	**Fee:** $505.80	**Benefit:** 75% = $379.35	85% = $454.90
	WRIST, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy) - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes. 17707 = 3B + 4T) (Assist.) *(See para T8.75 of explanatory notes to this Category)*		
49218	**Fee:** $212.50	**Benefit:** 75% = $159.40	85% = $180.65
	WRIST, arthroscopic surgery of, involving any 1 or more of: drilling of defect; removal of loose body; release of adhesions; local synovectomy; or debridement of one area - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes. 17708 = 3B + 5T) (Assist.) *(See para T8.75 of explanatory notes to this Category)*		
49221	**Fee:** $476.45	**Benefit:** 75% = $357.35	85% = $425.55
	WRIST, arthroscopic debridement of 2 or more distinct areas; or osteoplasty including excision of the distal ulna; or total synovectomy (Anaes. 17709 = 3B + 6T) (Assist.) *(See para T8.75 of explanatory notes to this Category)*		
49224	**Fee:** $549.70	**Benefit:** 75% = $412.30	85% = $498.80
	WRIST, arthroscopic pinning of osteochondral fragment or stabilisation procedure for ligamentous disruption - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes. 17709 = 3B + 6T) (Assist.) *(See para T8.75 of explanatory notes to this Category)*		
49227	**Fee:** $549.70	**Benefit:** 75% = $412.30	85% = $498.80
	HIP		
	SACROILIAC JOINT arthrodesis of (Anaes. 17718 = 8B + 10T) (Assist.)		
49300	**Fee:** $405.80	**Benefit:** 75% = $304.35	85% = $354.90
	HIP, arthrotomy of, including lavage, drainage or biopsy when performed (Anaes. 17710 = 6B + 4T) (Assist.)		
49303	**Fee:** $425.10	**Benefit:** 75% = $318.85	85% = $374.20
	HIP arthrodesis of (Anaes. 17716 = 6B + 10T) (Assist.)		
49306	**Fee:** $842.90	**Benefit:** 75% = $632.20	85% = $792.00
	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (Austin Moore or similar (non cement)) (Anaes. 17714 = 6B + 8T) (Assist.)		
49309	**Fee:** $586.40	**Benefit:** 75% = $439.80	85% = $535.50
	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (cemented, porous coated or similar) (Anaes. 17716 = 6B + 10T) (Assist.)		
49312	**Fee:** $732.95	**Benefit:** 75% = $549.75	85% = $682.05
	HIP, arthroplasty of, unipolar or bipolar (Anaes. 17712 = 6B + 6T) (Assist.)		
49315	**Fee:** $659.70	**Benefit:** 75% = $494.80	85% = $608.80
	HIP, total replacement arthroplasty of, including minor bone grafting (Anaes. 17720 = 10B + 10T) (Assist.)		
49318	**Fee:** $1,026.10	**Benefit:** 75% = $769.60	85% = $975.20
	HIP, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes. 17733 = 14B + 19T) (Assist.)		
49319	**Fee:** $1,802.50	**Benefit:** 75% = $1,351.90	85% = $1,751.60
	HIP, total replacement arthroplasty of, including major bone grafting, including obtaining of graft (Anaes. 17721 = 10B + 11T) (Assist.)		
49321	**Fee:** $1,246.15	**Benefit:** 75% = $934.65	85% = $1,195.25
	HIP, total replacement arthroplasty of, revision procedure including removal of prosthesis (Anaes. 17724 = 10B + 14T) (Assist.)		
49324	**Fee:** $1,466.00	**Benefit:** 75% = $1,099.50	85% = $1,415.10
	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (Anaes. 17725 = 10B + 15T) (Assist.)		
49327	**Fee:** $1,685.85	**Benefit:** 75% = $1,264.40	85% = $1,634.95

49330	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Anaes. 17725 = 10B + 15T) (Assist.) **Fee:** $1,685.85 **Benefit:** 75% = $1,264.40 85% = $1,634.95
49333	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Anaes. 17727 = 10B + 17T) (Assist.) **Fee:** $1,905.75 **Benefit:** 75% = $1,429.35 85% = $1,854.85
49336	HIP, treatment of a fracture of the femur where revision total hip replacement is required as part of the treatment of the fracture (not including intra-operative fracture), being a service associated with a service to which items 49324 to 49333 apply (Anaes. 17725 = 10B + 15T) (Assist.) **Fee:** $278.50 **Benefit:** 75% = $208.90 85% = $236.75
49339	HIP, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cm in length (Anaes. 17728 = 10B + 18T) (Assist.) **Fee:** $2,162.20 **Benefit:** 75% = $1,621.65 85% = $2,111.30
49342	HIP, revision total replacement of, requiring anatomic specific allograft of acetabulum (Anaes. 17728 = 10B + 18T) (Assist.) **Fee:** $2,162.20 **Benefit:** 75% = $1,621.65 85% = $2,111.30
49345	HIP, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (Anaes. 17732 = 10B + 22T) (Assist.) **Fee:** $2,565.40 **Benefit:** 75% = $1,924.05 85% = $2,514.50
49346	HIP, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (Anaes. 17718 = 10B + 8T) (Assist.) **Fee:** $659.70 **Benefit:** 75% = $494.80 85% = $608.80
49348	HIP, congenital dislocation of, treatment of, by closed reduction (Anaes. 17707 = 4B + 3T) **Fee:** $124.65 **Benefit:** 75% = $93.50 85% = $106.00
49351	HIP, congenital dislocation of, treatment of, involving supervision of splint, harness or cast - each attendance (Anaes. 17707 = 4B + 3T) **Fee:** $44.00 **Benefit:** 75% = $33.00 85% = $37.40
49354	HIP, congenital dislocation of, open reduction of (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $659.70 **Benefit:** 75% = $494.80 85% = $608.80
49357	HIP SPICA, initial application of, for congenital dislocation of hip (excluding aftercare) (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $276.25 **Benefit:** 75% = $207.20 85% = $234.85
49360	HIP, diagnostic arthroscopy of (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $267.80 **Benefit:** 75% = $200.85 85% = $227.65
49363	HIP, diagnostic arthroscopy of, with synovial biopsy (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $322.45 **Benefit:** 75% = $241.85 85% = $274.10
49366	HIP, arthroscopic surgery of (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $476.45 **Benefit:** 75% = $357.35 85% = $425.55
	KNEE
49500	KNEE, arthrotomy of, involving 1 or more of; capsular release, biopsy or lavage, or removal of loose body or foreign body (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $293.20 **Benefit:** 75% = $219.90 85% = $249.25
49503	KNEE, meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patello-femoral stabilisation or single transfer of ligament or tendon or any other single procedure (not being a service to which another item in this Group applies) - any 1 procedure (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $381.15 **Benefit:** 75% = $285.90 85% = $330.25
49506	KNEE, meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patello-femoral stabilisation or single transfer of ligament or tendon or any other single procedure (not being a service to which another item in this Group applies) - any 2 or more procedures (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $571.75 **Benefit:** 75% = $428.85 85% = $520.85

49509	KNEE, total synovectomy or arthrodesis of (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $586.40 **Benefit:** 75% = $439.80 85% = $535.50
49512	KNEE, arthrodesis of, with removal of prosthesis (Anaes. 17716 = 4B + 12T) (Assist.) **Fee:** $842.90 **Benefit:** 75% = $632.20 85% = $792.00
49515	KNEE, removal of prosthesis, cemented or uncemented, including associated cement, as the first stage of a 2 stage procedure (Anaes. 17714 = 4B + 10T) (Assist.) **Fee:** $659.70 **Benefit:** 75% = $494.80 85% = $608.80
49517	KNEE, hemiarthroplasty of (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $939.20 **Benefit:** 75% = $704.40 85% = $888.30
49518	KNEE, total replacement arthroplasty of (Anaes. 17717 = 7B + 10T) (Assist.) **Fee:** $1,026.10 **Benefit:** 75% = $769.60 85% = $975.20
49519	KNEE, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes. 17728 = 10B + 18T) (Assist.) **Fee:** $1,802.50 **Benefit:** 75% = $1,351.90 85% = $1,751.60
49521	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft (Anaes. 17718 = 7B + 11T) (Assist.) **Fee:** $1,246.15 **Benefit:** 75% = $934.65 85% = $1,195.25
49524	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including obtaining of graft (Anaes. 17719 = 7B + 12T) (Assist.) **Fee:** $1,466.00 **Benefit:** 75% = $1,099.50 85% = $1,415.10
49527	KNEE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes. 17721 = 7B + 14T) (Assist.) **Fee:** $1,246.15 **Benefit:** 75% = $934.65 85% = $1,195.25
49530	KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, including obtaining of graft and including removal of prosthesis (Anaes. 17723 = 7B + 16T) (Assist.) **Fee:** $1,539.30 **Benefit:** 75% = $1,154.50 85% = $1,488.40
49533	KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to both femur and tibia, including obtaining of graft and including removal of prosthesis (Anaes. 17725 = 7B + 18T) (Assist.) **Fee:** $1,759.15 **Benefit:** 75% = $1,319.40 85% = $1,708.25
49534	KNEE, patello-femoral joint of, total replacement arthroplasty as a primary procedure (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $349.90 **Benefit:** 75% = $262.45 85% = $299.00
49536	KNEE, repair or reconstruction of, for chronic instability (open or arthroscopic, or both) involving either cruciate or collateral ligaments, including notchplasty when performed (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $732.95 **Benefit:** 75% = $549.75 85% = $682.05
49539	KNEE, reconstructive surgery of cruciate ligaments (open or arthroscopic, or both), including notchplasty when performed and surgery to other internal derangements, not being a service to which another item in this Group applies (Anaes. 17713 = 4B + 9T) (Assist.) **Fee:** $732.95 **Benefit:** 75% = $549.75 85% = $682.05
49542	KNEE, reconstructive surgery to cruciate ligaments (open or arthroscopic, or both), including notchplasty, meniscus repair, extracapsular procedure and debridement when performed (Anaes. 17714 = 4B + 10T) (Assist.) **Fee:** $1,026.10 **Benefit:** 75% = $769.60 85% = $975.20
49545	KNEE, revision arthrodesis of (Anaes. 17714 = 4B + 10T) (Assist.) **Fee:** $586.40 **Benefit:** 75% = $439.80 85% = $535.50
49548	KNEE, revision of patello-femoral stabilisation (Anaes. 17711 = 4B + 7T) (Assist.) **Fee:** $732.95 **Benefit:** 75% = $549.75 85% = $682.05
49551	KNEE, revision of procedures to which item 49536, 49539 or 49542 applies (Anaes. 17716 = 4B + 12T) (Assist.) **Fee:** $1,026.10 **Benefit:** 75% = $769.60 85% = $975.20
49554	KNEE, revision of total replacement of, by anatomic specific allograft of tibia or femur (Anaes. 17721 = 7B + 14T) (Assist.) **Fee:** $1,466.00 **Benefit:** 75% = $1,099.50 85% = $1,415.10

49557	KNEE, diagnostic arthroscopy of (including biopsy, simple trimming of meniscal margin or plica) - not being a service associated with any other arthroscopic procedure of the knee region (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $212.50 **Benefit:** 75% = $159.40 85% = $180.65
49558	KNEE, arthroscopic surgery of, involving 1 or more of: debridement, osteoplasty or chondroplasty - not associated with any other arthroscopic procedure of the knee region (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $212.50 **Benefit:** 75% = $159.40 85% = $180.65
49559	KNEE, arthroscopic surgery of, involving chondroplasty requiring multiple drilling or carbon fibre (or similar) implant; including any associated debridement or oestoplasty - not associated with any other arthroscopic procedure of the knee region (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $318.10 **Benefit:** 75% = $238.60 85% = $270.40
49560	KNEE, arthroscopic surgery of, involving 1 or more of: meniscectomy, removal of loose body or lateral release - not being a service associated with any other arthroscopic procedure of the knee region (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $429.45 **Benefit:** 75% = $322.10 85% = $378.55
49561	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: meniscectomy, removal of loose body or lateral release; where the procedure includes associated debridement, osteoplasty or chrondoplasty - not associated with any other arthroscopic procedure of the knee region (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $524.80 **Benefit:** 75% = $393.60 85% = $473.90
49562	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: meniscectomy, removal of loose body or lateral release; where the procedure includes chondroplasty requiring multiple drilling or carbon fibre (or similar) implant and associated debridement or osteoplasty - not associated with any other arthroscopic procedure of the knee region (Anaes. 17714 = 4B + 10T) (Assist.) **Fee:** $572.60 **Benefit:** 75% = $429.45 85% = $521.70
49563	KNEE, arthroscopic surgery of, involving 1 or more of: meniscus repair; osteochondral graft; or chondral graft - not associated with any other arthroscopic procedure of the knee region (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $620.25 **Benefit:** 75% = $465.20 85% = $569.35
49564	KNEE, patello-femoral stabilisation of, combined arthroscopic and open procedure, including lateral release, medial capsulorrhaphy and tendon transfer (Anaes. 17714 = 4B + 10T) (Assist.) **Fee:** $715.45 **Benefit:** 75% = $536.60 85% = $664.55
49566	KNEE, arthroscopic total synovectomy of (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $586.40 **Benefit:** 75% = $439.80 85% = $535.50
49569	KNEE, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $586.40 **Benefit:** 75% = $439.80 85% = $535.50
	ANKLE
49700	ANKLE, diagnostic arthroscopy of, including biopsy (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $212.50 **Benefit:** 75% = $159.40 85% = $180.65
49703	ANKLE, arthroscopic surgery of (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $476.45 **Benefit:** 75% = $357.35 85% = $425.55
49706	ANKLE, arthrotomy of, involving 1 or more of: lavage, removal of loose body or division of contracture (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $256.60 **Benefit:** 75% = $192.45 85% = $218.15
49709	ANKLE, ligamentous stabilisation of (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $549.70 **Benefit:** 75% = $412.30 85% = $498.80
49712	ANKLE, arthrodesis of (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $586.40 **Benefit:** 75% = $439.80 85% = $535.50
49715	ANKLE, total joint replacement of (Anaes. 17721 = 7B + 14T) (Assist.) **Fee:** $879.55 **Benefit:** 75% = $659.70 85% = $828.65
49718	ANKLE, Achilles' tendon or other major tendon, repair of (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $293.20 **Benefit:** 75% = $219.90 85% = $249.25

49721	ANKLE, Achilles' tendon rupture managed by non-operative treatment **Fee:** $183.30 **Benefit:** 75% = $137.50 85% = $155.85
49724	ANKLE, Achilles' tendon, secondary repair or reconstruction of (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $513.15 **Benefit:** 75% = $384.90 85% = $462.25
49727	ANKLE, Achilles' tendon, operation for lengthening (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $219.80 **Benefit:** 75% = $164.85 85% = $186.85
	FOOT
49800	FOOT, flexor or extensor tendon, primary repair of (Anaes. 17707 = 3B + 4T) **Fee:** $102.65 **Benefit:** 75% = $77.00 85% = $87.30
49803	FOOT, flexor or extensor tendon, secondary repair of (Anaes. 17708 = 3B + 5T) **Fee:** $131.95 **Benefit:** 75% = $99.00 85% = $112.20
49806	FOOT, subcutaneous tenotomy of, 1 or more tendons (Anaes. 17704 = 3B + 1T) **Fee:** $102.65 **Benefit:** 75% = $77.00 85% = $87.30
49809	FOOT, open tenotomy of, with or without tenoplasty (Anaes. 17706 = 3B + 3T) **Fee:** $168.50 **Benefit:** 75% = $126.40 85% = $143.25
49812	FOOT, tendon or ligament transplantation of, not being a service to which another item in this Group applies (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $337.10 **Benefit:** 75% = $252.85 85% = $286.55
49815	FOOT, triple arthrodesis of (Anaes. 17712 = 3B + 9T) (Assist.) **Fee:** $586.40 **Benefit:** 75% = $439.80 85% = $535.50
49818	FOOT, excision of calcaneal spur (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $212.50 **Benefit:** 75% = $159.40 85% = $180.65
49821	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - unilateral (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $337.10 **Benefit:** 75% = $252.85 85% = $286.55
49824	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - bilateral (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $590.05 **Benefit:** 75% = $442.55 85% = $539.15
49827	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - unilateral (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $366.45 **Benefit:** 75% = $274.85 85% = $315.55
49830	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - bilateral (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $641.35 **Benefit:** 75% = $481.05 85% = $590.45
49833	FOOT, correction of hallux valgus by osteotomy of first metatarsal including internal fixation where performed - unilateral (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $403.15 **Benefit:** 75% = $302.40 85% = $352.25
49836	FOOT, correction of hallux valgus by osteotomy of first metatarsal including internal fixation where performed - bilateral (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $696.25 **Benefit:** 75% = $522.20 85% = $645.35
49837	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, including internal fixation where performed - unilateral (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $503.95 **Benefit:** 75% = $378.00 85% = $453.05
49838	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, including internal fixation where performed - bilateral (Anaes. 17713 = 3B + 10T) (Assist.) **Fee:** $870.30 **Benefit:** 75% = $652.75 85% = $819.40
49839	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $403.15 **Benefit:** 75% = $302.40 85% = $352.25

49842	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $696.25 **Benefit:** 75% = $522.20 85% = $645.35
49845	FOOT, arthrodesis of, first metatarso-phalangeal joint (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $366.45 **Benefit:** 75% = $274.85 85% = $315.55
49848	FOOT, correction of claw or hammer toe (Anaes. 17706 = 3B + 3T) **Fee:** $124.65 **Benefit:** 75% = $93.50 85% = $106.00
49851	FOOT, correction of claw or hammer toe with internal fixation (Anaes. 17706 = 3B + 3T) **Fee:** $161.20 **Benefit:** 75% = $120.90 85% = $137.05
49854	FOOT, radical plantar fasciotomy or fasciectomy of (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $293.20 **Benefit:** 75% = $219.90 85% = $249.25
49857	FOOT, metatarso-phalangeal joint replacement (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $271.15 **Benefit:** 75% = $203.40 85% = $230.50
49860	FOOT, synovectomy of metatarso-phalangeal joint, single joint (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $219.80 **Benefit:** 75% = $164.85 85% = $186.85
49863	FOOT, synovectomy of metatarso-phalangeal joint, 2 or more joints (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $329.85 **Benefit:** 75% = $247.40 85% = $280.40
49866	FOOT, neurectomy for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $234.45 **Benefit:** 75% = $175.85 85% = $199.30
49878	TALIPES EQUINOVARUS, calcaneo valgus or metatarus varus, treatment by cast, splint or manipulation - each attendance (Anaes. 17705 = 3B + 2T) **Fee:** $44.00 **Benefit:** 75% = $33.00 85% = $37.40
	OTHER JOINTS
50100	JOINT, diagnostic arthroscopy of (including biopsy), not being a service to which another item in this Group applies and not being a service associated with any other arthroscopic procedure (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $212.50 **Benefit:** 75% = $159.40 85% = $180.65
50102	JOINT, arthroscopic surgery of, not being a service to which another item in this Group applies (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $476.45 **Benefit:** 75% = $357.35 85% = $425.55
50103	JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $256.60 **Benefit:** 75% = $192.45 85% = $218.15
50104	JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $243.10 **Benefit:** 75% = $182.35 85% = $206.65
50106	JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $366.45 **Benefit:** 75% = $274.85 85% = $315.55
50109	JOINT, arthrodesis of, not being a service to which another item in this Group applies (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $366.45 **Benefit:** 75% = $274.85 85% = $315.55
50112	CICATRICIAL FLEXION OR EXTENSION CONTRACTION OF JOINT, correction of, involving tissues deeper than skin and subcutaneous tissue, not being a service to which another item in this Group applies (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $281.10 **Benefit:** 75% = $210.85 85% = $238.95
50115	JOINT or JOINTS, manipulation of, performed in the operating theatre of a hospital or approved day-hospital facility, not being a service associated with a service to which another item in this Group applies (Anaes. 17706 = 4B + 2T) **Fee:** $110.00 **Benefit:** 75% = $82.50 85% = $93.50
50118	SUBTALAR JOINT, arthrodesis of (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $337.10 **Benefit:** 75% = $252.85 85% = $286.55
50121	GREATER TROCHANTER, transplantation of ileopsoas tendon to (Anaes. 17713 = 4B + 9T) (Assist.) **Fee:** $659.70 **Benefit:** 75% = $494.80 85% = $608.80

50124	JOINT or other SYNOVIAL CAVITY, aspiration of, injection into, or both of these procedures; payable on not more than 25 occasions in any 12 month period (Anaes. 17705 = 4B + 1T) *(See para T8.76 of explanatory notes to this Category)* **Fee:** $23.05	**Benefit:** 75% = $17.30	85% = $19.60
50125	JOINT OR OTHER SYNOVIAL CAVITY, aspiration of, or injection into, or both of these procedures - ***where it can be demonstrated that a 26th or subsequent treatment (including any treatments to which item 50124 applies) is indicated in a 12 month period*** (Anaes. 17705 = 4B + 1T) *(See para T8.76 of explanatory notes to this Category)* **Fee:** $23.05	**Benefit:** 75% = $17.30	85% = $19.60
50127	JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies (Anaes. 17715 = 4B + 11T) (Assist.) **Fee:** $546.95	**Benefit:** 75% = $410.25	85% = $496.05
50130	JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $243.10	**Benefit:** 75% = $182.35	85% = $206.65
	MALIGNANT DISEASE		
50200	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes. 17706 = 4B + 2T) **Fee:** $146.60	**Benefit:** 75% = $109.95	85% = $124.65
50203	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $322.50	**Benefit:** 75% = $241.90	85% = $274.15
50206	BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $476.45	**Benefit:** 75% = $357.35	85% = $425.55
50209	BONE TUMOUR, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes. 17711 = 4B + 7T) (Assist.) **Fee:** $586.40	**Benefit:** 75% = $439.80	85% = $535.50
50212	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, without reconstruction (Anaes. 17719 = 8B + 11T) (Assist.) **Fee:** $1,282.70	**Benefit:** 75% = $962.05	85% = $1,231.80
50215	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, with intercalary reconstruction (prosthesis, allograft or autograft) (Anaes. 17722 = 8B + 14T) (Assist.) **Fee:** $1,612.55	**Benefit:** 75% = $1,209.45	85% = $1,561.65
50218	MALIGNANT TUMOUR of LONG BONE, enbloc resection of, with replacement or arthrodesis of adjacent joint (Anaes. 17724 = 8B + 16T) (Assist.) **Fee:** $2,125.65	**Benefit:** 75% = $1,594.25	85% = $2,074.75
50221	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of (Anaes. 17724 = 8B + 16T) (Assist.) **Fee:** $1,979.00	**Benefit:** 75% = $1,484.25	85% = $1,928.10
50224	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of, with reconstruction by prosthesis, allograft or autograft (Anaes. 17727 = 8B + 19T) (Assist.) **Fee:** $2,198.85	**Benefit:** 75% = $1,649.15	85% = $2,147.95
50227	MALIGNANT BONE TUMOUR, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement (Anaes. 17732 = 8B + 24T) (Assist.) **Fee:** $2,565.40	**Benefit:** 75% = $1,924.05	85% = $2,514.50
50230	BENIGN TUMOUR, resection of, requiring anatomic specific allograft, with or without internal fixation (Anaes. 17719 = 7B + 12T) (Assist.) **Fee:** $1,319.35	**Benefit:** 75% = $989.55	85% = $1,268.45
50233	MALIGNANT TUMOUR, amputation for, hemipelvectomy or interscapulo-thoracic (Anaes. 17739 = 15B + 24T) (Assist.) **Fee:** $1,685.85	**Benefit:** 75% = $1,264.40	85% = $1,634.95

50236	MALIGNANT TUMOUR, amputation for, hip disarticulation, shoulder disarticulation or proximal third femur (Anaes. 17729 = 9B + 20T) (Assist.) **Fee:** $1,319.35 **Benefit:** 75% = $989.55 85% = $1,268.45
50239	MALIGNANT TUMOUR, amputation for, not being a service to which another item in this Group applies (Anaes. 17714 = 4B + 10T) (Assist.) **Fee:** $879.55 **Benefit:** 75% = $659.70 85% = $828.65
	CONGENITAL ORTHOPAEDIC SURGERY ***LIMB LENGTHENING AND DEFORMITY CORRECTION***
50300	JOINT DEFORMITY, slow correction of, using ring fixator or similar device, including all associated attendances - payable only once in any 12 month period (Anaes. 17718 = 4B + 14T) (Assist.) **Fee:** $901.30 **Benefit:** 75% = $676.00 85% = $850.40
50303	LIMB LENGTHENING, up to and including 5cm, requiring slow distraction under general anaesthesia in the operating theatre of a hospital or approved day-hospital facility, with or without application of a ring fixator or similar device, including all associated attendances - payable only once in any 12 month period (Anaes. 17721 = 4B + 17T) (Assist.) **Fee:** $1,230.50 **Benefit:** 75% = $922.90 85% = $1,179.60
50306	LIMB LENGTHENING , where the lengthening is bipolar, or bone transport is performed or where the fixator is extended to correct an adjacent joint deformity (Anaes. 17734 = 4B + 30T) (Assist.) **Fee:** $1,921.35 **Benefit:** 75% = $1,441.05 85% = $1,870.45
50309	RING FIXATOR OR SIMILAR DEVICE, adjustment of, with or without insertion or removal of fixation pins, performed under general anaesthesia in the operating theatre of a hospital or approved day-hospital facility, not being a service to which item 50303 or 50306 applies (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $237.40 **Benefit:** 75% = $178.05 85% = $201.80
50312	ANKLE, synovectomy of (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $545.10 **Benefit:** 75% = $408.85 85% = $494.20
50315	TALIPES EQUINOVARUS, posterior release of (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $539.70 **Benefit:** 75% = $404.80 85% = $488.80
50318	TALIPES EQUINOVARUS, medial release of (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $539.70 **Benefit:** 75% = $404.80 85% = $488.80
50321	TALIPES EQUINOVARUS, combined postero-medial release of (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $723.20 **Benefit:** 75% = $542.40 85% = $672.30
50324	TALIPES EQUINOVARUS, combined postero-medial release of, revision procedure (Anaes. 17715 = 3B + 12T) (Assist.) **Fee:** $1,030.85 **Benefit:** 75% = $773.15 85% = $979.95
50327	TALIPES EQUINOVARUS, bilateral procedures (Anaes. 17718 = 3B + 15T) (Assist.) **Fee:** $1,257.45 **Benefit:** 75% = $943.10 85% = $1,206.55
50330	TALIPES EQUINOVARUS, or talus, vertical congenital - post operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital or approved day-hospital facility, not being a service to which item 50315, 50318, 50321, 50324 or 50327 applies (Anaes. 17707 = 3B + 4T) **Fee:** $178.05 **Benefit:** 75% = $133.55 85% = $151.35
50333	TARSAL COALITION, excision of, with interposition of muscle, fat graft or similar graft (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $480.30 **Benefit:** 75% = $360.25 85% = $429.40
50336	TALUS, VERTICAL, CONGENITAL, combined anterior and posterior reconstruction (Anaes. 17716 = 3B + 13T) (Assist.) **Fee:** $717.80 **Benefit:** 75% = $538.35 85% = $666.90
50339	FOOT AND ANKLE, tibialis anterior tendon (split or whole) transfer to lateral column (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $437.20 **Benefit:** 75% = $327.90 85% = $386.30
50342	FOOT AND ANKLE, tibialis or tibialis posterior tendon transfer, through the interosseous membrane to anterior or posterior aspect of foot (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $507.30 **Benefit:** 75% = $380.50 85% = $456.40

50345	HYPEREXTENSION DEFORMITY OF TOE, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $269.90	**Benefit:** 75% = $202.45	85% = $229.45
	HIP, KNEE AND LEG PROCEDURES		
50348	KNEE, deformity of, post-operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17707 = 3B + 4T) **Fee:** $178.05	**Benefit:** 75% = $133.55	85% = $151.35
50351	HIP, congenital or developmental dislocation of, open reduction of (Anaes. 17720 = 6B + 14T) (Assist.) **Fee:** $777.15	**Benefit:** 75% = $582.90	85% = $726.25
50354	TIBIA, pseudarthrosis of, congenital, resection and internal fixation (Anaes. 17715 = 3B + 12T) (Assist.) **Fee:** $1,020.05	**Benefit:** 75% = $765.05	85% = $969.15
50357	KNEE, LEG OR THIGH, rectus femoris tendon transfer, or medial or lateral hamstring tendon transfer (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $437.20	**Benefit:** 75% = $327.90	85% = $386.30
50360	KNEE, LEG OR THIGH, combined medial and lateral hamstring tendon transfer (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $507.30	**Benefit:** 75% = $380.50	85% = $456.40
50363	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, unilateral (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $388.65	**Benefit:** 75% = $291.50	85% = $337.75
50366	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, bilateral (Anaes. 17718 = 4B + 14T) (Assist.) **Fee:** $680.05	**Benefit:** 75% = $510.05	85% = $629.15
50369	KNEE, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, unilateral (Anaes. 17714 = 4B + 10T) (Assist.) **Fee:** $507.30	**Benefit:** 75% = $380.50	85% = $456.40
50372	KNEE, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, bilateral (Anaes. 17720 = 4B + 16T) (Assist.) **Fee:** $890.50	**Benefit:** 75% = $667.90	85% = $839.60
50375	HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, unilateral (Anaes. 17714 = 4B + 10T) (Assist.) **Fee:** $388.65	**Benefit:** 75% = $291.50	85% = $337.75
50378	HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, bilateral (Anaes. 17718 = 4B + 14T) (Assist.) **Fee:** $680.05	**Benefit:** 75% = $510.05	85% = $629.15
50381	HIP, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, unilateral (Anaes. 17714 = 4B + 10T) (Assist.) **Fee:** $507.30	**Benefit:** 75% = $380.50	85% = $456.40
50384	HIP, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, bilateral (Anaes. 17722 = 4B + 18T) (Assist.) **Fee:** $890.50	**Benefit:** 75% = $667.90	85% = $839.60
50387	HIP, iliopsoas tendon transfer to greater trochanter, or transfer of abdominal musculature to greater trochanter, or transfer of adductors to ischium (Anaes. 17716 = 4B + 12T) (Assist.) **Fee:** $507.30	**Benefit:** 75% = $380.50	85% = $456.40
50390	PERTHES, CEREBRAL PALSY, or other neuromuscular conditions, affecting hips or knees, application of cast under general anaesthesia, performed in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17709 = 3B + 6T) **Fee:** $178.05	**Benefit:** 75% = $133.55	85% = $151.35
50393	PELVIS, bone graft or shelf procedures for acetabular dysplasia (Anaes. 17720 = 6B + 14T) (Assist.) **Fee:** $658.40	**Benefit:** 75% = $493.80	85% = $607.50

50394	ACETABULAR DYSPLASIA, treatment of, by multiple peri-acetabular osteotomy, including internal fixation where performed (Anaes. 17728 = 10B + 18T) (Assist.) **Fee:** $2,162.20 **Benefit:** 75% = $1,621.65 85% = $2,111.30
	SHOULDER, ARM AND FOREARM PROCEDURES
50396	HAND, congenital abnormalities or duplication of digits, amputation or splitting of phalanx or phalanges, with ligament or joint reconstruction (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $361.65 **Benefit:** 75% = $271.25 85% = $310.75
50399	FOREARM, RADIAL APLASIA OR DYSPLASIA (radial club hand), centralisation or radialisation of (Anaes. 17727 = 3B + 24T) (Assist.) **Fee:** $717.80 **Benefit:** 75% = $538.35 85% = $666.90
50402	TORTICOLLIS, bipolar release of sternocleidomastoid muscle and associated soft tissue (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $329.25 **Benefit:** 75% = $246.95 85% = $279.90
50405	ELBOW, flexorplasty, or tendon transfer to restore elbow function (Anaes. 17713 = 3B + 10T) (Assist.) **Fee:** $447.95 **Benefit:** 75% = $336.00 85% = $397.05
50408	SHOULDER, congenital or developmental dislocation, open reduction of (Anaes. 17721 = 5B + 16T) (Assist.) **Fee:** $777.15 **Benefit:** 75% = $582.90 85% = $726.25
	AMPUTATIONS OR RECONSTRUCTIONS FOR CONGENITAL DEFORMITIES
50411	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion (Anaes. 17721 = 5B + 16T) (Assist.) **Fee:** $1,020.05 **Benefit:** 75% = $765.05 85% = $969.15
50414	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion and rotationplasty (Anaes. 17732 = 5B + 27T) (Assist.) **Fee:** $1,376.20 **Benefit:** 75% = $1,032.15 85% = $1,325.30
50417	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the tibia by reconstruction of the knee, involving transfer of fibula or tibia, and repair of quadriceps mechanism (Anaes. 17727 = 5B + 22T) (Assist.) **Fee:** $1,020.05 **Benefit:** 75% = $765.05 85% = $969.15
50420	PATELLA, congenital dislocation of, reconstruction of the quadriceps (Anaes. 17720 = 4B + 16T) (Assist.) **Fee:** $841.95 **Benefit:** 75% = $631.50 85% = $791.05
50423	TIBIA, FIBULA OR BOTH, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes. 17720 = 4B + 16T) (Assist.) **Fee:** $777.15 **Benefit:** 75% = $582.90 85% = $726.25
	TUMOROUS CONDITIONS
50426	DIAPHYSEAL ACLASIA, removal of lesion or lesions from bone - 1 approach (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $361.65 **Benefit:** 75% = $271.25 85% = $310.75

GROUP T9 - ASSISTANCE AT OPERATIONS

NOTE: *Benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more than one medical practitioner.*

‡ 51300	Assistance at any operation identified by the word "Assist." for which the fee does not exceed $434.70 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed $434.70 *(See para T9.2 of explanatory notes to this Category)* **Fee:** $67.20	**Benefit:** 75% = $50.40	85% = $57.15
‡ 51303	Assistance at any operation identified by the word "Assist." for which the fee exceeds $434.70 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds $434.70 *(See para T9.3 of explanatory notes to this Category)* **Derived Fee:** one fifth of the established fee for the operation or combination of operations		
51306	Assistance at a delivery involving Caesarean section **Fee:** $97.10	**Benefit:** 75% = $72.85	85% = $82.55
51309	Assistance at a series or combination of operations which have been identified by the word "Assist." and assistance at a delivery involving Caesarean section *(See para T9.4 of explanatory notes to this Category)* **Derived Fee:** one fifth of the established fee for the operation or combination of operations (the fee for item 16520 being the Schedule fee for the Caesarean section component in the calculation of the established fee)		
51312	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615, 16627 and 16633 **Derived Fee:** one fifth of the established fee for the procedure or combination of procedures		
51315	Assistance at cataract and intraocular lens surgery covered by item 42698,42701, 42702, 42704 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42746, 42749, 42752, 42776 or 42779 **Fee:** $212.05	**Benefit:** 75% = $159.05	85% = $180.25
51318	Assistance at cataract and intraocular lens surgery where patient has: - total loss of vision, including no potential for central vision, in the fellow eye; or - previous significant surgical complication in the fellow eye; or - pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, corneal scarring, pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan's syndrome, homocysteinuria or previous blunt trauma causing intraocular damage **Fee:** $139.95	**Benefit:** 75% = $105.00	85% = $119.00

INDEX TO
GENERAL MEDICAL SERVICES

PLEASE NOTE:

This index is a reference point for medical services which attract Medicare benefits under items included in the Schedule of General Medical Services. Medical practitioners should peruse the actual description of the item in the Schedule to ensure the correct item number is selected and to ascertain whether there are any restrictions relating to the payment of benefits. Restrictions are, as far as practicable, included in the description of the item. Otherwise they will be outlined in the notes immediately preceding the particular Category of the Schedule.

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*** Payable on attendance basis**

*** Payable on attendance basis**

*** Payable on attendance basis**

*** Payable on attendance basis**

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- with GA	30663
- without GA	*
Cisternal puncture	39003
shunt diversion, insertion of	40003
shunt, revision or removal of	40009
Clavicle, dislocation, treatment of	47003,47006
fracture, treatment of	47462,47465
operation for acute osteomyelitis	43503
operation for chronic osteomyelitis	43512
osteectomy/osteotomy	48406,48409
Claw toe, correction of	49848
Cleft lip, operations for	45677-45704
palate, correction of	45707,45710,45713
Clitoris, amputation of, medically indicated	35530
Clitoroplasty, reduction, ambiguous genitalia	37845,37848

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F

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Service	Item
free fascia for facial nerve paralysis	45575,45578
free, skin	45400-45494
inlay, using a mould	45445
micro-arterial or micro-venous	45503
nerve	39315,39318
skin, to orbit	42524
venous, to fenestration cavity	41605
Grafting, bypass, occlusive arterial disease	(see bypass)
bypass, treatment of aneurysm	(see aneurysm)
for symblepharon	45629
patch, to artery or vein	33545,33548
Granuloma, cautery of	42677
removal from eye, surgical excision	42689
umbilical, excision under GA	43948
Gravid uterus, evacuation of contents by curettage	35643
Great vessel, intrathoracic operation on, other	38456
vessel, ligation or exploration, other	34103
Greater trochanter, transplant of ileopsoas tendon	50121
Groin, lymph, excision of	30329,30330
Grommet, free, in canal, removal of	*
in situ in drum, removal of	41500
insertion of	41632
Group psychotherapy	342
psychotherapy, family	342,344,346
therapy, family	170,171,172
Gunderson flap operation	42638
Gynaecological examination under GA	35500
Gynatresia, vaginal reconstruction for	35565

H

Haemangioma, cauterisation of (restriction)	45027
excision of	45030-45036
of neck, deep-seated, excision of	45036
Haemapheresis	13750,13755
Haematoma, aspiration of	30216
breast, exploration and drainage	30364
incision and drainage, without GA	30219
large, incision and drainage, with GA	30222,30223
pelvic, drainage of	30387
Haemochromatosis	13757
Haemodialysis, in hospital	13100,13103
Haemofiltration, continuous (ICU)	13885,13888
in hospital	13100,13103
Haemoperfusion, in hospital	13100,13103
Haemorrhage, antepartum, treatment of	16509
arrest of	*
- following circumcision, with GA	30663
- following circumcision, without GA	*
- following tonsillectomy, with GA	41796,41797
extremity, reoperation for control of	33848
intracranial, burr-hole craniotomy for	39600
nasal, arrest of	41656,41677
nasal, cryotherapy for treatment of	41680
post-op, control under GA, independent	30058
post-operative, following gynaecological surgery	35759
post-operative, laparotomy for	30385
postpartum, treatment of	16567
subdural, tap for	39009
Haemorrhoidectomy	32138,32139
Haemorrhoids, injection into	*
removal of	32138,32139
rubber band ligation of	32135
sclerotherapy for	32132
Hair transplants, congenital/traumatic alopecia	45560
Hallux rigidus/valgus, correction of	49821-49842
Halo, application	47711,47714
femoral traction, application of	47720,47723
thoracic traction, application of	47717
Hammer toe, correction of	49848
Hand, amputation or disarticulation of	44325,44328
arthrotomy	46327,46330
bone grafting for pseudarthrosis	46405
congenital abnormalities, amputation of phalanges	50396
congenital abnormalities, splitting of phalanges	50396
decompression fasciotomy	47981
digits, flexor/extensor contracture, correction	46492
duplication of digits, amputation of phalanges	50396
duplication of digits, splitting of phalanges	50396
extensor tendon of, repair of	46420,46423
extensor tendon of, tenolysis of	46450
flexor tendon of, repair of	46423-46435
flexor tendon of, tenolysis of	46453
ganglion, excision of	46494
middle palmar/thenar/hypothenar spaces, drainage	46519
osteectomy/osteotomy	46396,46399
paronychia/pulp space infection, incision for	46525
tendon sheath, operation for tendovaginitis	46363
tendon transfer for restoration of function	46417
Hare lip	(see cleft lip)
Harrington rods, in treatment of scoliosis or kyphosis	48609
rods, re-exploration for adjustment /removal	48615
Hartmann's operation	32030
Health assessments	700-706
Heart arrhythmia, ablation of	38287,38290,38293
arrhythmia, surgery for	38512-38536
catheterisation of	38200,38203,38206
electrical stimulation of	13400
intrathoracic operation on, not otherwise covered	38456
mitral annulus, reconstruction after decalcification	38485
subvalvular structures, reconstruction, re-implantation	38490
surgery for congenital heart disease	38700-38766
surgery, open, not otherwise covered	38653
valve replacement	38488,38489
valve, repair	38480,38481
Heller's operation	30532,30533
Hemiarthroplasty, hand	46309-46321
knee	49517
Hemicircumcision, for hypospadias	37354
Hemicolectomy	32000,32003,32006
Hemiepiphysis, staple arrest of	48509
Hemifacial microsomia, construction condyle and ramus	45791
Hemilaryngectomy, vertical, with tracheostomy	41837
Hemispherectomy, for intractible epilepsy	40706
Hemithyroidectomy	30306
Hemivulvectomy	35536
Hepatic duct, common, resection for carcinoma	30463,30464
duct, common, repair of	30472
ducts, Roux-en-Y bypass	30466,30467
Hernia, antireflux operations for	30527,30529,30530
diaphragmatic, neonatal, repair of	43837,43840
diaphragmatic, repair of	30600,30601
diaphragmatic, simple closure of	30387
femoral or inguinal, repair of	30609,30612,30614
inguinal, repair, age less than 3 months	44108,44111,44114
spigelian, repair of	30403,30405
strangulated, incarcerated or obstructed, repair of	30615
umbilical, epigastric, or linea alba, repair of	30616-30621

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Service	Item
laparoscopically assisted hysterectomy	35750,35753,35756
sterilisation via	35687,35688
with biopsy	30391
with drainage of pus	31454
with transection/resection Fallopian tubes	35687,35688
Laparostomy	30397,30399
Laparotomy and division of adhesions	30376,30378,30379
exploratory	30373
for control of post-operative haemorrhage	30385,33845
for drainage	30394
for grading of lymphoma	30384
for gross intra-peritoneal sepsis	30396
for intussusception, paediatric	43933,43936
for neonatal conditions	43801-43831
for staging of gynaecological malignancy	35726
for thrombosis	33845
for trauma, involving 3 or more organs	30388
involving gynaecology (exc. hysterectomy)	35712-35717
involving other op on abdominal viscera	30375,30387
with division of extensive adhesions	30379
with insertion of portacath	30400
Large intestine, resection of	32000,32003
intestine, subtotal colectomy	32004,32005
Laryngeal web, division of	41868
Laryngectomy	41834
supraglottic	41840
Laryngofissure, external operation on	41876
Laryngopharyngectomy	41843
- or primary restoration of alimentary continuity after	41843
- with tracheostomy and plastic reconstruction	30294
Laryngoplasty	41876,41879
Laryngoscopy	41846,41849,41852
fibreoptic, with examination of larynx	41764
Larynx, direct examination of	41846
direct examination of, with biopsy	41849
direct examination of, with removal of tumour	41852
external operation on	41876
fibreoptic examination of	41764
fractured, operation for	41873
Laser ablation of prostate, endoscopic	37207,37208
angioplasty, peripheral	35315
capsulotomy	42788,42789
coagulation corneal/scleral vessels	42797
destruction of bladder tumour with cystoscopy	36839,36845
destruction of stone with urethroscopy	37318
division of suture, eye	42794
excision, tumours of face/neck	30190
excision/ablation, carbon dioxide, of rhinophyma	45652
excision/ablation, carbon dioxide, vermilionectomy	45669
incision of palate	41787
iridotomy	42785,42786
photocoagulation of iris tumour	42806
photocoagulation of neoplastic skin lesions	30195
photocoagulation of vascular lesions	14100-14132
photoiridosyneresis	42808
photomydriasis	42807
resurfacing, carbon dioxide, face or neck	45025,45026
therapy for intraepithelial neoplasia	35539,35542,35545
therapy for malignancy of gastrointestinal tract	30479
trabeculoplasty	42782,42783
treatment, eye	42782-42806
vitreolysis/corticolysis	42791,42792
Lateral pharyngeal bands, removal of	41804
pharyngotomy	41779
rhinotomy with removal of tumour	41728
Lavage and proof puncture of maxillary antrum	41698,41701
colonic, total, intra-operative	32186
colostomy	*
gastric, in the treatment of ingested poison	14200
maxillary antrum	41704
stomach	*
uterine (saline flushing)	*
Le Fort osteotomies	45753,45754
operation for genital prolapse	35584
Leg, amputation	44367,44370
hamstring tendon transfer	50357,50360
rectus femoris tendon transfer	50357
Lens, artificial, insertion of	42701,42703
artificial, removal and replacement	42707,42710
artificial, removal or repositioning	42704
extraction	42698
extraction and insertion of artificial lens	42702
intraocular, repositioning of	42713
Lensectomy	42731
Lesion, craniocervical junction, transoral approach for	40315
intradural, laminectomy for, not otherwise covered	40312
Lesions, skin, multiple injections for	30207
Leukoplakia, tongue, diathermy for	*
Leveen shunt, insertion of	30408
Lid, ophthalmic, suturing of	42584
scleral graft to	42860
Ligament, finger joint, repair of	46333
of foot, repair of	49812
or tendon transfer	47966
ruptured medial palpebral, repair of	42854
transplantation	47966
Ligation, great vessel	34103
purse string, cervix	16511
rubber band, of haemorrhoids or rectal prolapse	32135
transantral, of maxillary artery	41707
Ligature of cervix, purse string, removal of	16512
Limb, fasciotomy of	30226
Limb, amputation	(see leg/arm)
ischaemic, debridement of tissue	35100,35103
lengthening procedures	50303,50306
lower, congenital deficiency, treatment of	50411,50414,50417
or chest, decompression escharotomy	45054
perfusion of	13600,34533
Limbic tumour, removal or excision of	42692,42695
Linea alba hernia, repair of, under 10 years	30616,30617
alba hernia, repair of, over 10 years	30620,30621
Lingual tonsil, removal of	41804
Lip, cleft, operations for	45677-45704
full thickness laceration, repair	30052
full thickness wedge excision	45665
reconstruction	45671,45674
tumour, excision of	(see tumour,other)
Lipectomy, radical abdominoplasty	30177
subumbilical excision	30174
wedge excision	30165,30168,30171
Lipoma, removal of	(see tumour, other)
Lipomeningocoele, tethered cord, release of	40112
Liposuction,treatment of post-traumatic pseudolipoma	45584,45585
Lippe's loop, introduction of	35503
loop, removal of under GA	35506
Lisfranc's amputation	44364
Litholapaxy, with or without cystoscopy	36863
Lithotripsy, extracorporeal shock wave (ESWL)	36546

*** Payable on attendance basis**

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Service	Item
removal of foreign body in	41825
Olecranon, excision of bursa of	30110,30111
fracture, treatment of	47396,47399,47402
Omentectomy, infra-colic	35726
with debulking operation	35720
Oophorectomy, laparoscopic	35638
with laparotomy, not with hysterectomy	35712-35717
with vaginal hysterectomy	35673
Open heart surgery, not otherwise covered	38653
Operative arteriography or venography	35200
cholangiography or pancreatography	30439
feeding jejunostomy	31462
laparoscopy, complicated	35641
Ophthalmological examination under GA	42503
Optic fundi, examination of	11212
nerve meninges, incision of	42548
Orbit, anophthalmic, insertion of cartilage or implant	42518
anophthalmic, placement of motility integrating peg	42518
eye, decompression of	42545
eye, exenteration of	42536
eye, exploration of	42530,42533
eye, exploration, removal tumour/foreign body	42539,42542,42543
eye, skin graft to	42524
Orbital cavity, bone or cartilage graft to	45593
cavity, reconstruction of	45590
contents, ultrasonic echography of	11240
dermoid, congenital, excision of	42574
dystopia, correction of	45776,45779
implant, enucleation of eye	42506,42509
implant, evisceration of eye and insertion of	42515
Orbitotomy	42530,42533
Orchidectomy	30638,30641
Orchidopexy for undescended testis	37803,37806,37809
Oro-antral fistula, plastic closure of	41722
pin or wire, insertion of	47921
Oro-nasal fistula, plastic closure of	45714
Orthopaedic pin or wire, insertion of	47921
ring fixator, adjustment of	50309
Osseo-integration procedures	45794,45797
Ossicular chain reconstruction	41539,41542
Osteectomy of accessory bone	48400
carpus	48406,48409
clavicle	48406,48409
femur	48424,48427
fibula	48406,48409
humerus	48412,48415
mandible or maxilla	45720-45752
metatarsal	48400,48403
pelvic bone	48424
pelvis	48427
phalanx	48400,48403
radius	48406
rib	48406
scapula (other than acromion)	48406
sesamoid bone	48400
tarsus	48406
tibia	48418,48421
ulna	48406
Osteomyelitis, acute or chronic, operations for	43500-43524
carpus, operation for	46462
metacarpal, operation for	46462
phalanx, operation for	46459,46462
skull, craniectomy for	39906
Osteoplasty of knee	49503,49506
Osteotomy of accessory bone	48400
carpus	48406,48409
clavicle	48406,48409
femur	48424,48427
fibula	48406,48409
foot	49833-49838
humerus	48412,48415
mandible or maxilla	45720-45752
metatarsal	48400,48403
midfacial	45753,45754
pelvic bone	48424
pelvis	48427
phalanx	48400,48403
radius	48406,48409
rib	48406,48409
scapula (other than acromion)	48406,48409
sesamoid bone	48400
tarsus	48406,48409
tibia	48418,48421
ulna	48406,48409
Otitis media, acute, operation for	41626
Oto-acoustic emission audiometry	11332
Oval window surgery	41615
Ovarian biopsy by laparoscopy	35637
cyst aspiration	35518
cyst, excision of, with hysterectomy	35673
cyst, excision of, with laparotomy	35712-35717
cyst, puncture of, via laparoscope	35637
cystectomy, laparoscopic	35638
transposition with hysterectomy for malignancy	35729
tumour, radical or debulking operation for	35720
Ovaries, prolapse, operation for	30387
Ovary, repositioning	35683,35684
Oxycephaly, cranial vault reconstruction for	45785
Oxygen consumption, estimation of	11503
therapy, hyperbaric	13020,13025,13030

P

Pacemaker electrode, permanent, insertion, sub-xyphoid	38473
gracilis neosphincter	32210
implanted, testing of	11718,11721
permanent, insertion or replacement	38281
Pacemaking electrode, temporary transvenous, insertion	38256
Palate, cleft, repair of	45707,45710,45713
Palmar warts, removal of	30186,30187
Palpebral ligament, medial, ruptured, repair of	42854
lobe of lacrimal gland, excision of	42593
Pancreas, drainage of	30375
excision of	30583
Pancreatectomy	30583,30593,30594
Pancreatic abscess, laparotomy and external drainage of	30575
cyst, anastomosis to Roux loop of jejunum	30587
cyst, anastomosis to stomach or duodenum	30586
juice, collection of	30488
necrosectomy	30577
Pancreatico-duodenectomy (Whipple's operation)	30584
Pancreatico-jejunostomy	30589,30590
Pancreato-cholangiography, endoscopic	30484
Pancreatography, operative	30439
Panendoscopy	30473,30476,30478
Panhysterectomy	35664
Pannus, treatment of, with cautery of conjunctiva	42677
Papilloma, bladder, transurethral resection	36839,36845

Service	Item
larynx, removal of	41852
removal of	(see tumour,other)
Papillomata, juvenile, removal with microlaryngoscopy	41858
removal of by laser surgery	41861
Papules, electrosurgical destruction or chemotherapy of	*
Para-oesophageal, hiatus hernia, repair of	31468
Paracentesis abdominis	30406
anterior or posterior chamber or both	42740
in relation to eye	42734
of pericardium	38406
of tympanum	41626
thoracic cavity	38403
Paralysis, facial nerve, plastic operations for	45575,45578
Parapharyngeal tumour, excision of	31409,31412
Paraphimosis, reduction of under GA	30666
Parathyroid operation for hyperparathyroidism	30315
Paretic states, eyebrows, elevation of	42872
Parks' intersphincteric operation	32126
Paronychia of foot, incision for	47912
of hand, incision for	46525
Parotid duct, diathermy or dilatation	30262
duct, meatotomy or marsupialisation	30265,30266
duct, removal of calculus	30265,30266
duct, repair of,	30246
fistula, repair of	30269
gland, superficial lobectomy/removal of tumour	30253
gland, total extirpation of	30247,30250
tumour, excision of	30251
Parovarian cyst, removal of	35712-35717
Patch angioplasty for vein stenosis	34815
grafting to artery or vein	33545,33548
testing, epicutaneous	12012-12021
Patella, bursa, excision of	30110,30111
congenital dislocation, reconstruction of quadriceps	50420
dislocation, treatment of	47057,47060
fracture, treatment of	47579,47582,47585
Patellar bursa, excision of	30110,30111
Patellectomy	49503,49506
Patello-femoral stabilisation	49503,49506
stabilisation, revision of	49548
Patent diseased coronary bypass vein graft, dissection	38637
ductus arteriosus, division/ligation	38700,38703
urachus, excision of	37800
Pectus carinatum, repair or radical correction	38457
excavatum, repair or radical correction	38457,38458
Pedicle, tubed, or indirect flap	
- delay of	45230
- formation of	45227
- preparation of site and attachment to site	45233
- spreading of pedicle	45236
Pelvi-ureteric junction, plastic procedures to	36564
cystoscopy of	36825
Pelvic abscess, drainage via rectum or vagina	30222,30223
abscess, laparotomy for drainage of	30394
bone, operation on, for osteomyelitis	43509,43518
bone, osteectomy or osteotomy of	48424,48427
floor abnormalities, diagnosis of	11830,11833
haematoma, drainage of	30387
lymph glands, excision of	35551,35664,35670
ring, fracture, treatment of	47474-47489
Pelvic lymphadenectomy	36502
Pelvis, bone graft/shelf procedure, acetabular dysplasia	50393
fracture, treatment of	47474-47510
osteotomy or osteectomy of	48424,48427
Penicillin, injection of	*
Penile warts, cystoscopy for treatment of	36815
Penis, amputation of	37402,37405
artificial erection device, insertion	37426,37429
artificial erection device, revision or removal of	37432
circumcision of	30653-30660
correction of chordee	37417
frenuloplasty	37435
injection for impotence	37415
lengthening by translocation of corpora	37423
paraphimosis, reduction of under GA	30666
partial amputation of	37402
repair of avulsion	37411
repair of laceration of cavernous tissue, or fracture	37408
surgery for penile drainage causing impotence	37420
Peptic ulcer, bleeding, control of	30505-30509
ulcer, perforated, suture of	30375
Per anal release, rectal stricture	32114
Perchlorate discharge study	12521
Percutaneous aspiration biopsy of deep organ	30094
cordotomy	39121
drainage of deep abscess, imaging guided	30224
endoscopic gastrostomy	30481,30482
epidural electrode, insertion	39130
epidural electrodes, management of	39131
epidural implant, removal	39136
gastrostomy tube, jejunal extension	31460
liver biopsy	30409
lumbar discectomy	48636
needle biopsy of lung	38412
neurotomy for facet joint denervation	39118
neurotomy of peripheral nerves	39323
neurotomy of spinal nerves	39115
transhepatic cholangiogram, imaging guided	30440
Perforated duodenal ulcer, suture of	30375
gastric ulcer, suture of	30375
peptic ulcer, suture of	30375
Perforating wound of eyeball, repair of	42551,42554,42557
Perfusion of donor kidney, continuous	13600
of limb or organ	13600
retrograde, cerebral (if performed)	13612
retrograde, intravenous, sympatholytic agent	14209
whole body	13603
whole body (prolonged)	13604
Perianal abscess, drainage of	32174,32175
abscess, incision with drainage	30222,30223
tag, removal of, without GA	*
thrombosis, incision of	32147
Pericardectomy	38447,38449
Pericardium, drainage of, sub-xyphoid	38452
drainage of, transthoracic	38450
paracentesis of	38406
Perimetry, quantitative	*
quantitative, computerised	11221-11225
Perineal anoplasty, ano-rectal malformation	43960
biopsy of prostate	37212
graciloplasty	32203,32209
graciloplasty, insert. stimulator & electrode	32209
prostatectomy	37200
recto-sigmoidectomy for rectal prolapse	32112
repair of rectocele	32131
repair, rectal prolapse	32120
stimulation maximal, electrical	*
stimulation maximal, for stress incontinence	*

*** Payable on attendance basis**

Service	Item
Perineorrhaphy	35576
and anterior colporrhaphy	35580
Perinephric abscess, drainage of	36537
area, exploration of	36537
Periorbital correction of Treacher Collins Syndrome	45773
Doppler examination, carotid vessels	11618,11621,11624
dermoid, congenital, excision of	42573
Peripheral arterial atherectomy	35312
arterial catheterisation	35321
cannulation for cardiopulmonary bypass	38603
laser angioplasty	35315
nerve, neurectomy/neurotomy/tumour	39324,39327
venous catheterisation	35317,35319,35320
vessels, examination of	11603-11612
Peritomy, conjunctival	42632
Peritoneal adhesions, division, with laparotomy	30376,30378,30379
biopsies, multiple, with infracolic omentectomy	35726
catheter, insertion and fixation of	13109
catheter, removal of	13110
dialysis	13112
Peritoneo venous (Leveen) shunt, insertion of	30408
Peritoneoscopy	(see laparoscopy)
Peritonitis, laparotomy for	30394
Peritonsillar abscess, incision of	41807
Periurethral injection for urinary incontinence	37339
Perthes, hips or knees, application of cast under GA	50390
Petro-clival and clival tumour, removal of	39653,39654,39656
Peyronie's plaque, operation for	37417
Phalanges, amputation/splitting, congenital abnormalities	50396
Phalanx, bone grafting of, for pseudarthrosis	46402,46405
distal, for osteomyelitis	46459
finger or thumb, fractures, treatment of	47300-47333
middle or proximal, for osteomyelitis	46462
operation for acute osteomyelitis	43500
operation for chronic osteomyelitis	43512
osteectomy or osteotomy of	46399,48400,48403
toe, fracture, treatment of	47663-47678
Pharyngeal adhesions, division of	41758
bands or lingual tonsils, removal of	41804
cysts, removal of	41813
flap for velo-pharyngeal incompetence	45716
pouch, endoscopic resection (Dohlman's op)	41773
pouch, removal of	41770
Pharyngectomy, partial	41782,41785
Pharyngoplasty	45716
Pharyngotomy (lateral)	41779
Pharynx, cauterisation or diathermy	41674
removal of foreign body from	30061
Phlebotomy	*
Phonoangiography, carotid vessels	11618,11621,11624
Phonocardiography	11706
Photocoagulation, laser, vascular lesions	14100-14132
of xenon arc	42782,42783
Photoiridosyneresis, laser	42808
Photomydriasis, laser	42807
Phototherapeutic, keratectomy	42810
Physician, consultant, attendance by	(see attendances)
Pigeon chest, correction of	38457
Pilonidal cyst or sinus, excision of	30675,30676
sinus, injection of sclerosant fluid	30679
Pin, orthopaedic, insertion of	47921
wire or screw, buried, removal of	47924,47927
Pinealoma, craniotomy for removal of	39712
Pinguecula, removal of	42689
Pinhole urinary meatus, dilatation of	37300
Pirogoff's amputation of foot	44361
Pitanguy abdominoplasty	30177
Pituitary tumour, removal of	39715
Placenta, retained, evacuation of	16564
ultrasonic localisation by Doppler	*
Placentography, preparation for	36800
Plantar fasciotomy, radical	49854
warts, removal of	30186,30187
Plaster jacket, application of, to spine	47708
Plastic procedures to pelvi-ureteric junction	36564
reconstruction for bicornuate uterus	35680
reconstruction of lacrimal canaliculus	42602
repair, direct flap	45209-45224
repair, of cervical oesophagostomy	30293
repair, single stage, local flap	45200,45203,45206
repair, to enlarge vaginal orifice	35569
Plate, rod or nail, removal of	47930
Plethysmography	11603-11612
Pleura, percutaneous biopsy of	30090
Pleural effusion	38403
Pleurectomy with thoracotomy	38424
Pleurodesis with thoracotomy	38424
Plexus, brachial, exploration of	39333
Plication, intestinal, with enterolysis, Noble type	30375
Pneumonectomy	38438,38441
Poison, ingested, gastric-lavage in the treatment of	14200
Polycythemia	13757
Polyhydramnios, attendance, not routine antenatal	16502
Polyp, anal, excision of	32142,32145
aural, removal of	41506,41509
cervix, removal of	35611
larynx, removal of	41852
nasal, removal of	41662,41665,41668
rectal, removal with sigmoidoscopy	32078,32081
uterus, removal of	35639,35640
Polypectomy, with hysteroscopy	35633
Popliteal artery, exploration of, for popliteal entrapment	34145
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Porta hepatitis, radical resection for carcinoma	30461
Portacath, laparatomy with insertion of	30400
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Porto caval shunt for portal hypertension	30602
Portoenterostomy for biliary atresia	43978
Posterior chamber, removal of silicone oil	42815
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spinal fusion	40321,40324,40327
vaginal repair	35576,35580
Postero-lateral bone graft to spine	48648,48651
Postnasal space, examination under GA	41653
space, direct examination with/without biopsy	41761
Postnatal care	16564-16573
Postoperative haemorrhage	30058
- control under GA, independent	30058
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following gynaecological surgery, under GA	35759
pain, control of	18206-18212
Postpartum haemorrhage, treatment of	16567
Pre-auricular sinus, excision of	30104
Preeclampsia, treatment of	16509
Pregnancy, attendance for complication by	
- acute intercurrent infection	16508
- diabetes or anaemia	16502

*** Payable on attendance basis**

*** Payable on attendance basis**

*** Payable on attendance basis**

*** Payable on attendance basis**

*** Payable on attendance basis**

*** Payable on attendance basis**

*** Payable on attendance basis**

*** Payable on attendance basis**

*** Payable on attendance basis**

*** Payable on attendance basis**

ORAL AND MAXILLOFACIAL SERVICES BY APPROVED DENTAL PRACTITIONERS

CATEGORY 4

PLEASE NOTE:

The information contained in this Category relates specifically to the Medicare Arrangements relating to Services by Approved Dental Practitioners. More comprehensive information on the Medicare Benefits Schedule book and the Medicare Arrangements are contained in the INTRODUCTION and the GENERAL EXPLANATORY NOTES to this book, which should be read in conjunction with this Category. (The arrangements set out in the INTRODUCTION and GENERAL EXPLANATORY NOTES apply equally to Approved Dental Practitioners)

CATEGORY 4 - ORAL AND MAXILLOFACIAL SERVICES
(by Approved Dental Practitioners)

OUTLINE OF ARRANGEMENTS

EXPLANATORY NOTES

SCHEDULE OF SERVICES

CATEGORY 4 - ORAL AND MAXILLOFACIAL SERVICES

(by Approved Dental Practitioners)

OUTLINE OF ARRANGEMENTS

OA. INTRODUCTION

OA.1 Benefits for Medical Services by Dental Practitioners

Under the provisions of the Health Insurance Act 1973 (the Act), Medicare benefits are payable where an eligible person incurs medical expenses in respect of certain professional services rendered by an approved dental practitioner. Approved dental practitioners may also request certain diagnostic imaging services (see paragraph DIA.4.8 of Category 5 Explanatory Notes).

Details of the services attracting Medicare benefits are set out in the Schedule following these explanatory notes.

OB. APPROVAL OF DENTAL PRACTITIONERS (ORAL AND MAXILLOFACIAL SURGEONS)

OB.1 Definition of Oral and Maxillofacial Surgery

Oral and Maxillofacial Surgery is defined as the surgical specialty which deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the oral and maxillofacial region.

OB.2 Application for Approval

State registered dentists practising in the specialty of oral and maxillofacial surgery may apply to the Medical Benefits (Dental Practitioners) Advisory Committee for the purposes of Subsection 3(1) of the Act for approval to carry out prescribed medical services (oral and maxillofacial surgery).

The Medical Benefits (Dental Practitioners) Advisory Committee considers applications lodged by dental practitioners and recommends to the Minister the names of those dental practitioners who, in its opinion, should be approved by the Minister for the purposes of Subsection 3(1) of the Act. Such dental practitioners must be State registered oral and maxillofacial surgeons in the State in which he/she is practising. In making its recommendations, the Committee may take into account a practitioner's training and experience in the field of oral and maxillofacial surgery and other factors which it may consider relevant. The Committee is comprised of dental practitioners nominated by the Australian Dental Association and appointed by the Minister.

When practitioners are approved to carry out prescribed medical services (oral and maxillofacial surgery) they may perform those items of oral and maxillofacial surgery listed in this category. All dental practitioners approved for the purposes of subsection 3(1) of the Act are also recognised to perform those items of oral and maxillofacial surgery listed in Group C2 of the booklet "Medicare Benefits for Treatment of Cleft Lip and Cleft Palate Conditions".

Practitioners who wish to be considered for approval for the purposes of Subsection 3(1) of the Act should write to the Manager (Eligibility), Health Insurance Commission, PO Box 1001, Tuggeranong, ACT, 2901 for an application form. Any enquiries may be directed to the Health Insurance Commission on (02) 6124 6753.

It is emphasised that -

(i) the sole purpose of granting approval to dental practitioners is to enable payment of Medicare benefits;

(ii) the services set out in Groups 01 to 011 of the Medicare Benefits Schedule book, and in the Cleft Lip and Cleft Palate Schedule are the only ones for which Medicare benefits are payable when the services are performed by an eligible dental practitioner.

OB.3 Right of Appeal for Dental Practitioners Not Approved

Where the Minister decides that a dental practitioner should not be approved as an oral and maxillofacial surgeon, the dental practitioner may appeal to the Medical Benefits (Dental Practitioners) Appeals Committee, which is composed of dental practitioners who are not on the Advisory Committee. The application should be made to the Manager (Eligibility), Health Insurance Commission, PO Box 1001, Tuggeranong, ACT, 2901.

EXPLANATORY NOTES

OC. INTERPRETATION OF THE SCHEDULE

OC.1 Principles of Interpretation

Each professional service listed in the Schedule is a complete medical service in itself. Where a service is rendered partly by one practitioner and partly by another, only the one amount of benefit is payable.

OC.2 Multiple Operation Rule
The Schedule fees for two or more operations performed on a patient on the one occasion are calculated by the following rule:- 100% for the item with the greatest Schedule fee, plus 50% for the item with the next greatest Schedule fee, plus 25% for each other item.

NOTE: 1. Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents
2. Where two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.
3. The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees and benefits specified in the Schedule apply. For these purposes the term "operation" includes all services in Groups O3 to O9.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

OC.3 After-care (Post-operative Treatment)
The fee specified for each of the operations listed in the Schedule contains a component for the consequential after-care customarily provided unless otherwise indicated. After-care is deemed to include all post-operative treatment rendered by practitioners and need not necessarily be limited to treatment given by the approved dental practitioner or to treatment given by any one practitioner. This does not preclude, however, the payment of benefit for professional services for the treatment by a dental practitioner of an intercurrent condition or an unusual complication arising from the operation.

Some minor operations are merely stages in the treatment of a particular condition. Professional services by dental practitioners subsequent to such operations should not be regarded as after-care but rather as continuation of the treatment of the original condition and should attract benefit. Item 52057 is a service to which this policy applies.

OC.4 Administration of Anaesthetics by Medical Practitioners
When a medical practitioner administers an anaesthetic in connection with a procedure prescribed for the payment of Medicare benefits (and the procedure has been performed by an approved dental practitioner), Medicare benefits are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.

Before Medicare benefits will be paid for the administration of an anaesthetic, or for the services of an assistant anaesthetist, the name of the practitioner who rendered the procedure must be shown on the account.

The Schedule fee and benefits payable for the administration of an anaesthetic in connection with a particular medical service are determined according to the number of anaesthetic units allocated to each procedure likely to be performed under anaesthesia. The appropriate anaesthetic item number and the number of "basic" and "time" units appropriate for each procedure are shown after the description of the procedure.

To ascertain the Schedule fee from the number of anaesthetic units so determined, medical practitioners should refer to Group T6, Subgroup 2 of Category 3 of this Book.

OC.5 Consultations (Items 51700, 51703)
The consultation item numbers (51700 and 51703) are to be used by approved dental practitioners in the practice of oral and maxillofacial surgery and are not to be used for dental procedures (eg scale and clean, construction of dentures, restorative dentistry or dental extraction).

OC.6 Assistance at Operations (Items 51800, 51803)
Items covering operations which are eligible for benefits for assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery or surgical assistance have been identified by the inclusion of the word "Assist" in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

The assistance must be rendered by a practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to an approved dental practitioner no additional benefits are payable. The assistance benefit is the same irrespective of the number of practitioners providing assistance.

Benefits payable under item 51800

Medicare benefits are payable under Item 51800 for assistance rendered at the following procedures:

51900, 51904, 52010, 52018, 52039, 52048, 52051, 52062, 52063, 52066, 52078, 52090, 52092, 52095, 52105, 52108, 52111, 52130, 52137, 52138, 52141, 52144, 52147, 52166, 52182, 52300, 52303, 52312, 52315, 52320, 52321, 52324, 52336, 52339, 52424, 52440, 52448, 52452, 52476, 52480, 52482, 52600, 52603, 52609, 52612, 52615, 52624, 52626, 52627, 52800, 52803, 52806, 52809, 52818, 52824, 52828, 52830, 53006, 53009, 53016, 53215, 53220, 53225, 53226, 53236, 53239, 53242, 53406, 53409, 53412, 53413, 53415, 53416, 53453, 53460.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under item 51300.

Benefits payable under Item 51803

51906, 52054, 52094, 52114, 52117, 52120, 52122, 52123, 52126, 52129, 52131, 52136, 52148, 52150, 52152, 52154, 52156, 52158, 52160, 52168, 52170, 52172, 52174, 52176, 52184, 52186, 52306, 52330, 52333, 52337, 52342, 52345, 52348, 52351, 52354, 52357, 52360, 52363, 52366, 52369, 52372, 52375, 52378, 52379, 52380, 52382, 52430, 52432, 52434, 52442, 52444, 52446, 52456, 52478, 52484, 52618, 52621, 52812, 52815, 52821, 52832, 53007, 53015, 53017, 53019, 53019, 53050, 53209, 53212, 53218, 53221, 53224, 53227, 53230, 53233, 53414, 53418, 53419, 53422, 53423, 53424, 53425, 53427, 53429, 53455.

or at a combination of procedures (including those identified as payable under item 51800 above) for which the aggregate fee exceeds the amount specified in the item.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under Item 51303.

Assistance at multiple operations

Where assistance is provided at two or more operations performed on a patient on the one occasion the multi operation formula is applied to all the operations to determine the surgical fee payable to each approved dental practitioner. The multi-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Items 51800/51300 or 51803/51303).

The derived fee applicable to Item 51803/51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery.

OC.7 Operations (Groups 3 TO 9)

Repair of Wound (Item 51900)
Item 51900 covers debridement of "deep and extensively contaminated" wound. Benefits are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

Lipectomy, Wedge Excision - Two or More Excisions (Item 51906)
Multiple lipectomies attract benefits under Item 51906 once only, i.e. the multiple operation rule does not apply. Medicare benefits are not payable in respect of liposuction.

Upper aerodigestive tract endoscopic procedures (Item 52035)
The following are guidelines of appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment. These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

Cleaning, disinfection and sterilisation procedures
Endoscopic procedures should be performed in facilities where endoscope and accessory reprocessing protocols follow procedures outlined in:-

(i) 'Infection and Endoscopy' (3rd edition), Gastroenterological Society of Australia;
(ii) 'Infection control in the health care setting - Guidelines for the prevention of transmission of infectious diseases', National Health and Medical Research Council; and
(iii) Australian Standard AS 4187-1994 (and Amendments), Standards Association of Australia.

Anaesthetic and resuscitation equipment
Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post operative and resuscitation facilities should conform to the standards outlined in 'Sedation for Endoscopy', Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons. These guidelines will be taken into account in determining appropriate practice in the context of the Professional Services Review process (see paragraph 8.1 of the General Notes for Guidance).

Tumour, cyst, ulcer or scar (Items 52036 to 52054)
It is recognised that odotogenic keratocysts, although not neoplastic, often require the surgical management of benign tumours.

Aspiration of haematoma (Item 52056)
Aspiration of haematoma is indicated in clinical situations where incision may leave an unsightly scar or where access is difficult for conventional drainage.

Dissection of lymph nodes of neck (Items 52166 - 52176)
For the purposes of these items, the lymph node levels referred to are as follows:-

Level I -	Submandibular and submental lymph nodes
Level II -	Lymph nodes of the upper aspect of the neck including the jugulodigastric node, upper jugular chain nodes and upper spinal accessory nodes
Level III -	Lymph nodes deep to the middle third of the sternomastoid muscle consisting of mid jugular chain nodes, the lower most of which is the jugulo-omohyoid node, lying at the level where the omohyoid muscle crosses the internal jugular vein
Level IV -	Lower jugular chain nodes, including those nodes overlying the scalenus anterior muscle
Level V -	Posterior triangle nodes, which are usually distributed along the spinal accessory nerve in the posterior triangle

Comprehensive dissection involves all 5 neck levels while ***selective*** dissection involves the removal of only certain lymph node groups, for example:-

Item 52168 (removal of 3 lymph node levels) - e.g. supraomohyoid neck dissection (levels I-III) or lateral neck dissection (levels II-IV).

Item 52170 (removal of 4 lymph node levels) - e.g. posterolateral neck dissection (levels II-V) or anterolateral neck dissection (levels I-IV)

Other combinations of node levels may be removed according to clinical circumstances.

Osteotomy of Jaw (Items 52342 - 52375)
The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, e.g. iliac crest, would attract additional benefit under Item 52318 or 52319 for the harvesting, plus item 52130 or 52131 for the grafting. For the purposes of these items, a reference to maxilla includes the zygoma.

Genioplasty (Item 52378)
Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

Fracture of Mandible or Maxilla (Items 53400 - 53439)
There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones. Hence a bilateral fracture of the mandible would be assessed as, say Item 53409 x 1½; two maxillae and one side of the mandible as Item 53406 x 1½ + 53409 x ¼.

Splinting in Item 53406 or 53409 refers to cap splints, arch bars, silver (cast metal) or acrylic splints.

OC.8 Diagnostic Procedures and Investigations (Group 10)

Skin sensitivity testing (Item 53600)
The allergens are local anaesthetics and the contents of anaesthetic capsules, acrylic and other polymers and metals.

OC.9 Regional or Field Nerve Blocks (Group 11)

Destruction of Nerve Branch by Neurolytic Agent (53706)
This item includes the use of botulinus toxin as a neurolytic agent.

	GROUP O1 - CONSULTATIONS
	APPROVED DENTAL PRACTITIONER, REFERRED CONSULTATION - SURGERY, HOSPITAL OR RESIDENTIAL AGED CARE FACILITY (Professional attendance at consulting rooms, hospital or residential aged care facility by an approved dental practitioner in the practice of oral and maxillofacial surgery where the patient is referred to him or her) *(The referral must be from a registered dental practitioner or a medical practitioner)*
‡ 51700	- INITIAL attendance in a single course of treatment **Fee:** $66.60 **Benefit:** 75% = $49.95 85% = $56.65
51703	- Each attendance SUBSEQUENT to the first in a single course of treatment **Fee:** $33.40 **Benefit:** 75% = $25.05 85% = $28.40
	GROUP O2 - ASSISTANCE AT OPERATION
‡ 51800	Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation identified by the word "Assist." for which the fee does not exceed $434.70 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed $434.70 *(See para OC. of explanatory notes to this Category)* **Fee:** $67.20 **Benefit:** 75% = $50.40 85% = $57.15
‡ 51803	Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation identified by the word "Assist." for which the fee exceeds $434.70 or at a series or combination of operations identified by the word "Assist." where the aggregate fee exceeds $434.70 *(See para OC. of explanatory notes to this Category)* **Derived Fee:** one fifth of the established fee for the operation or combination of operations
	GROUP O3 - GENERAL SURGERY
† 51900	WOUND OF SOFT TISSUE IN THE ORAL AND MAXILLOFACIAL REGION, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes. 17707 = 4B + 3T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $215.75
† 51902	WOUNDS, OF THE ORAL AND MAXILLOFACIAL REGION, DRESSING OF, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes. 17706 = 4B + 2T) **Fee:** $57.55 **Benefit:** 75% = $43.20 85% = $48.95
† 51904	LIPECTOMY - wedge excision of skin or fat - 1 EXCISION (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $354.15 **Benefit:** 75% = $265.65 85% = $303.25
† 51906	LIPECTOMY - wedge excision of skin or fat - 2 OR MORE EXCISIONS (Anaes. 17712 = 4B + 8T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $538.65 **Benefit:** 75% = $404.00 85% = $487.75
52000	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes. 17709 = 4B + 5T) **Fee:** $64.20 **Benefit:** 75% = $48.15 85% = $54.60
52003	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes. 17709 = 4B + 5T) **Fee:** $91.50 **Benefit:** 75% = $68.65 85% = $77.80
52006	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes. 17709 = 4B + 5T) **Fee:** $91.50 **Benefit:** 75% = $68.65 85% = $77.80
52009	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes. 17709 = 4B + 5T) **Fee:** $144.60 **Benefit:** 75% = $108.45 85% = $122.95

† 52010	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $197.75	**Benefit:** 75% = $148.35	85% = $168.10
52012	SUPERFICIAL FOREIGN BODY, removal of, as an independent procedure (Anaes. 17706 = 4B + 2T) **Fee:** $18.25	**Benefit:** 75% = $13.70	85% = $15.55
52015	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and suture, as an independent procedure (Anaes. 17707 = 4B + 3T) **Fee:** $85.60	**Benefit:** 75% = $64.20	85% = $72.80
52018	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $215.45	**Benefit:** 75% = $161.60	85% = $183.15
52021	ASPIRATION BIOPSY of 1 or MORE JAW CYSTS as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (Anaes. 17707 = 5B + 2T) **Fee:** $22.95	**Benefit:** 75% = $17.25	85% = $19.55
52024	BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure (Anaes. 17706 = 4B + 2T) **Fee:** $40.65	**Benefit:** 75% = $30.50	85% = $34.60
† 52025	LYMPH NODE OF NECK, biopsy of (Anaes. 17709 = 5B + 4T) **Fee:** $143.15	**Benefit:** 75% = $107.40	85% = $121.70
‡ 52027	BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure and not being a service to which item 52025 applies (Anaes. 17706 = 4B + 2T) **Fee:** $116.60	**Benefit:** 75% = $87.45	85% = $99.15
52030	SINUS, excision of, involving superficial tissue only (Anaes. 17706 = 4B + 2T) **Fee:** $70.05	**Benefit:** 75% = $52.55	85% = $59.55
† 52031	PRE-AURICULAR SINUS, excision of (Anaes. 17706 = 4B + 2T) **Fee:** $98.85	**Benefit:** 75% = $74.15	85% = $84.05
52033	SINUS, excision of, involving muscle and deep tissue (Anaes. 17706 = 4B + 2T) **Fee:** $143.15	**Benefit:** 75% = $107.40	85% = $121.70
‡ 52034	PREMALIGNANT LESIONS of the oral mucous, treatment by cryotherapy, diathermy or carbon dioxide laser **Fee:** $33.40	**Benefit:** 75% = $25.05	85% = $28.40
† 52035	ENDOSCOPIC LASER THERAPY for neoplasia and benign vascular lesions or strictures of the upper aerodigestive tract (Anaes. 17711 = 5B + 6T) *(See para OC. of explanatory notes to this Category)* **Fee:** $370.65	**Benefit:** 75% = $278.00	85% = $319.75
52036	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 52039 applies (Anaes. 17706 = 4B + 2T) *(See para OC. of explanatory notes to this Category)* **Fee:** $98.85	**Benefit:** 75% = $74.15	85% = $84.05
52039	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes. 17707 = 4B + 3T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $253.80	**Benefit:** 75% = $190.35	85% = $215.75
52042	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes. 17706 = 4B + 2T) *(See para OC. of explanatory notes to this Category)* **Fee:** $134.30	**Benefit:** 75% = $100.75	85% = $114.20

52045	TUMOUR, CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), removal of, not being a service to which another item in Groups O3 to O9 applies, involving muscle, bone, or other deep tissue (Anaes. 17707 = 4B + 3T) *(See para OC. of explanatory notes to this Category)* **Fee:** $191.90 **Benefit:** 75% = $143.95 85% = $163.15
52048	TUMOUR OR DEEP CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), removal of, requiring wide excision, not being a service to which another item in Groups O3 to O9 applies (Anaes. 17709 = 4B + 5T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $289.20 **Benefit:** 75% = $216.90 85% = $245.85
52051	TUMOUR, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes. 17708 = 4B + 4T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $391.05 **Benefit:** 75% = $293.30 85% = $340.15
52054	TUMOUR, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes. 17709 = 4B + 5T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $457.55 **Benefit:** 75% = $343.20 85% = $406.65
‡ 52055	HAEMATOMA, SMALL ABSCESS OR CELLULITIS IN THE ORAL AND MAXILLOFACIAL REGION, not requiring admission to a hospital or day-hospital facility, INCISION WITH DRAINAGE OF (excluding after care) **Fee:** $21.25 **Benefit:** 75% = $15.95 85% = $18.10
† 52056	HAEMATOMA IN THE ORAL AND MAXILLOFACIAL REGION, aspiration of (Anaes. 17705 = 4B + 1T) *(See para OC. of explanatory notes to this Category)* **Fee:** $21.25 **Benefit:** 75% = $15.95 85% = $18.10
‡ 52057	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion IN THE ORAL AND MAXILLOFACIAL REGION, requiring admission to a hospital or day-hospital facility, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes. 17706 = 4B + 2T) **Fee:** $126.90 **Benefit:** 75% = $95.20 85% = $107.90

† 52058	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS IN THE ORAL AND MAXILLOFACIAL REGION, using interventional imaging techniques - but not including imaging (Anaes. 17707 = 4B + 3T) **Fee:** $185.00	**Benefit:** 75% = $138.75	85% = $157.25
† 52059	ABSCESS IN THE ORAL AND MAXILLOFACIAL REGION DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes. 17706 = 4B + 2T) **Fee:** $208.35	**Benefit:** 75% = $156.30	85% = $177.10
‡ 52060	MUSCLE IN THE ORAL AND MAXILLOFACIAL REGION, excision of (Anaes. 17708 = 5B + 3T) **Fee:** $147.45	**Benefit:** 75% = $110.60	85% = $125.35
† 52061	MUSCLE, IN THE ORAL AND MAXILLOFACIAL REGION, RUPTURED, repair of (limited), not associated with external wound (Anaes. 17707 = 4B + 3T) **Fee:** $174.10	**Benefit:** 75% = $130.60	85% = $148.00
† 52062	MUSCLE, IN THE ORAL AND MAXILLOFACIAL REGION, RUPTURED, repair of (extensive), not associated with external wound (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $230.20	**Benefit:** 75% = $172.65	85% = $195.70
‡ 52063	BONE TUMOUR IN THE ORAL AND MAXILLOFACIAL REGION, INNOCENT, excision of, not being a service to which another item in Groups O3 to O9 applies (Anaes. 17708 = 5B + 3T) (Assist.) **Fee:** $277.45	**Benefit:** 75% = $208.10	85% = $235.85
† 52064	BONE CYST IN THE ORAL AND MAXILLOFACIAL REGION, injection into or aspiration of (Anaes. 17706 = 4B + 2T) **Fee:** $131.95	**Benefit:** 75% = $99.00	85% = $112.20
52066	SUBMANDIBULAR GLAND, extirpation of (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $346.80	**Benefit:** 75% = $260.10	85% = $295.90
52069	SUBLINGUAL GLAND, extirpation of (Anaes. 17707 = 5B + 2T) **Fee:** $154.60	**Benefit:** 75% = $115.95	85% = $131.45
52072	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes. 17706 = 5B + 1T) **Fee:** $45.75	**Benefit:** 75% = $34.35	85% = $38.90
† 52073	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes. 17707 = 5B + 2T) **Fee:** $116.60	**Benefit:** 75% = $87.45	85% = $99.15
52075	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes. 17707 = 5B + 2T) **Fee:** $116.60	**Benefit:** 75% = $87.45	85% = $99.15
52078	TONGUE, partial excision of (Anaes. 17707 = 5B + 2T) (Assist.) **Fee:** $230.20	**Benefit:** 75% = $172.65	85% = $195.70
52081	TONGUE TIE, division or excision of frenulum (Anaes. 17707 = 5B + 2T) **Fee:** $36.20	**Benefit:** 75% = $27.15	85% = $30.80
52084	TONGUE TIE, MANDIBULAR FRENULUM OR MAXILLARY FRENULUM, division or excision of frenulum, in a person aged not less than 2 years (Anaes. 17707 = 5B + 2T) **Fee:** $93.00	**Benefit:** 75% = $69.75	85% = $79.05
52087	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes. 17709 = 5B + 4T) **Fee:** $159.40	**Benefit:** 75% = $119.55	85% = $135.50
‡ 52090	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $277.45	**Benefit:** 75% = $208.10	85% = $235.85
52092	OPERATION on SKULL for OSTEOMYELITIS (Anaes. 17719 = 12B + 7T) (Assist.) **Fee:** $361.60	**Benefit:** 75% = $271.20	85% = $310.70
† 52094	OPERATION ON ANY COMBINATION OF ADJOINING BONES IN THE ORAL AND MAXILLOFACIAL REGION, being bones referred to in item 52092 (Anaes. 17715 = 8B + 7T) (Assist.) **Fee:** $457.50	**Benefit:** 75% = $343.15	85% = $406.60

† 52095	BONE GROWTH STIMULATOR IN THE ORAL AND MAXILLOFACIAL REGION, insertion of (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $296.45	**Benefit:** 75% = $222.35	85% = $252.00
52096	ORTHOPAEDIC PIN OR WIRE, insertion of, into maxilla or mandible or zygoma, as an independent procedure (Anaes. 17707 = 5B + 2T) **Fee:** $87.90	**Benefit:** 75% = $65.95	85% = $74.75
† 52097	EXTERNAL FIXATION IN THE ORAL AND MAXILLOFACIAL REGION, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17706 = 4B + 2T) **Fee:** $124.65	**Benefit:** 75% = $93.50	85% = $106.00
† 52098	EXTERNAL FIXATION IN THE ORAL AND MAXILLOFACIAL REGION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes. 17706 = 4B + 2T) **Fee:** $146.60	**Benefit:** 75% = $109.95	85% = $124.65
52099	BURIED WIRE, PIN or SCREW, 1 or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, not being a service associated with a service to which item 52102 or 52105 applies (Anaes. 17708 = 5B + 3T) **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50
52102	BURIED WIRE, PIN or SCREW, 1 or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, where undertaken in the operating theatre of a hospital or approved day-hospital facility, per bone (Anaes. 17708 = 5B + 3T) **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50
52105	PLATE, 1 or more of, and associated screw and wire which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, not being a service associated with a service to which item 52099 or 52102 applies (Anaes. 17708 = 5B + 3T) (Assist.) **Fee:** $205.25	**Benefit:** 75% = $153.95	85% = $174.50
52106	ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17706 = 4B + 2T) **Fee:** $84.80	**Benefit:** 75% = $63.60	85% = $72.10
52108	LIP, full thickness wedge excision of, with repair by direct sutures (Anaes. 17707 = 5B + 2T) (Assist.) **Fee:** $253.80	**Benefit:** 75% = $190.35	85% = $215.75
52111	VERMILIONECTOMY (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $253.80	**Benefit:** 75% = $190.35	85% = $215.75
52114	MANDIBLE or MAXILLA, segmental resection of, for tumours or cysts (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $457.55	**Benefit:** 75% = $343.20	85% = $406.65
52117	MANDIBLE, including lower border, or MAXILLA, sub-total resection of (Anaes. 17720 = 10B + 10T) (Assist.) **Fee:** $544.55	**Benefit:** 75% = $408.45	85% = $493.65
52120	MANDIBLE, hemimandiblectomy of, including condylectomy where performed (Anaes. 17729 = 10B + 19T) (Assist.) **Fee:** $641.95	**Benefit:** 75% = $481.50	85% = $591.05
52122	MANDIBLE, hemi-mandibular reconstruction of, OR MAXILLA, reconstruction of, with BONE GRAFT, PLATE, TRAY OR ALLOPLAST, not being a service associated with a service to which item 52123 applies (Anaes. 17722 = 10B + 12T) (Assist.) **Fee:** $644.05	**Benefit:** 75% = $483.05	85% = $593.15
52123	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes. 17735 = 10B + 25T) (Assist.) **Fee:** $729.20	**Benefit:** 75% = $546.90	85% = $678.30
52126	MAXILLA, total resection of (Anaes. 17726 = 10B + 16T) (Assist.) **Fee:** $701.05	**Benefit:** 75% = $525.80	85% = $650.15
52129	MAXILLA, total resection of both maxillae (Anaes. 17735 = 10B + 25T) (Assist.) **Fee:** $938.40	**Benefit:** 75% = $703.80	85% = $887.50
† 52130	BONE GRAFT IN THE ORAL AND MAXILLOFACIAL REGION, not being a service to which another item in Groups O3 to O9 applies (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $344.50	**Benefit:** 75% = $258.40	85% = $293.60

† 52131	BONE GRAFT WITH INTERNAL FIXATION, IN THE ORAL AND MAXILLOFACIAL REGION, not being a service to which another item in Groups O3 to O9 applies (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $476.45	**Benefit:** 75% = $357.35	85% = $425.55
52132	TRACHEOSTOMY (Anaes. 17710 = 6B + 4T) **Fee:** $185.95	**Benefit:** 75% = $139.50	85% = $158.10
† 52133	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes. 17708 = 6B + 2T) **Fee:** $70.85	**Benefit:** 75% = $53.15	85% = $60.25
52135	POST-OPERATIVE or POST-NASAL HAEMORRHAGE, or both, control of, where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17707 = 5B + 2T) **Fee:** $112.40	**Benefit:** 75% = $84.30	85% = $95.55
† 52136	ARTERIAL OR VENOUS ANASTOMOSIS, as an independent procedure (Anaes. 17722 = 12B + 10T) (Assist.) **Fee:** $614.75	**Benefit:** 75% = $461.10	85% = $563.85
† 52137	ARTERIAL OR VENOUS ANASTOMOSIS not being a service to which another item applies, when performed in combination with another vascular operation (including graft to graft anastomosis) (Anaes. 17722 = 12B + 10T) (Assist.) **Fee:** $213.10	**Benefit:** 75% = $159.85	85% = $181.15
52138	MAXILLARY ARTERY, ligation of (Anaes. 17712 = 7B + 5T) (Assist.) **Fee:** $346.80	**Benefit:** 75% = $260.10	85% = $295.90
52141	FACIAL, MANDIBULAR or LINGUAL ARTERY or VEIN or ARTERY and VEIN, ligation of, not being a service to which item 52138 applies (Anaes. 17712 = 7B + 5T) (Assist.) **Fee:** $345.40	**Benefit:** 75% = $259.05	85% = $294.50
52144	FOREIGN BODY, deep, removal of using interventional imaging techniques (Anaes. 17707 = 5B + 2T) (Assist.) **Fee:** $321.95	**Benefit:** 75% = $241.50	85% = $273.70
52147	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $303.85	**Benefit:** 75% = $227.90	85% = $258.30
52148	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $537.00	**Benefit:** 75% = $402.75	85% = $486.10
† 52150	PAROTID GLAND, total extirpation of (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $575.55	**Benefit:** 75% = $431.70	85% = $524.65
† 52152	PAROTID GLAND, total extirpation of, with preservation of facial nerve (Anaes. 17718 = 5B + 13T) (Assist.) **Fee:** $973.95	**Benefit:** 75% = $730.50	85% = $923.05
† 52154	RECURRENT PAROTID TUMOUR, excision of, with preservation of facial nerve (Anaes. 17723 = 5B + 18T) (Assist.) **Fee:** $1,496.10	**Benefit:** 75% = $1,122.10	85% = $1,445.20
† 52156	PAROTID GLAND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $649.40	**Benefit:** 75% = $487.05	85% = $598.50
† 52158	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $864.70	**Benefit:** 75% = $648.55	85% = $813.80
† 52160	RADICAL EXCISION OF INTRA-ORAL TUMOUR INVOLVING RESECTION OF MANDIBLE AND LYMPH GLANDS OF NECK (commando-type operation) (Anaes. 17718 = 7B + 11T) (Assist.) **Fee:** $1,372.45	**Benefit:** 75% = $1,029.35	85% = $1,321.55
† 52166	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes. 17713 = 5B + 8T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $312.75	**Benefit:** 75% = $234.60	85% = $265.85
† 52168	LYMPH NODES OF NECK, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes. 17715 = 5B + 10T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $625.55	**Benefit:** 75% = $469.20	85% = $574.65

† 52170	LYMPH NODES OF NECK, selective dissection of 4 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes. 17719 = 5B + 14T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $974.80 **Benefit:** 75% = $731.10 85% = $923.90
† 52172	LYMPH NODES OF NECK, bilateral dissection of levels I, II and III (bilateral supraomohyoid dissections) (Anaes. 17723 = 5B + 18T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,042.55 **Benefit:** 75% = $781.95 85% = $991.65
† 52174	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck (Anaes. 17719 = 5B + 14T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $766.30 **Benefit:** 75% = $574.75 85% = $715.40
† 52176	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes. 17723 = 5B + 18T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,214.60 **Benefit:** 75% = $910.95 85% = $1,163.70
	MALIGNANT DISEASE
† 52180	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR IN THE ORAL AND MAXILLOFACIAL REGION, biopsy of (not including aftercare) (Anaes. 17706 = 4B + 2T) **Fee:** $146.60 **Benefit:** 75% = $109.95 85% = $124.65
† 52182	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR IN THE ORAL AND MAXILLOFACIAL REGION, lesional or marginal excision of (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $322.50 **Benefit:** 75% = $241.90 85% = $274.15
† 52184	BONE TUMOUR IN THE ORAL AND MAXILLOFACIAL REGION, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $476.45 **Benefit:** 75% = $357.35 85% = $425.55
† 52186	BONE TUMOUR IN THE ORAL AND MAXILLOFACIAL REGION, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes. 17711 = 4B + 7T) (Assist.) **Fee:** $586.40 **Benefit:** 75% = $439.80 85% = $535.50

GROUP O4 - PLASTIC & RECONSTRUCTIVE

52300	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, with skin or mucosa (Anaes. 17708 = 5B + 3T) (Assist.) **Fee:** $221.40	**Benefit:** 75% = $166.05	85% = $188.20
52303	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, with buccal pad of fat (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $316.05	**Benefit:** 75% = $237.05	85% = $268.65
52306	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, using temporalis muscle (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $469.10	**Benefit:** 75% = $351.85	85% = $418.20
52309	FREE GRAFTING (mucosa or split skin) of a granulating area (Anaes. 17707 = 5B + 2T) **Fee:** $159.40	**Benefit:** 75% = $119.55	85% = $135.50
52312	FREE GRAFTING (mucosa, split skin or connective tissue) to 1 defect including elective dissection (Anaes. 17708 = 5B + 3T) (Assist.) **Fee:** $221.40	**Benefit:** 75% = $166.05	85% = $188.20
52315	FREE GRAFTING, FULL THICKNESS, to 1 defect (mucosa or skin) (Anaes. 17708 = 5B + 3T) (Assist.) **Fee:** $368.90	**Benefit:** 75% = $276.70	85% = $318.00
52318	BONE GRAFT, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies - Autogenous - small quantity (Anaes. 17707 = 5B + 2T) **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50
52319	BONE GRAFT, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies - Autogenous - large quantity (Anaes. 17708 = 5B + 3T) **Fee:** $183.00	**Benefit:** 75% = $137.25	85% = $155.55
† 52320	VASCULARISED PEDICLE BONE GRAFT TO BE USED IN THE ORAL AND MAXILLOFACIAL REGION, harvesting of, in conjunction with another service (Anaes. 17710 = 6B + 4T) (Assist.) **Fee:** $293.20	**Benefit:** 75% = $219.90	85% = $249.25
52321	FOREIGN IMPLANT (NON-BIOLOGICAL), insertion of, for CONTOUR RECONSTRUCTION of pathological deformity, not being a service associated with a service to which item 52624 applies (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $368.90	**Benefit:** 75% = $276.70	85% = $318.00
52324	DIRECT FLAP REPAIR, using tongue, first stage (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $368.90	**Benefit:** 75% = $276.70	85% = $318.00
52327	DIRECT FLAP REPAIR, using tongue, second stage (Anaes. 17711 = 5B + 6T) **Fee:** $183.00	**Benefit:** 75% = $137.25	85% = $155.55
52330	PALATAL DEFECT (oro-nasal fistula), plastic closure of, including services to which item 52300, 52303, 52306 or 52324 applies (Anaes. 17716 = 7B + 9T) (Assist.) **Fee:** $608.80	**Benefit:** 75% = $456.60	85% = $557.90
52333	CLEFT PALATE, primary repair (Anaes. 17715 = 7B + 8T) (Assist.) **Fee:** $608.80	**Benefit:** 75% = $456.60	85% = $557.90
52336	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $380.50	**Benefit:** 75% = $285.40	85% = $329.60
52337	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $832.35	**Benefit:** 75% = $624.30	85% = $781.45
52339	CLEFT PALATE, secondary repair, lengthening procedure (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $433.35	**Benefit:** 75% = $325.05	85% = $382.45
52342	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17718 = 10B + 8T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $752.70	**Benefit:** 75% = $564.55	85% = $701.80

‡ 52345	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes. 17720 = 10B + 10T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $848.85	**Benefit:** 75% = $636.65	85% = $797.95
52348	MANDIBLE or MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17725 = 10B + 15T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $959.25	**Benefit:** 75% = $719.45	85% = $908.35
‡ 52351	MANDIBLE or MAXILLA, bilateral osteotomy of osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes. 17729 = 10B + 19T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,077.20	**Benefit:** 75% = $807.90	85% = $1,026.30
52354	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17729 = 10B + 19T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,092.05	**Benefit:** 75% = $819.05	85% = $1,041.15
‡ 52357	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes. 17732 = 10B + 22T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,229.50	**Benefit:** 75% = $922.15	85% = $1,178.60
52360	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17726 = 10B + 16T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,254.30	**Benefit:** 75% = $940.75	85% = $1,203.40
‡ 52363	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes. 17732 = 10B + 22T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,410.95	**Benefit:** 75% = $1,058.25	85% = $1,360.05
52366	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17753 = 10B + 43T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,379.80	**Benefit:** 75% = $1,034.85	85% = $1,328.90
‡ 52369	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes. 17758 = 10B + 48T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,551.40	**Benefit:** 75% = $1,163.55	85% = $1,500.50
52372	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17758 = 10B + 48T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,505.30	**Benefit:** 75% = $1,129.00	85% = $1,454.40
‡ 52375	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes. 17771 = 10B + 61T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,686.10	**Benefit:** 75% = $1,264.60	85% = $1,635.20

52378	GENIOPLASTY including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17713 = 5B + 8T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $582.85	**Benefit:** 75% = $437.15	85% = $531.95
52379	FACE, contour reconstruction of 1 region, using autogenous bone or cartilage graft (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $995.25	**Benefit:** 75% = $746.45	85% = $944.35
52380	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17758 = 10B + 48T) (Assist.) **Fee:** $1,696.20	**Benefit:** 75% = $1,272.15	85% = $1,645.30
‡ 52382	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes. 17764 = 10B + 54T) (Assist.) **Fee:** $2,033.20	**Benefit:** 75% = $1,524.90	85% = $1,982.30
52420	MANDIBLE, fixation by intermaxillary wiring, excluding wiring for obesity **Fee:** $187.75	**Benefit:** 75% = $140.85	85% = $159.60
† 52424	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) IN THE ORAL AND MAXILLOFACIAL REGION (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $368.80	**Benefit:** 75% = $276.60	85% = $317.90
† 52430	MICROVASCULAR REPAIR OF THE ORAL AND MAXILLOFACIAL REGION using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $848.85	**Benefit:** 75% = $636.65	85% = $797.95
† 52432	MICROVASCULAR ANASTOMOSIS of artery or vein IN THE ORAL AND MAXILLOFACIAL REGION using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes. 17743 = 10B + 33T) (Assist.) **Fee:** $1,381.75	**Benefit:** 75% = $1,036.35	85% = $1,330.85
† 52434	MICRO-ARTERIAL OR MICRO-VENOUS GRAFT IN THE ORAL AND MAXILLOFACIAL REGION using microsurgical techniques (Anaes. 17726 = 8B + 18T) (Assist.) **Fee:** $1,580.75	**Benefit:** 75% = $1,185.60	85% = $1,529.85
† 52440	CLEFT LIP, unilateral - primary repair, 1 stage, without anterior palate repair (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $421.50	**Benefit:** 75% = $316.15	85% = $370.60
† 52442	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes. 17716 = 7B + 9T) (Assist.) **Fee:** $526.95	**Benefit:** 75% = $395.25	85% = $476.05
† 52444	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $585.45	**Benefit:** 75% = $439.10	85% = $534.55
† 52446	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes. 17718 = 7B + 11T) (Assist.) **Fee:** $690.90	**Benefit:** 75% = $518.20	85% = $640.00
† 52448	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $203.75	**Benefit:** 75% = $152.85	85% = $173.20
† 52450	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes. 17711 = 6B + 5T) **Fee:** $234.15	**Benefit:** 75% = $175.65	85% = $199.05
† 52452	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes. 17713 = 6B + 7T) (Assist.) **Fee:** $380.50	**Benefit:** 75% = $285.40	85% = $329.60
† 52454	CLEFT LIP, primary columella lengthening procedure, bilateral (Anaes. 17711 = 6B + 5T) **Fee:** $357.15	**Benefit:** 75% = $267.90	85% = $306.25
† 52456	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $644.05	**Benefit:** 75% = $483.05	85% = $593.15

† 52458	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes. 17708 = 6B + 2T) **Fee:** $234.15 **Benefit:** 75% = $175.65 85% = $199.05
† 52460	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes. 17711 = 5B + 6T) **Fee:** $608.80 **Benefit:** 75% = $456.60 85% = $557.90
† 52470	FACIAL NERVE PALSY, excision of tissue for (Anaes. 17709 = 5B + 4T) **Fee:** $215.45 **Benefit:** 75% = $161.60 85% = $183.15
† 52476	EYELID closure in facial nerve paralysis, insertion of foreign implant for (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $427.40 **Benefit:** 75% = $320.55 85% = $376.50
† 52478	EYELID, WHOLE THICKNESS RECONSTRUCTION OF other than by direct suture only (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $457.55 **Benefit:** 75% = $343.20 85% = $406.65
† 52480	COMPOSITE GRAFT (Chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $391.05 **Benefit:** 75% = $293.30 85% = $340.15
† 52482	MACROCHEILIA or macroglossia, operation for (Anaes. 17716 = 5B + 11T) (Assist.) **Fee:** $376.25 **Benefit:** 75% = $282.20 85% = $325.35
† 52484	MACROSTOMIA, operation for (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $447.90 **Benefit:** 75% = $335.95 85% = $397.00

GROUP 05 - PREPROSTHETIC

52600	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $263.40	**Benefit:** 75% = $197.55	85% = $223.90
52603	MYLOHYOID RIDGE, reduction of (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $251.75	**Benefit:** 75% = $188.85	85% = $214.00
52606	MAXILLARY TUBEROSITY, reduction of (Anaes. 17711 = 5B + 6T) **Fee:** $192.05	**Benefit:** 75% = $144.05	85% = $163.25
52609	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $251.75	**Benefit:** 75% = $188.85	85% = $214.00
52612	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $316.05	**Benefit:** 75% = $237.05	85% = $268.65
52615	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $392.30	**Benefit:** 75% = $294.25	85% = $341.40
52618	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $456.55	**Benefit:** 75% = $342.45	85% = $405.65
52621	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes. 17719 = 5B + 14T) (Assist.) **Fee:** $456.55	**Benefit:** 75% = $342.45	85% = $405.65
52624	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $368.80	**Benefit:** 75% = $276.60	85% = $317.90
52626	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $226.15	**Benefit:** 75% = $169.65	85% = $192.25
52627	OSSEO-INTEGRATION PROCEDURE - extra oral implantation of titanium fixture (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $392.30	**Benefit:** 75% = $294.25	85% = $341.40
52630	OSSEO-INTEGRATION PROCEDURE - fixation of transcutaneous abutment (Anaes. 17707 = 5B + 2T) **Fee:** $145.20	**Benefit:** 75% = $108.90	85% = $123.45
52633	OSSEO-INTEGRATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes. 17711 = 6B + 5T) **Fee:** $392.30	**Benefit:** 75% = $294.25	85% = $341.40
52636	OSSEO-INTEGRATION PROCEDURE - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes. 17706 = 4B + 2T) **Fee:** $145.20	**Benefit:** 75% = $108.90	85% = $123.45

GROUP O6 - NEUROSURGICAL

52800	NEUROLYSIS BY OPEN OPERATION, without transposition, not being a service associated with a service to which item 52803 applies (Anaes. 17707 = 5B + 2T) (Assist.) **Fee:** $215.45	**Benefit:** 75% = $161.60	85% = $183.15
52803	NERVE TRUNK, internal (interfascicular), NEUROLYSIS of, using microsurgical techniques (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $310.25	**Benefit:** 75% = $232.70	85% = $263.75
52806	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from superficial peripheral nerve (Anaes. 17708 = 5B + 3T) (Assist.) **Fee:** $215.45	**Benefit:** 75% = $161.60	85% = $183.15
52809	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from deep peripheral nerve (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $368.90	**Benefit:** 75% = $276.70	85% = $318.00
52812	NERVE TRUNK, PRIMARY repair of, using microsurgical techniques (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $526.95	**Benefit:** 75% = $395.25	85% = $476.05
52815	NERVE TRUNK, SECONDARY repair of, using microsurgical techniques (Anaes. 17713 = 4B + 9T) (Assist.) **Fee:** $556.10	**Benefit:** 75% = $417.10	85% = $505.20
52818	NERVE, TRANSPOSITION OF (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $368.90	**Benefit:** 75% = $276.70	85% = $318.00
52821	NERVE GRAFT TO NERVE TRUNK (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes. 17718 = 5B + 13T) (Assist.) **Fee:** $802.00	**Benefit:** 75% = $601.50	85% = $751.10
52824	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $345.40	**Benefit:** 75% = $259.05	85% = $294.50
† 52826	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes. 17709 = 5B + 4T) **Fee:** $185.00	**Benefit:** 75% = $138.75	85% = $157.25
† 52828	CUTANEOUS NERVE, primary repair of, using microsurgical techniques (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $275.15	**Benefit:** 75% = $206.40	85% = $233.90
† 52830	CUTANEOUS NERVE, secondary repair of, using microsurgical techniques (Anaes. 17711 = 4B + 7T) (Assist.) **Fee:** $362.90	**Benefit:** 75% = $272.20	85% = $312.00
† 52832	CUTANEOUS NERVE, nerve graft to, using microsurgical techniques (Anaes. 17713 = 4B + 9T) (Assist.) **Fee:** $497.65	**Benefit:** 75% = $373.25	85% = $446.75

GROUP O7 - EAR, NOSE & THROAT

53000	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes. 17707 = 5B + 2T) **Fee:** $25.30 **Benefit:** 75% = $19.00 85% = $21.55
‡ + 53003	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes. 17707 = 5B + 2T) **Fee:** $71.65 **Benefit:** 75% = $53.75 85% = $60.95
† 53004	MAXILLARY ANTRUM, LAVAGE OF - each attendance at which the procedure is performed, including any associated consultation (Anaes. 17707 = 5B + 2T) **Fee:** $26.15 **Benefit:** 75% = $19.65 85% = $22.25
53006	ANTROSTOMY (RADICAL) (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $405.80 **Benefit:** 75% = $304.35 85% = $354.90
† 53007	ANTROSTOMY (RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $472.20 **Benefit:** 75% = $354.15 85% = $421.30
53009	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $230.20 **Benefit:** 75% = $172.65 85% = $195.70
53012	ANTRUM, drainage of, through tooth socket (Anaes. 17708 = 5B + 3T) **Fee:** $91.50 **Benefit:** 75% = $68.65 85% = $77.80
53015	ORO-ANTRAL FISTULA, plastic closure of (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $457.55 **Benefit:** 75% = $343.20 85% = $406.65
53016	NASAL SEPTUM, septoplasty, submucous resection or closure of septal perforation (Anaes. 17708 = 5B + 3T) (Assist.) **Fee:** $376.25 **Benefit:** 75% = $282.20 85% = $325.35
† 53017	NASAL SEPTUM, reconstruction of (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $469.45 **Benefit:** 75% = $352.10 85% = $418.55
53019	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes. 17717 = 5B + 12T) (Assist.) **Fee:** $452.20 **Benefit:** 75% = $339.15 85% = $401.30
† 53050	LATERAL RHINOTOMY with removal of tumour (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $698.55 **Benefit:** 75% = $523.95 85% = $647.65
† 53052	POST-NASAL SPACE, direct examination of, with or without biopsy (Anaes. 17707 = 5B + 2T) **Fee:** $95.55 **Benefit:** 75% = $71.70 85% = $81.25
† 53054	NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX and LARYNX, one or more of these procedures (Anaes. 17707 = 5B + 2T) **Fee:** $95.50 **Benefit:** 75% = $71.65 85% = $81.20
† 53056	EXAMINATION OF NASAL CAVITY or POST-NASAL SPACE, or NASAL CAVITY AND POST-NASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes. 17707 = 5B + 2T) **Fee:** $56.05 **Benefit:** 75% = $42.05 85% = $47.65
† 53058	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes. 17709 = 5B + 4T) **Fee:** $95.50 **Benefit:** 75% = $71.65 85% = $81.20
† 53060	CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES OR PHARYNX FOR OBSTRUCTION OR HAEMORRHAGE SECONDARY TO SURGERY (OR TRAUMA) - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes. 17707 = 5B + 2T) **Fee:** $78.20 **Benefit:** 75% = $58.65 85% = $66.50
† 53062	POST SURGICAL NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes. 17709 = 5B + 4T) **Fee:** $70.05 **Benefit:** 75% = $52.55 85% = $59.55

† 53064	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes. 17708 = 5B + 3T) **Fee:** $126.90 **Benefit:** 75% = $95.20 85% = $107.90
† 53066	DISLOCATION OF TURBINATE OR TURBINATES, 1 or both sides, not being a service associated with a service to which another item in this Group applies (Anaes. 17707 = 5B + 2T) **Fee:** $56.05 **Benefit:** 75% = $42.05 85% = $47.65
* 53068	TURBINECTOMY or TURBINECTOMIES, partial or total, unilateral (Anaes. 17707 = 5B + 2T) **Fee:** $105.00 **Benefit:** 75% = $78.75 85% = $89.25
† 53070	TURBINATES, submucous resection of, unilateral (Anaes. 17707 = 5B + 2T) **Fee:** $138.65 **Benefit:** 75% = $104.00 85% = $117.90

GROUP O8 - TEMPOROMANDIBULAR JOINT

+ 53200	MANDIBLE, treatment of a dislocation of, not requiring open reduction (Anaes. 17706 = 5B + 1T) **Fee:** $55.00	**Benefit:** 75% = $41.25	85% = $46.75
53203	MANDIBLE, treatment of a dislocation of, requiring open reduction (Anaes. 17707 = 5B + 2T) **Fee:** $92.50	**Benefit:** 75% = $69.40	85% = $78.65
53206	TEMPOROMANDIBULAR JOINT, manipulation of, performed in the operating theatre of a hospital or approved day-hospital facility, not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes. 17706 = 5B + 1T) **Fee:** $111.20	**Benefit:** 75% = $83.40	85% = $94.55
53209	GLENOID FOSSA, ZYGOMATIC ARCH and TEMPORAL BONE, reconstruction of (Obwegeser technique) (Anaes. 17719 = 5B + 14T) (Assist.) **Fee:** $1,283.85	**Benefit:** 75% = $962.90	85% = $1,232.95
53212	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes. 17716 = 5B + 11T) (Assist.) **Fee:** $693.60	**Benefit:** 75% = $520.20	85% = $642.70
53215	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $318.10	**Benefit:** 75% = $238.60	85% = $270.40
53218	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedures (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $508.95	**Benefit:** 75% = $381.75	85% = $458.05
† 53220	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $256.60	**Benefit:** 75% = $192.45	85% = $218.15
53221	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $679.15	**Benefit:** 75% = $509.40	85% = $628.25
53224	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $752.85	**Benefit:** 75% = $564.65	85% = $701.95
53225	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $226.15	**Benefit:** 75% = $169.65	85% = $192.25
† 53226	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $243.10	**Benefit:** 75% = $182.35	85% = $206.65
53227	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including meniscectomy when performed, with or without microsurgical techniques (Anaes. 17717 = 5B + 12T) (Assist.) **Fee:** $925.05	**Benefit:** 75% = $693.80	85% = $874.15
53230	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes. 17721 = 5B + 16T) (Assist.) **Fee:** $1,042.10	**Benefit:** 75% = $781.60	85% = $991.20
‡ 53233	TEMPOROMANDIBULAR JOINT, surgery of, involving procedures to which items 53224, 53226, 53227 and 53230 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes. 17725 = 5B + 20T) (Assist.) **Fee:** $1,170.90	**Benefit:** 75% = $878.20	85% = $1,120.00
† 53236	TEMPOROMANDIBULAR JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $366.45	**Benefit:** 75% = $274.85	85% = $315.55

† 53239	TEMPOROMANDIBULAR JOINT, arthrodesis of, not being a service to which another item in this Group applies (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $366.45 **Benefit:** 75% = $274.85 85% = $315.55
† 53242	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $243.10 **Benefit:** 75% = $182.35 85% = $206.65

GROUP O9 - TREATMENT OF FRACTURES

53400	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting *(See para OC. of explanatory notes to this Category)* **Fee:** $100.60	**Benefit:** 75% = $75.45	85% = $85.55
53403	MANDIBLE, treatment of fracture of, not requiring splinting *(See para OC. of explanatory notes to this Category)* **Fee:** $122.90	**Benefit:** 75% = $92.20	85% = $104.50
53406	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes. 17714 = 5B + 9T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $316.60	**Benefit:** 75% = $237.45	85% = $269.15
53409	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes. 17714 = 5B + 9T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $316.60	**Benefit:** 75% = $237.45	85% = $269.15
53410	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction *(See para OC. of explanatory notes to this Category)* **Fee:** $66.70	**Benefit:** 75% = $50.05	85% = $56.70
53411	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes. 17707 = 5B + 2T) *(See para OC. of explanatory notes to this Category)* **Fee:** $185.95	**Benefit:** 75% = $139.50	85% = $158.10
53412	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes. 17709 = 5B + 4T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $305.25	**Benefit:** 75% = $228.95	85% = $259.50
53413	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes. 17710 = 5B + 5T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $373.05	**Benefit:** 75% = $279.80	85% = $322.15
53414	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes. 17711 = 5B + 6T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $429.60	**Benefit:** 75% = $322.20	85% = $378.70
53415	MAXILLA, treatment of fracture of, requiring open reduction (Anaes. 17709 = 5B + 4T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $339.20	**Benefit:** 75% = $254.40	85% = $288.35
53416	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes. 17709 = 5B + 4T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $339.20	**Benefit:** 75% = $254.40	85% = $288.35
53418	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes. 17711 = 5B + 6T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $440.90	**Benefit:** 75% = $330.70	85% = $390.00
53419	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes. 17711 = 5B + 6T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $440.90	**Benefit:** 75% = $330.70	85% = $390.00
53422	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes. 17712 = 5B + 7T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $559.60	**Benefit:** 75% = $419.70	85% = $508.70

53423	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes. 17712 = 5B + 7T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $559.60	**Benefit:** 75% = $419.70	85% = $508.70
53424	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes. 17712 = 5B + 7T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $480.10	**Benefit:** 75% = $360.10	85% = $429.20
53425	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes. 17712 = 5B + 7T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $480.10	**Benefit:** 75% = $360.10	85% = $429.20
53427	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes. 17714 = 5B + 9T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $655.75	**Benefit:** 75% = $491.85	85% = $604.85
53429	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes. 17714 = 5B + 9T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $655.75	**Benefit:** 75% = $491.85	85% = $604.85
53439	MANDIBLE, treatment of a closed fracture of, involving a joint surface (Anaes. 17707 = 5B + 2T) *(See para OC. of explanatory notes to this Category)* **Fee:** $185.95	**Benefit:** 75% = $139.50	85% = $158.10
53453	ORBITAL CAVITY, reconstruction of a wall or floor with or without foreign implant (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $376.25	**Benefit:** 75% = $282.20	85% = $325.35
53455	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $441.95	**Benefit:** 75% = $331.50	85% = $391.05
53458	NASAL BONES, treatment of fracture of, not being a service to which item 53459 or 53460 applies **Fee:** $33.45	**Benefit:** 75% = $25.10	85% = $28.45
53459	NASAL BONES, treatment of fracture of, by reduction (Anaes. 17707 = 5B + 2T) **Fee:** $183.30	**Benefit:** 75% = $137.50	85% = $155.85
53460	NASAL BONES, treatment of fractures of, by open reduction involving osteotomies (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $373.90	**Benefit:** 75% = $280.45	85% = $323.00

	GROUP O10 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
† 53600	SKIN SENSITIVITY TESTING for allergens to anaesthetics and materials used in OMS surgery, USING 1 TO 20 ALLERGENS *(See para OC. of explanatory notes to this Category* **Fee:** $30.30 **Benefit:** 75% = $22.75 85% = $25.80
	GROUP O11 - REGIONAL OR FIELD NERVE BLOCKS
	(Note. Where an anaesthetic combines a regional nerve block with a general anaesthetic for an operative procedure, benefits will be paid only under the anaesthetic item relevant to the operation. The items in this Group are to be used in the practice of oral and maxillofacial surgery and are not to be used for dental procedures (eg. restorative dentistry or dental extraction.))
† 53700	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent **Fee:** $97.20 **Benefit:** 75% = $72.90 85% = $82.65
† 53702	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent **Fee:** $48.65 **Benefit:** 75% = $36.50 85% = $41.40
† 53704	FACIAL NERVE, injection of an anaesthetic agent **Fee:** $29.30 **Benefit:** 75% = $22.00 85% = $24.95
† 53706	NERVE BRANCH IN THE ORAL AND MAXILLOFACIAL REGION, destruction by a neurolytic agent, not being a service to which any other item in this Group applies *(See para OC. of explanatory notes to this Category)* **Fee:** $97.20 **Benefit:** 75% = $72.90 85% = $82.65

INDEX TO
ORAL AND MAXILLOFACIAL
SERVICES

DIAGNOSTIC IMAGING SERVICES

CATEGORY 5

PLEASE NOTE:

The information contained in this Category relates specifically to the Diagnostic Imaging Services Arrangements under Medicare. More comprehensive information on the Medicare Benefits Schedule book and the Medicare Arrangements are contained in the INTRODUCTION and the GENERAL EXPLANATORY NOTES to this book, which should be read in conjunction with this Category.

CATEGORY 5 - DIAGNOSTIC IMAGING SERVICES

OUTLINE OF ARRANGEMENTS

SCHEDULE OF SERVICES

OUTLINE OF ARRANGEMENTS

DIA. DIAGNOSTIC IMAGING SERVICES IN RELATION TO MEDICARE BENEFITS

DIA.1 Introduction

Changes to the Health Insurance Act from 1 May 1991 imposed certain conditions on the payment of Medicare benefits for diagnostic imaging services and prohibited certain practices in the provision of those services. The services currently covered by this legislation are diagnostic radiology, Computed Tomography (CT) scanning, ultrasound, nuclear medicine scanning and Magnetic Resonance Imaging (MRI).

Under this legislation, except in certain circumstances, Medicare benefits are only payable for a diagnostic service if it is rendered following a written request for that service by another medical practitioner. For X-rays of the head and certain other services, the requesting practitioner may also be a dental practitioner, periodontist, endodontist, pedeodontist, orthodontist, prosthodontist, oral medicine surgeon, oral pathology surgeon, or oral and maxillofacial surgeon. For X-rays of the spine and pelvic region the requesting practitioner may also be a chiropractor or a physiotherapist and for specified X-rays of the foot the requesting practitioner may also be a podiatrist (see DIA.4.8)

To help in defining a diagnostic imaging service, a separate Diagnostic Imaging Services Table was established.

The items of service which are subject to the written request requirement are classified as "R-type" (requested) services and are identified in the Diagnostic Imaging Services Table with the symbol "(R)" after the item description.

The items of service not subject to the request requirement are classified as "NR-type" (not requested) services and are identified with the symbol "(NR)" after the item description.

The "NR-type" items of service are in Group I1 - Ultrasound and Group I3 - Diagnostic Radiology. "NR-type" items in Group I1 - Ultrasound are Items 55029, 55031, 55033, 55035, 55037, 55039, 55045, 55047, 55049, 55051, 55053, 55073, 55079, 55703, 55705, 55709, 55715, 55723, 55725, 55733, 55739, 55762, 55766, 55770, 54774, 55802, 55806, 55810, 55814, 55818, 55822, 55826, 55830, 55834, 55838, 55842, 55846. In Group I3 - Diagnostic Radiology, the "NR-type" Items are 57506, 57512, 57518, 57524, 57700, 57706, 58500, 58900, 60072, 60075, 60078, and all items in Group I3 Subgroup 16 (Preparation). All other diagnostic imaging services are classified as "R-type" services.

Items 60072, 60075 and 60078 (selective Digital Subtraction Angiography (DSA)) and items in Group I3, Subgroup 16, can only be rendered with certain "R-type" services. These items have not been classified as "R-type" services because this would require that there be a written request for the services referred to in these NR items in addition to the particular service requested.

DIA.2 Services Rendered "On Behalf Of" Medical Practitioners

DIA.2.1 ***Medicare Benefits Attracted***
Diagnostic imaging services attract Medicare benefits if the service is rendered by:

(a) a medical practitioner;
(b) a person, other than a medical practitioner, who:

(i) is employed by a medical practitioner; or
(ii) provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

Benefits are not payable, for example, when a medical practitioner refers patients to self-employed paramedical personnel, such as radiographers or other persons who either bill the patient or the practitioner requesting the service.

DIA.3 Basic Requirements

DIA.3.1 ***General Rule for Medicare Eligibility***
Except in circumstances detailed below, a Medicare benefit is not payable for a diagnostic imaging service unless, prior to commencing the relevant service, the providing practitioner receives a signed and dated written request from a referring practitioner who determined that the service was necessary (the treating practitioner). A valid request can be made by a medical practitioner on behalf of the treating practitioner, for example by a resident medical officer at a hospital on behalf of the patient's practitioner.

The requesting practitioner must turn his or her mind to the clinical relevance of the request and determine that the service is necessary for the adequate professional care of the patient.

DIA.3.2 ***Referral to Specified Practitioner Not Required***
It is not necessary that a written request for a diagnostic imaging service be addressed to a particular practitioner or that, if the request is addressed to a particular practitioner, the service must be rendered by that practitioner.

DIA.3.3 ***Request for More Than One Service and Limit on Time to Render Services***
A practitioner may use a single request to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within seven days after the rendering of the first service.

DIA.4 Exemptions from Basic Requirements

DIA.4.1 ***General Provision***
There are exemptions from the general written request requirements. These are detailed below.

DIA.4.2 ***Consultant Physician or Specialist***
Except for R-type items which preclude in their description (such as most R-type items in General Ultrasound and items 59300, 59303) an exemption from the written request provisions, a written request is not required for the payment of Medicare benefits when the diagnostic imaging service is provided by or on behalf of a consultant physician or a specialist (other than a specialist in diagnostic radiology) in the course of that consultant physician or specialist practising in his or her specialty and after determining that the service was necessary. See section DIB.1.3 for details required on accounts.

DIA.4.3 ***Remote Area Exemption***
A written request is not required for the payment of Medicare benefits for an "R-type" diagnostic imaging service rendered by a medical practitioner in a remote area, provided:

- the "R-type" service is not one for which there is a corresponding "NR-type" service; and
- the medical practitioner rendering the service has been granted a remote area exemption for that service.

Further information regarding the remote area exemption is set out in section DIC of these explanatory notes. See section DIB.1.3 for details required on accounts.

DIA.4.4 ***Emergencies***
The written request requirement does not apply if the providing practitioner determined that, because the need for the service arose in an emergency, the service should be performed as quickly as possible. See section DIB.1.3 for details required on accounts.

DIA.4.5 ***Lost Requests***
The written request requirement does not apply where:

- the person who received the diagnostic imaging service or someone acting on that person's behalf claimed that a medical practitioner, dentist, chiropractor, physiotherapist or podiatrist had made a written request for such a service but that the request had been lost; and

- the provider of the diagnostic imaging service or that practitioner's agent or employee obtained confirmation from the requesting practitioner.

In respect of requests by dentists, chiropractors, physiotherapists or podiatrists, the lost request exemption is applicable only to radiographic examinations of the specific areas they can request. For details required on accounts, see section DIB.1.3.

DIA.4.6 ***Additional Necessary Services***
A written request is not required for a diagnostic imaging service if that service was rendered after one which had been formally requested and the providing practitioner had determined that, on the basis of the results obtained from the requested service, that an additional service was necessary. For details required on accounts, see section DIB.1.3.

DIA.4.7 ***Pre-existing Diagnostic Imaging Practices***
The legislation provides for exemption from the written request requirement for services provided by practitioners who have operated pre-existing diagnostic imaging practices. To qualify for this "grandparent" exemption the providing practitioner must:

(a) be treating his or her own patient;
(b) have determined that the service was necessary;

(c) have rendered between 17 October 1988 and 16 October 1990 at least 50 services (which resulted in the payment of Medicare benefits) of the kind which have been designated "R-type" services from 1 May 1991;
(d) provide the exempted services at the practice location where the services which enabled the practitioner to qualify for the "grandparent" exemption were rendered; and
(e) be enrolled in an approved continuing medical education and quality assurance program from 1 January 2001. For further information, please phone (02) 6289 8728.

Benefits are only payable for services exempted under these provisions where the service was rendered by the exempted medical practitioner at the exempted location. Exemptions are not transferable.

The above exemption applies to the services covered by the following Items: 57712, 57715, 57901, 57902, 57903, 57912, 57915, 57921, 58100, 58103, 58106, 58109, 58112, 58115, 58521, 58524, 58527, 58700, 58924 and 59103.

For details required on accounts, see section DIB.1.3.

DIA.4.8 ***Diagnostic Imaging Services Requested by Dental Practitioners, Chiropractors, Physiotherapists and Podiatrists***

The legislation specifies (R) type diagnostic imaging services which may be requested by dental practitioners, chiropractors, physiotherapists and podiatrists, subject to the requirements of State and Territory laws.

Dental practitioners (including oral and maxillofacial surgeons and prosthodontists) may request the following Items:

57509, 57515, 57521, 57527, 57901, 57902, 57903, 57906, 57909, 57912, 57915, 57918, 57921, 57924, 57927, 57930, 57933, 57936, 57939, 57942, 57945, 58100, 58300, 58503, 58903, 59733, 59739, 59751, 60100, 60500, 60503.

Dental specialists (periodontistry, endodontistry, pedeodontistry, orthodontistry and prosthodontistry) may request the following Items:

56022, 56062, 58306, 61421, 61454, 61457, 63621, 63671, 63712.

Oral and maxillofacial surgeons may also request the following Items:

55028, 55030, 55032, 55050, 55052, 56001, 56007, 56010, 56013, 56016, 56022, 56028, 56041, 56047 56050, 56053, 56056, 56062, 56068, 56101, 56107, 56141, 56147, 56210, 56216, 56250, 56256, 56301, 56307, 56341, 56347, 56401, 56407, 56409, 56412, 56441, 56447, 56449, 56452, 56501, 56507, 56541, 56547, 56801, 56807, 56841, 56847, 57001, 57007, 57041, 57047, 57341, 57345, 57703, 57709, 57712, 57715, 58103, 58106, 58109, 58112, 58115, 58306 58506, 58521, 58524, 58527, 58909, 59103, 59703, 59924, 60000, 60003, 60006, 60009, 60506, 60509, 61109, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446 61449, 61450, 61453, 61454, 61457, 61462, 63621, 63671, 63712.

Oral medicine and oral pathology surgeons may also request the following Items:

55030, 55032, 55050, 55052, 56001, 56007, 56010, 56013, 56016, 56022, 56028, 56041, 56047, 56050, 56053, 56056, 56062, 56068, 56101, 56107, 56141, 56147, 56301, 56307, 56341, 56347, 56401, 56407, 56441, 56447, 57341, 57345, 58306, 58506, 58909, 59103, 59703, 59924, 60000, 60003, 60006, 60009, 60506, 60509, 61109, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63003, 63103, 63273, 63621, 63671, 63712.

Prosthodontists may also request the following Items:

55050, 55052, 56013, 56016, 56022, 56028, 56053, 56056, 56062, 56068, 58306, 61421, 61425, 61429
61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63621, 63671, 63712.

Chiropractors and physiotherapists may request the following Items:

57712, 57715, 58100, 58103, 58106, 58109, 58112, 58115.

Podiatrists may request the following Items:

57521, 57527.

DIA.5 Medicare Benefits Not Payable

DIA.5.1 ***Medicare Benefits in Relation to Diagnostic Imaging Services Rendered in Contravention of State or Territory Laws***

Where a diagnostic imaging service is rendered by or on behalf of a medical practitioner and the rendering of that service by the doctor or any other person contravenes a State or Territory law relating directly or indirectly to the use of diagnostic imaging procedures or equipment, Medicare benefits are not payable.

DIA.5.2 ***Medicare Benefit Not Payable in Respect of Services Rendered by Disqualified Practitioners***

Medicare benefits are not payable for a diagnostic imaging service if, at the time the service was rendered, the providing practitioner or the practitioner on whose behalf the service was rendered was disqualified fully or partially from the Medicare benefits arrangements.

DIA.5.3 ***Notification of Contraventions of Certain State and Territory Laws to Relevant Authorities***

The Managing Director of the Health Insurance Commission may notify the relevant State or Territory authorities if he/she believes that a person may have contravened a law of a State or Territory relating directly or indirectly to the use of diagnostic imaging procedures or equipment.

DIA.6 ***Multiple Services Rules***

The multiple services rules apply to services rendered on or after 20 January 1997. There are three rules, and more than one rule may apply in a patient episode.

The rules do not apply to diagnostic imaging services rendered in a remote area by a practitioner who has a remote area exemption for that area. (See DIC re Remote Area Exemptions).

Reference is made in these rules to "R-type" and "NR-type" services and an explanation of these services is set out in paragraph DIA.1.

Rule A. When more that one diagnostic imaging service, R-type or NR-type, is provided to a patient by the same practitioner on the one day, then:

- the diagnostic imaging service with the highest Schedule fee has an unchanged Schedule fee; and
- the Schedule fee for each additional diagnostic imaging service is reduced by $5.

Rule B. When an R-type diagnostic imaging service and a consultation are rendered for a patient by the same practitioner on the one day, there is a deduction to the Schedule fee for the diagnostic imaging service with the highest Schedule fee. The amount of the deduction will vary depending on the level of the Schedule fee for the consultation. The deductions are as follows:

- When the Schedule fee for the consultation is $40 or more:
  - the Schedule fee for the diagnostic imaging service with the highest Schedule fee is reduced by $35; or
  - if the Schedule fee for the diagnostic imaging service with the highest Schedule fee is less than $35, the reduction will be the amount of that Schedule fee.
- When the Schedule fee for the consultation is less than $40:
  - the Schedule fee for the diagnostic imaging service with the highest Schedule fee is reduced by $15.

The deduction under Rule B is made once only. If there is more than one consultation, the relevant consultation is that with the highest Schedule fee. There is no further deduction for additional consultations.

A 'consultation' is a service rendered under an item from Category 1 of the Medicare Benefits Schedule, that is, items 1 to 10815 inclusive.

Rule C. When an R-type diagnostic imaging service or services and a medical service are carried out for a patient by the same practitioner on the one day:

- the Schedule fee for the diagnostic imaging service with the highest Schedule fee is reduced by $5.

A deduction under Rule C is made once only. There is no further deduction for any additional medical services.

For Rule C, a 'medical service' is defined as any following item from the MBS:

- Category 2, items 11000 to 12533;
- Category 3, items 13020 to 51312;
- Category 4, items 51700 to 53460;
- Cleft Lip and Palate services, items 75001 to 75854.

Pathology services are not included in Rule C.

When both Rules B and C apply, the sum of the deductions in the Schedule fee for the diagnostic imaging service with the highest Schedule fee is not to exceed that Schedule fee.

DIB. DIAGNOSTIC IMAGING SERVICES REQUESTS

DIB.1 Form etc. of Request

DIB.1.1 ***Details of Services Requested***
A written request for a diagnostic imaging service does not have to be in any particular form. However, the legislation provides that a request must contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item of service requested. Responsibility for the adequacy of requesting details rests with the requesting practitioner.

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

DIB.1.2 ***Contravention of Request Requirements***
A practitioner who, without reasonable excuse, makes a request for a diagnostic imaging service that does not include the required information in his or her request or in a request made on his or her behalf is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine of $1000.

A medical practitioner who renders "R-type" diagnostic imaging services and who, without reasonable excuse, provides either directly or indirectly to a requesting practitioner a document to be used in the making of a request which would contravene the request information requirements is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine of $1000.

DIB.1.3 ***Details Required on Accounts, Receipts and Medicare Assignment of Benefits Forms***
In addition to the normal particulars of the patient, date of service, the services performed and the fees charged, the details which are to be entered on accounts or receipts, and Medicare assignment of benefits forms in respect of diagnostic imaging services are as follow:

- If the professional service is provided by a specialist in diagnostic radiology the name and either the practice address or provider number of the radiologist who provided the service.

- If the medical practitioner is not a specialist in diagnostic radiology the name and either the practice address or provider number of the practitioner who is claiming or has received payment or is the assignee under a direct billing agreement in respect of the service provided.

- For "R-type" (requested) services and services rendered subsequent to lost requests, the account or receipt or the Medicare assignment form must indicate the date of the request and the name and provider number, or the name and address, of the requesting practitioner.

  - **Accounts for services that are self determined must be endorsed with the letters "SD" to indicate that the service was self determined. Services may be self determined when:**
    ***rendered by a consultant physician or specialist, in the course of that consultant physician or specialist practising his or her speciality (other than a specialist in diagnostic radiology), or**
    ***rendered in a remote area, or**
    ***rendered as an additional service, or**
    ***rendered under a pre-existing diagnostic imaging practice exemption.**

- For emergencies, the account etc. must be endorsed "emergency".

. In respect of lost requests the account etc. must be endorsed "lost request".

DIB.1.4 ***Retention of R-type Requests etc.***
A medical practitioner who has rendered an "R-type" diagnostic imaging service in response to a written request must retain that request for the period of 18 months commencing on the day on which the service was rendered.

A medical practitioner must, if requested by the Managing Director of the Health Insurance Commission, produce to an officer of the Commission written requests retained by that practitioner for an "R-type" diagnostic imaging service as soon as practicable but in any case no later than the end of the day after the day on which the Managing Director's request was made.

The officer of the Health Insurance Commission is authorised to make and retain copies of or take and retain extracts from written requests or written confirmations of lost requests.

A medical practitioner who, without reasonable excuse, fails to comply with the above requirements is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine of $1000.

DIB.1.5 ***Other Records of Diagnostic Imaging Services***
Providers of diagnostic imaging services must keep records of diagnostic imaging services in a manner that facilitates retrieval on the basis of the patient's name and date of service.

These records must include the report by the providing practitioner on the diagnostic imaging service.

For services rendered after a lost request, the records must include words to the effect that the request was lost but confirmed by the requesting practitioner and the manner of confirmation, e.g. how and when.

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

Medical practitioners must retain records of R-type diagnostic imaging services for a period of 18 months commencing on the day on which the service was rendered.

If requested by the Managing Director of the Health Insurance Commission, records retained by a providing practitioner must be produced to an officer of the Commission as soon as practicable but in any event within seven days after the day the Managing Director requests the production of those records.

Officers of the Health Insurance Commission may make and retain copies, or take and retain extracts, of such records.

A medical practitioner who, without reasonable excuse, contravenes any of the above provisions is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine of $1000.

DIC. REMOTE AREA EXEMPTIONS

DIC.1 Remote Areas

DIC.1.1 ***Designation of Remote Areas***
For remote area exemption purposes a remote area is one:

(a) that is more than 30 kilometres by road from a hospital which provides a radiology service under the direction of a specialist in the specialty of diagnostic radiology; and
(b) that is more than 30 kilometres by road from a free-standing radiology facility under the direction of a specialist in the specialty of diagnostic radiology; and
(c) where the facilities for rendering R-type diagnostic imaging services in the area in which the practice is situated (including facilities provided by practitioners visiting the area regularly) are such that patients in the area would suffer physical or financial hardship.

As is explained in section DIC.1.5, a remote area exemption may be restricted to certain services.

DIC.1.2 ***Application for Remote Area Exemption***
A medical practitioner who believes that he or she qualifies for exemption under the remote area definition and wishes to apply for such an exemption should make application, using the approved form (which is obtainable from the Health Insurance Commission), to the Managing Director, Health Insurance Commission, c/o General Manager, Medicare Benefits, PO Box 9822 in the Capital city in his or her State.

The form requires that the applicant provide the following details:

(a) the practitioner's name, address and practice location;
(b) a statement setting out the services for which exemption is sought;
(c) the reasons for seeking the exemption;
(d) the name, location, and distance from the applicant's practice, of the nearest radiology facility under the direction of a specialist radiologist; and
(e) if any arrangements exist for the provision of services by a visiting radiologist, the nature of those arrangements.

DIC.1.3 ***Quality assurance requirement***

From 1 January 2001, application for, or continuation of, the exemption will be contingent on practitioners being enrolled in an approved continuing medical education and quality assurance program. For further information, please contact the Australian College of Rural and Remote Medicine on (07) 33528600

DIC.1.4 ***Request for Further Information***
An applicant for remote area exemption may be requested by the Minister for Health to provide additional information within 60 days of a remote area exemption application having been made.

DIC.1.5 ***Grant of Remote Area Exemption***
The applicant must be granted a remote area exemption if the Minister is satisfied:

(a) the applicant provided the required information;
(b) the applicant's practice is located in a remote area; and
(c) the facilities for rendering "R-type" diagnostic imaging services in the area in which the applicant's practice is located, including any visiting facilities, are such that, were the formal written request requirement to apply to the rendering of those services, patients in the area would suffer physical or financial hardship.

DIC.1.6 ***Restrictions on Remote Area Exemption***
Where the physical or financial hardship would only apply to the rendering of a limited range of diagnostic imaging services, the notice granting exemption from the written request requirements may restrict the remote area exemption to those services.

If a limited exemption is granted, the applicant will be provided in writing with the reasons for that restriction.

The person to whom a remote area exemption applies may apply in writing at any time seeking the removal of the restriction or a reduction in its scope.

The applicant may be requested in writing, within 60 days of making the application for removal of a restriction or a reduction in its scope, to provide additional information relating to the application.

If the Minister is satisfied that retention of the restriction or the refusal to grant a reduction in its scope would cause physical or financial hardship to patients in the area, the restriction must be removed or reduced in scope and the applicant must be notified in writing accordingly.

DIC.1.7 ***Refusal of Application***
The Minister may refuse an application for a remote area exemption, the removal of a restriction on a remote area exemption, or a reduction in the scope of a restriction on a remote area exemption by giving the applicant written notice of the refusal and the reasons for the refusal.

DIC.1.8 ***Deemed Refusal for Review Purposes***
For the purposes of review by the Administrative Appeals Tribunal, the Minister will be deemed to have refused an application for a remote area exemption, the removal of a remote area restriction or a reduction in the scope of such a restriction if, at the end of 60 days after the application was made, the Minister has not made a decision, or has not sought further information from the applicant, or, having obtained additional information from the applicant, has not notified the applicant of his or her decision.

DIC.1.9 ***Duration of Remote Area Exemption***
A remote area exemption remains in force for a period of up to 3 years unless revoked by the Minister.

DIC.1.10 ***Renewal of Exemption***
A holder of a remote area exemption may apply for its renewal at any time within six months before it is due to expire. In any event, the Health Insurance Commission will send the holder a reminder notice and a renewal application six weeks before the current exemption expires.

The arrangements for dealing with renewal applications are the same as those applying to initial applications.

DIC.1.11 ***Revocation of Exemption***
The Minister may revoke a remote area exemption if satisfied that the practice of the practitioner granted the exemption is no longer situated in a remote area, or that adequate diagnostic imaging facilities have become available in the relevant area to enable the written request requirement to operate without causing physical or financial hardship to patients in that area.

The Minister may also revoke an exemption if a Medicare Participation Review Committee has so advised.

Before revoking a remote area exemption, the practitioner must be given written notice indicating that revocation is being considered, detailing the grounds for considering revocation, and stating that the practitioner has the right to make a written submission, within six months of being given the notice, as to why the exemption should not be revoked.

The Minister must give due consideration to any such submissions made by or on behalf of the practitioner during those six months.

DID. REVIEW OF DECISIONS

DID.1 Administrative Appeals Tribunal

DID.1.1 ***Review by Administrative Appeals Tribunal***
A practitioner may apply to the Administrative Appeals Tribunal for a review of:

(a) a decision to restrict a remote area exemption to certain "R-type" diagnostic imaging services; or
(b) a decision to reduce the scope of a remote area exemption; or
(c) a decision to refuse a remote area exemption; or
(d) a deemed refusal of a remote area exemption application or of the reduction of the scope of an exemption; or
(e) a decision to revoke a remote area exemption following advice by a Medicare Participation Review Committee.

DID.1.2 ***Statements to Accompany Notification of Decisions***
When a person affected by a decision set out in DID.1.1 above is given written notice of that decision, the notice must include a statement advising that, if the person is dissatisfied with the decision, an application may be made to the Administrative Appeals Tribunal for a review of that decision.

Failure to comply with the above requirement does not affect the validity of the decision.

DIE. PROHIBITED PRACTICES

DIE.1 Prohibited Diagnostic Imaging Practices

For Medicare benefit purposes, a person is taken to be engaged in a prohibited diagnostic practice if:

(a) the person is a service provider who directly or indirectly offers any inducement (whether by way of money, property or other benefit or advantage), or threatens any detriment or disadvantage, to a practitioner or any other person in order to encourage the practitioner to request the rendering of a diagnostic imaging service; or
(b) the person is a service provider who, without reasonable excuse:
    (i) directly or indirectly invites a practitioner to request the rendering of a diagnostic imaging service; or
    (ii) does any act or thing that the person knows, or ought reasonably to know, is likely to have the effect of directly or indirectly encouraging a practitioner to request the rendering of a diagnostic imaging service; or
(c) the person is a practitioner, or the employer of a practitioner, who, without reasonable excuse, asks, receives or obtains, or agrees to receive or obtain, any property, benefit or advantage of any kind for himself or herself, or any other person, from a service provider or a person acting on behalf of the service provider; or
(d) the person is a practitioner who:
    (i) accepts a request from another practitioner to render a diagnostic imaging service; and
    (ii) in respect of any service (including a service for the use of diagnostic imaging equipment) connected with the rendering of the diagnostic imaging service, makes a payment, directly or indirectly:
        (A) to the other practitioner; or

(B) if the diagnostic imaging service is not provided in a hospital - to a person who is the other practitioner's employer or to an employee of such a person; or

(e) the person is a practitioner who accepts a request from another practitioner to render a diagnostic imaging service where there is in force an arrangement under which:

(i) the two practitioners share, directly or indirectly, the cost of employing staff, or of buying, renting or maintaining items of equipment; and

(ii) the amounts payable under the arrangement are not fixed at normal commercial rates; or

(f) the person is a practitioner who accepts a request from another practitioner to render a diagnostic imaging service where there is in force an arrangement under which:

(i) the 2 practitioners share a particular space in a building; or

(ii) one practitioner provides, directly or indirectly, space in a building for the use or occupation of the other practitioner or permits the other practitioner to use or occupy space in a building;

and the amounts payable under the arrangement are not fixed at normal commercial rates; or

(g) the person is a specialist in the speciality of diagnostic radiology who stations diagnostic imaging equipment or employees of the specialist at the premises of another practitioner (whether it is a full-time arrangement or not), so that diagnostic imaging services may be rendered to the practitioner's patients by or on behalf of the specialist.

DIF.1 NOTICE OF POSSIBLE BREACHES

DIF.1.1 ***Minister to Give Notice***

Where the Minister has reasonable grounds for believing that a person has engaged in prohibited diagnostic imaging practices, the Minister is required to notify that person in writing giving the grounds for that belief and setting out the particulars of the prohibited practice. The Minister is also required to invite the practitioner to show cause within 28 days, commencing on the day the notice is given, why no further action should be taken in relation to the person.

DIF.1.2 ***Minister to Consider Submissions***

Where a person makes a submission to the Minister within 28 days, the Minister must take the submission into account in determining whether to take further action in respect of that person.

DIF.1.3 ***Minister May Take Further Action***

If after 28 days the person has not made submissions to the Minister, or the person has made submissions and the Minister is satisfied that there are reasonable grounds for believing the person may have engaged in a prohibited diagnostic imaging practice, the Minister must give notice in writing to the Chairperson of a Medicare Participation Review Committee, setting out the particulars of the prohibited diagnostic imaging practice and the grounds for the Minister's belief.

Where a person provides a submission within the 28 day period and the Minister decides that no further action be taken against the person, that decision must be conveyed to the person in writing.

DIG. MEDICARE PARTICIPATION REVIEW COMMITTEE

DIG.1 Chairperson to Establish Committee

DIG.1.1 ***Establishment of Committee***

Upon receiving a notice from the Minister that a person is believed to have engaged in a prohibited diagnostic imaging practice, the Chairperson of a Medicare Participation Review Committee must establish a Committee.

Where a Chairperson receives a notice in relation to a practitioner, and the Committee has already been established in relation to the practitioner but the Committee has yet to make a determination in relation to the practitioner, the Chairperson must as soon as practicable, bring the notice to the attention of the Committee.

DIG.1.2 ***Composition of Committees***

For the purposes of determining whether a person has engaged in a prohibited diagnostic imaging practice, the Medicare Participation Review Committee will consist of five persons.

With the exception of the Chairperson, who must be a legal practitioner of not less than five years standing, all members must be medical practitioners experienced in the rendering of diagnostic services.

No Committee member may have a direct or indirect interest (whether pecuniary or otherwise) in a matter to be considered by the Committee.

DIG.1.3 ***Provision of Information to Person***

Any information given to a Committee by the Health Insurance Commission about a person must also be given to that person at or about the same time.

DIG.1.4 ***Committee may add Parties to Proceedings***
Where a Committee has reasonable grounds to believe that a person who employs or employed the practitioner (in respect of whom the Committee was established), or is or was an officer of a body corporate that employs or employed that practitioner may have caused or permitted the practitioner, or any other person, to engage in prohibited diagnostic imaging practices, it may determine whether the person caused or permitted those prohibited practices.

If the Committee has been established in relation to a body corporate which employs or employed a practitioner and the Committee has reasonable grounds to believe that a person who is or was an officer of the body corporate caused or permitted the practitioner to engage in a prohibited practice, it may determine whether it should consider whether that officer caused or permitted that prohibited practice to be engaged in.

DIG.1.5 ***Written Notice to Persons***
Written notice of any determination made by a Medicare Participation Review Committee must be given to the person in respect of whom the determination is made.

DIG.1.6 ***Committee Determinations***
If a Committee determines that a person engaged in, or permitted another person to engage in, a prohibited diagnostic imaging practice, it must make one of the following determinations:

- that no action should be taken against the person;
- that it should counsel the person;
- that it should reprimand the person;
- that the person, if a practitioner, is disqualified for the purposes of attracting Medicare benefits for some or all diagnostic imaging services for a specified period of not more than 5 years;
- where the person employs, or has employed, a practitioner - that any practitioner who is employed by the person is, while so employed, taken to be disqualified;
- where the person is or has been an officer of a body corporate that employs, or has employed, a practitioner - that any practitioner who is employed by a body corporate of which the person is an officer is, while so employed at a time when the person is such an officer, taken to be disqualified.

All determinations by Medicare Participation Review Committees must be in writing.

DIG.1.7 ***Nature Of Disqualification***
A Committee, having determined that a practitioner is disqualified or taken to be disqualified, must specify whether the disqualification is full or partial; if partial the Committee must indicate whether the disqualification is in respect of one or more of the following:

- the provision of specified professional services, or the provision of professional services other than specified professional services;
- the provision of professional services to a specified class of persons, or the provision of professional services to persons other than a specified class of persons; and
- the provision of professional services within a specified location, or the provision of professional services otherwise than within a specified location.

DIG.1.8 ***Specification of Period of Disqualification***
Where a Committee determines that a practitioner is disqualified, or taken to be disqualified, the Committee must specify in the determination the period of disqualification which must not exceed 5 years.

DIG.1.9 ***Determination of Services***
A Committee must identify all services it determines were rendered as the result of a person engaging in prohibited diagnostic imaging practices. If Medicare benefits were paid to a practitioner or have been paid or are payable to a person other than a practitioner, the Committee must determine that the benefits or a specified part of the benefits be paid by the practitioner to the Commonwealth. If Medicare benefits are payable but have not been paid, the Committee must determine that the benefits or a specified proportion of the benefits cease to be payable.

DIG.1.10 ***Revocation of Remote Area Exemption***
If a Committee determines that a medical practitioner engaged in, or caused or permitted another person to engage in a prohibited diagnostic imaging practice, and the practitioner has been granted a remote area exemption, the Committee must include in its determination advice to the Minister on whether the remote area exemption should be revoked and give its reasons for so advising.

DIG.1.11 ***Recovery of Benefits Paid***
Any Medicare payment made for a diagnostic imaging service which contravened a State or Territory law relating to the use of diagnostic imaging procedures or equipment is payable to the Commonwealth by the person who contravened the law.

EXPLANATORY NOTES

Principles of Interpretation and Billing

(1) The service rendered must be clinically relevant for Medicare benefits to be payable. A "clinically relevant" service is a service rendered by a medical practitioner that is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered.

As an example, an ultrasound to determine the sex of a foetus is not a clinically relevant service (unless there is an indication that the sex of the foetus will determine further courses of treatment, e.g., a genetic background to a sex-related disease or condition).

(2) A service may only be billed for Medicare benefit purposes where the service rendered complies with the description in the relevant item.

Where a service is covered specifically by an item, another item which also covers the service in more general terms, cannot be used.

Examples are:-

(a) Ultrasound of the prostate, bladder base and urethra are covered by Items 55300 and 55303. A Medicare benefit is only payable for examination of these organs when the service fulfils the conditions set out in these item descriptions. Items covering examination of the urinary tract - Items 55038 and 55039, or male pelvis - Items 55044 and 55045, cannot be used instead of 55300 and 55303 for an ultrasound examination of the prostate, bladder base and urethra alone.

(b) For some items, benefits are not payable unless there is a written request and the referring practitioner is not a member of the group of practitioners of which the rendering practitioner is also a member.

This requirement relates specifically to R-type ultrasound services of body regions in General Ultrasound (Items 55028, 55030, 55032, 55034, 55036, 55038, 55044, 55048, and 55058), Obstetric and Gynaecological Ultrasound (55700, 55704, 55706, 55712, 55718, 55721, 55725, 55728, 55731, 55736, 55759, 55764,55768, 55772) and Musculoskeletal Ultrasound (55800, 55804, 55808, 55812, 55816, 55820, 55824, 55828, 55832, 55836, 55840, 55844, 55848, 55850). Services under these items cannot be "self-determined" by a radiologist, by any other specialist or consultant physician or by any other medical practitioner. However, a medical practitioner may bill for the "NR-type" where he or she determines that the service is clinically relevant for the treatment of the patient's condition.

DIH. ULTRASOUND

DIH.1 Cardiac ultrasound

Items 55102 and 55105 have been deleted on advice from representatives of the Cardiac Society of Australia and New Zealand, Royal Australian and New Zealand College of Radiologists, Royal Australian College of Physicians, Australian and New Zealand Association of Physicians in Nuclear Medicine, and Australian Society of Ultrasound in Medicine. It was considered that services performed under these items should be performed under item 55112, as the latter provides for a more comprehensive service. Items 55116 and 55117 have been introduced for the imaging component of stress echocardiography testing. The descriptor for items 55112 and 55118 have also had minor amendments to bring them into line with current clinical practice.

DIH.2 Ultrasonic Cross-sectional Echography (Items 55028 to 55052, 55700 to 55774, and 55800 to 55850)

Items in this range identified with the symbol "(NR)" cover ultrasonic cross-sectional echography where the examination is rendered by a practitioner on his/her patient. Items in this range identified with the symbol "(R)" cover the examination where the patient has been referred to a medical practitioner outside the referring practitioner's practice specifically for the ultrasound scanning.

As a rule, benefit is payable once only for ultrasonic examination at the one attendance, irrespective of the areas involved.

Except as indicated in the succeeding paragraphs, "attendance" means that there is a clear separation between one service and the next. For example, from 1 November 1993, where there is a short time between one ultrasound and the next, benefits will be payable for one service only - as a guide, the Health Insurance Commission will look to a separation of 3 hours between services and this must be stated on accounts issued for more than 1 service on the one day.

However, where more than one ultrasound service is rendered on the one occasion and the additional service relates to a non-contiguous body area (and the services provided are "clinically relevant", that is, the service is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered), benefits greater than the single rate may be payable. Accounts should be marked "non-contiguous body areas".

Benefits for two contiguous areas may be payable where it is generally accepted that there are different preparation requirements for the patient and a clear difference in set-up time and scanning. Accounts should be endorsed "contiguous body area with different setup requirements".

DIH.3 Subgroup 6 Musculoskeletal (Items 55800 to 55850)

The musculoskeletal ultrasound items have been restructured and placed in a separate ultrasound subgroup. The musculoskeletal ultrasound items 55050 and 55051 and the joint ultrasound items 55052 and 55053 have been deleted, and replaced by twenty six new items.

These changes were developed on advice from representatives from the Royal Australian and New Zealand College of Radiologists, the Royal Australian College of General Practitioners, the Australian Rheumatology Association, the Australian College of Sports Physicians, the Australian Orthopaedic Association, the Australian and New Zealand Association of Physicians in Nuclear Medicine, the Australasian Musculoskeletal Imaging Group, and the Australian Sonographers Association.

<u>New rules for musculoskeletal ultrasound</u>

DIH.3.1 Single rebate per day

Ultrasound of one or more musculoskeletal areas (55800 to 55850) is payable only once irrespective of the number of regions scanned.

DIH.3.2 Comparison musculoskeletal ultrasound

Where it is necessary for one or more views of the opposite limb to be taken for comparison purposes, benefits are payable for the sonographic examination of one limb only. Comparison views are considered to be part of the examination requested.

DIH.3.3 Equipment

Items 55800 to 55850 only apply to an ultrasound service performed using an ultrasound system which has available on-site a transducer capable of operation at, at least, 7.5 megahertz.

DIH.3.4 Personal attendance for Musculoskeletal Ultrasound

Medicare Benefits are only payable for a musculoskeletal ultrasound service (items 55800 to 55850) performed by or on behalf of a medical practitioner where the medical practitioner responsible for the conduct and report of the examination personally attends during the provision of the scan and personally examines the patient.

Services that are performed because of medical necessity in a remote location are exempt from this requirement. For the purposes of personal attendance for musculoskeletal ultrasound, remote areas include all areas in Australia which are more than 30 kilometres by direct road route from another practice where services that comply with the personal attendance requirement for musculoskeletal ultrasound are available.

DIH.4 Routine Ultrasonic Scanning

Medicare benefits are not attracted for routine ultrasonic screening associated with the termination of pregnancy.

Details of diagnostic imaging requesting requirement are set out in Section DIA.

DIH.5 Investigations of Vascular Disease (Items 55238-55290)

Note that the common vascular ultrasound items are included together with the common combinations. Correct billing itemisation will assist ongoing fee relativity assessment in this area.

The fees include components for interpretation of the results and provision of the report which must be performed by a medical practitioner.

Where it is clinically necessary to perform studies on a patient on successive days in the same week, two studies are allowed in the working week.

Restrictions apply to items 55288 and 55290. Item 55288 is used when two examinations from items 55238 to 55290 (excluding items 55282 and 55284) are performed. However only one of the two examinations can be from the one block, (a) to (e). Benefits are not payable for combinations of items from any **one** block, (a) to (e) eg 55238, 55240.

Item 55290 is used when three examinations from items 55238 to 55290 (excluding items 55282 and 55284) are performed. The same restrictions apply as for item 55288.

Where item 55276 or 55278 is rendered with another item or items as 'components' of the combination items 55288 or 55290, benefits are only payable where the services referred to at 55276 or 55278 have been performed in accordance with the descriptions where the study takes not less than 45 minutes, to the exclusion of any other service.

Example 1: A benefit is not payable where a practitioner performs items 55238 and 55240 together on a patient because both items are in the one block, (a). If a practitioner performs items 55238 and 55244, he/she would bill under item 55288, because 55238 and 55244 are in different blocks, (a) and (b).

Example 2: If a practitioner performs items 55238, 55276 and 55280, he/she would bill under item 55290.

DIH.6 Professional Supervision for Ultrasound Services

A professional supervision requirement was introduced for ultrasound services from 1 September 1999, with the exception of items 55600 and 55603. This has been amended to require the same level of supervision for referred services performed on behalf of eligible non-specialist practitioners as applies to services performed on behalf of specialists and consultant physicians.

Ultrasound services marked with the symbol *(R)* are not eligible for a Medicare rebate unless the service is performed:

a) under the professional supervision of a specialist or a consultant physician in the practice of his or her specialty who is available to monitor and influence the conduct and diagnostic quality of the examination, and if necessary to personally attend the patient; or

b) under the professional supervision of a practitioner who is not a specialist of consultant physician who meets the requirements of sub-rule (1), and who is available to monitor and influence the conduct and diagnostic quality of the examination and, if necessary, to personally attend the patient; or

c) under the professional supervision of a practitioner who meets the requirements of sub-rule (2), and who is available to monitor and influence the conduct and diagnostic quality of the examination, and if necessary, to personally attend the patient; or

d) if paragraph (a), (b) or (c) cannot be complied with:

(i) in an emergency; or
(ii) in a remote location that is not less than 30 kilometres by the most direct road route from another practice where services that comply with subparagraph (a) or (b) are available; or

Sub-rule (1) The requirements of this sub-rule are that, between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner at the location where the service was rendered and the rendering of those services resulted in the payment of a Medicare benefit.

Sub-rule (2) The requirements of this sub-rule are that between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner to a patient in a nursing home or at the patient's residence and the rendering of those services resulted in the payment of a Medicare benefit.

DIH.7 Urological - Transrectal Ultrasound (Items 55600 and 55603)

Benefits for these items are attracted only where the service is rendered in the circumstances specified in both items. These provide that -

- a digital rectal examination was personally performed by the medical practitioner who also personally rendered the ultrasound service; and

- the equipment used meets specifications; and

- the patient was assessed prior to the service by a medical practitioner recognised in one or more of the specialties specified, not more than 60 days prior to the ultrasound service.

Item 55300 provides for the service where rendered by a medical practitioner who **did not** assess the patient, whereas Item 55603 provides for the service where rendered by a medical practitioner who **did** assess the patient.

DIH.8 Obstetric and Gynaecological Ultrasound Item Restructure

The obstetric and gynaecological ultrasound items have been restructured and placed in a separate ultrasound subgroup. The obstetric items 55040 and 55041 have been deleted, and replaced with thirteen new items. The gynaecological items have undergone a fee adjustment and have changed item numbers to maintain them in sequence with the obstetric items. Item 55042 becomes 55731, item 55043 becomes 55733, 55046 becomes items 55736, item 55047 becomes item 55739.

These changes were developed on advice from representatives of Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the National Association of Specialist Obstetricians and Gynaecologists (NASOG), the Royal Australian and New Zealand College of Radiologists (RANZCR) and the Australian and New Zealand Association of Physicians in Nuclear Medicine (ANZAPNM). The Australian College of Rural and Remote Medicine (ACCRM) and the Royal Australasian College of General Practitioners (RACGP) were also consulted during the development process.

The new structure contains items which are clinically based and which will assist the more appropriate utilisation of these items. The fees for the new items are structured to reflect the varying levels of complexity in obstetric ultrasound.

New rules for Obstetric Ultrasound

There are two new rules in relation to obstetric ultrasound. These are:

NR Requests

Medicare benefits are not payable for more than 3 items of NR-type ultrasound services in Subgroup 5 of Group I1 (ultrasound) that are performed on the same patient in any 1 pregnancy.

Clinical indications

For items where clinical indications are listed, or where a clinical indication is required for performance of subsequent scans (items 55712, 55715, 55721 or 55725) the referral must identify the relevant clinical indication for the service. It should be noted that a patient must have previously had either a 55706 or 55709 ultrasound in the same pregnancy to be eligible to claim for either a 55712 or 55715 obstetric service. To be eligible to claim for either a 55721 or 55725 obstetric service, a patient must have previously had either a 55718 or 55723 ultrasound in the same pregnancy.

If the service is self-determined, the clinical condition or indication must be recorded in the medical practitioner's clinical notes.

New Obstetric Ultrasound Items for Multiple Pregnancies

As of 1 November 2000, new obstetric ultrasound items (55759 to 55774) have been introduced to cover scanning of a patient who is experiencing a multiple pregnancy. The items were developed on recommendations by the profession via the Obstetric and Gynaecological Ultrasound Monitoring and Review Group, whose membership includes the RANZCOG, the RANZCR, the RACGP and ACRRM.

The new items incorporate a fee adjustment in recognition of the added complexity and costs associated with scanning multiple pregnancies. Based on the recommendations of the profession, the new items will apply only to patients where a multiple pregnancy has been confirmed by ultrasound.

The items include identical restrictions and provisions as the 2nd and 3rd trimester items (55706-55725), and include items for referred and non-referred services. The '(xix) multiple pregnancy' clinical indication that was included in items 55718 and 55723 has also been removed.

DIH.9 Ultrasound Scan of Pelvis or Abdomen, pregnancy related – Item 55728

This item should only be utilised in situations where a patient with a clinical condition not listed in items 55718, 55721, 55723 and 55725 requires a post 22 week ultrasound. Claims for this item are required to be assessed by the Health Insurance Commission on an individual basis and should be accompanied by details of the clinical basis for the service. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Note.)

DIH.10 Obstetric ultrasound and non-metropolitan providers (Items 55712, 55721 and 55728)

In relation to items 55712, 55721 and 55728, non-metropolitan area includes any location outside of the Sydney, Melbourne, Brisbane, Adelaide, Perth, Greater Hobart, Darwin or Canberra major statistical divisions, as defined in the Australian Standard Geographical Classification 1999 published by the Australian Bureau of Statistics (publication number 1216.0 of 1999)

DIH.11 Referral forms from practitioners who have non-metropolitan obstetric privileges

Where a practitioner who has obstetric privileges at a non-metropolitan hospital refers for items 55712, 55721 and 55728, the practitioner must confirm his/her eligibility by stating 'non-metropolitan obstetric privileges' on the referral form.

DII. COMPUTED TOMOGRAPHY (excluding Magnetic Resonance Imaging - see Note DIL.)

DII.1 General

Pre-contrast scans are included in an item of service with contrast medium only when the pre-contrast scans are of the same region.

DII.2 Scan of more than one area

Items have been provided to cover the common combinations of regions - see DII.6. However, where regions are scanned on the one occasion which are not covered by a combination item, for example, Item 57001 (scan of brain) and Item 56619 (scan of extremities), both examinations would attract separate benefit.

DII.3 CT Scan of Spine with Intrathecal Contrast Medium (Item 56219)

The item incorporates the cost of contrast medium for intrathecal injection and associated x-rays. Benefits are not payable for this item when rendered in association with myelograms (Item 59724).

Where a myelogram is rendered under Item 59724 and a CT is necessary, the relevant Item would be scan of spine without intravenous contrast (Item 56210).

DII.4 CT Scans of Multiple Regions

The Schedule provides Items to cater for the common combinations of regions. The Items relating to the individual regions should not be used when scans of multiple regions are performed.

DII.5 More than one Attendance of the Patient to Complete a Scan

Where a patient attends for a scan which is only partly undertaken and the patient attends later that day or on a subsequent day to complete the scan, benefits are only payable for the one scan.

For example, where a request relates to two or more regions of the spine and one region only is scanned on one occasion with the balance of regions being scanned on a subsequent occasion, benefits are payable for one service only.

DII.6 Professional Supervision for Computed Tomography (CT)

A professional supervision requirement was introduced for CT services from 1 March 1999.

CT 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, 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 service under the direction of a specialist in the specialty of diagnostic radiology.

DII.7 Capital sensitive items

From 1 March 1999, a reduced Schedule fee applied to CT services provided on equipment that is 10 years old or older. This equipment must have been first installed in Australia ten or more years ago, or in the case of imported pre-used equipment, must have been first manufactured ten or more years ago.

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

56041, 56047, 56050, 56053, 56056, 56062, 56068, 56070, 56076, 56141, 56147, 56250, 56256, 56259, 56341, 56347, 56441, 56447, 56449, 56452, 56541, 56547, 56659, 56665, 56841, 56847, 57041, 57047, 57247, 57345, 57355.

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

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.

DII.8 Exclusion of acoustic neuroma

Where axial scans are undertaken for the exclusion of acoustic neuroma, Medicare benefits are payable under item 56001 or 56007.

DII.9 Assessment of headache

If the service described in item 56007 or 56047 is to be used for the assessment of headache of a patient to whom this rule applies, the fee mentioned in the item applies only if:
(a) a scan without intravenous contrast medium has been undertaken on the patient; and
(b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal.

This rule applies to a patient who
(a) is under 50 years; and
(b) is (apart from the headache) otherwise well; and
(c) has no localising symptoms or signs; and
(d) has no history of malignancy or immunosuppression.

DIJ. DIAGNOSTIC RADIOLOGY

DIJ.1 Examination and Report

The benefits allocated to each item from 57506 to 61109 inclusive covers the total procedure, i.e. the examination, reading and report. Separate benefits are not payable for individual components of the service, eg preliminary reading.

Where preliminary plain films were frequently billed with a procedure item, the value of the plain film fee(s) have been incorporated into the new item fee and the descriptions amended to include words such as "including any preliminary plain films". Benefits are not separately payable for associated plain films involved with these items.

DIJ.2 Films - exposure of more than one

Where the radiographic examination of a specific area involves the exposure of more than one film, benefits are payable once only, except where special provision is made in the description of the item for the inclusion of all films taken for the purpose of the examination.

DIJ.3 Comparison X-rays - Limbs

Where it is necessary for one or more films of the opposite limb to be taken for comparison purposes, benefits are payable for radiographic examination of one limb only. Comparison views are considered to be part of the examination requested.

DIJ.4 Plain Abdominal Film (Item 58900/58903)

Benefits are not attracted for Items 58900/58903 in association with barium meal examinations or cholecystograms whether provided on the same day or previous day. Preliminary plain films are covered in each study.

DIJ.5 Mammography - Professional Supervision

A professional supervision requirement was introduced for mammography services from 1 March 1999.

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 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 mammography service under the direction of a specialist in the specialty of diagnostic radiology.

DIJ.6 Radiography of the Breast.

Benefits under items 59300 and 59303 are attracted only where the patient has been referred in specific circumstances as indicated in the description of the items. To facilitate these provisions, the Regulations to the Health Insurance Act require the requesting medical practitioner to include in the request letter or note, the clinical indication for the requested procedure. The request must be personally signed by the requesting practitioner.

DIJ.7 Myelogram (Items 59724)

Benefits are not payable where a myelogram is rendered in association with a CT myelogram (Item 56219 - see DII above). Where it is necessary to render a CT and a myelogram, CT Item 56210 would apply.

DIJ.8 Digital Subtraction Angiography (DSA) (Items 60000-60078)

Benefits are payable only where these services are rendered in an angiography suite. However, benefits are not payable when these services are rendered using mobile DSA imaging equipment as these services are covered by item 59970.

Each item includes all preparation and contrast injections other than for selective catheterisation. For Digital Subtraction Angiography (DSA), benefits are payable for a maximum of 1 DSA item (from Items 60000 to 60069). For selective DSA - 1 DSA item (from Items 60000 to 60069) and 1 item covering selective catheterisation (from 60072, 60075 or 60078).

If a DSA examination covers more than one of the specified regions/combinations, then the region/combination forming the major part of the examination should be selected, with itemisation to cover the total number of film runs obtained. A run is the injection of contrast, data acquisition, and the generation of a hard copy record.

DIJ.9 Preparation Items (Items 60903-60927)

Benefits are not payable for preparation items when rendered with any service other than that specified in each item.

DIK. NUCLEAR MEDICINE IMAGING

DIK.1 General

Benefits are only payable where a nuclear medicine service is rendered by a medical specialist (see NOTE at the commencement of Group I4).

Benefits for a nuclear scanning service cover the preliminary examination of the patient, estimation of dosage, supervision of the administration of the dose and the performance of the scan, and compilation of the final report. Additional benefits will only be attracted for specialist physician or consultant physician attendances under Category 1 of the Schedule where there is a request for a full medical examination accompanied by a referral letter or note.

DIK.2 Accreditation for nuclear medicine imaging services

To ensure appropriate standards for the provision of nuclear medicine imaging services, from 1 November 2000, Medicare rebates will be only available to patients of practitioners who are recognised as credentialled specialists in nuclear medicine.

Payment of Medicare rebates for nuclear medicine imaging services will be limited to medical specialists who are credentialled by the Joint Nuclear Medicine Credentialling and Accreditation Committee of the Royal Australian College of Physicians (RACP) and the Royal Australian and New Zealand College of Radiologists (RANZCR). Re-credentialling will occur every two years.

The scheme has been developed by the profession in consultation with Government to ensure that specialists in nuclear medicine are appropriately trained and licensed, provide appropriate personal supervision of procedures and are involved in ongoing continuing medical education.

For information regarding the Scheme and for application forms, please phone the RACP or RANZCR.

DIK.3 Radiopharmaceuticals

The Schedule fees for nuclear medicine imaging services incorporate the costs of radiopharmaceuticals. Sestamibi myocardial perfusion studies have now been incorporated into items in Group I4.

DIK.4 Single Photon Emission Tomography (SPECT)

Where SPECT has been performed in conjunction with another study and is not covered under the item descriptor or is not covered under Item 61462, no Medicare benefit is payable for the SPECT study.

DIK.5 Single Myocardial Perfusion Studies (Items 61302 and 61303)

Items 61302 and 61303 apply to single myocardial perfusion studies which can only be used once and cannot be used in conjunction with any other myocardial perfusion study for an individual patient referral.

DIK.6 Myocardial Perfusion (Items 61306 and 61307)

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

DIK.7 Hepatobiliary Study (pre-treatment) (Item 61360)

Item 61360 - the standard hepatobiliary item - also includes allowance of the pre-procedural CCK administration for preparatory emptying of the gall bladder and also morphine augmentation.

DIK.8 Hepatobiliary Study (infusion) (Item 61361)

Item 61361applies specifically to a standard hepatobiliary study to which has been added an infusion of sinaclide (CCK-8) following which acquisition is continued and quantification of gallbladder ejection fraction and/or common bile duct activity time curves are performed.

DIK.9 Whole Body Studies (Items 61426-61438)

"Whole body" studies must include the trunk, head and upper and lower limbs down to the elbow and knee joints respectively, whether acquired as multiple overlapping camera views or whole body sweeps (runs) with additional camera views as required. Any study that does not fulfil these criteria is a localised study.

DIK.10 Repeat Studies (Item 61462)

Item 61462 covers repeat planar (whole body or localised) and/or SPECT imaging performed on a separate occasion using the same administration of radiopharmaceutical. This does not apply to bone scans, adrenal studies or gastro-oesophageal reflux studies, myocardial perfusion studies, colonic transit or CFS transport studies, where allowance for performance of the delayed study is incorporated into the baseline benefit fee. The repeat planar and SPECT imaging when performed on a separate occasion using the same administration of radiopharmaceutical should be itemised as item 61462 and the original item and date of service should be indicated for reference purposes.

DIK.11 Thyroid Study (Item 61473)

Item 61473 incorporates the measurement of thyroid uptake on a gamma camera using a proven technique, where clinically indicated.

DIL. MAGNETIC RESONANCE IMAGING

DIL.1 General

New arrangements for the payment of Medicare benefits for Magnetic Resonance Imaging (MRI) came into effect from 1 September 1998. These changes are in response to recommendations made by the Australian Health Technology Advisory Committee (AHTAC) 'Review of magnetic resonance imaging'. The new arrangements include a detailed itemisation and a number of eligibility criteria relating to MRI provision.

DIL.2 Itemisation

A series of items, Group I5, has been introduced for clinical applications of MRI, where AHTAC found evidence that MRI has a proven clinical role and is superior or complementary to other imaging modalities.

MRI items 63000 to 63946 are divided into subgroups defined according to the area of the body to be scanned, (ie head, spine, musculoskeletal system, cardiovascular system or body) and whether the scan is for the exclusion, further investigation or monitoring of a clinical condition. Subgroups are then divided into individual items, with each item being for a specific clinical indication.

Requests
MRI services can only be requested by a specialist or consultant physician. A referral must be in writing and identify the clinical indications for the service. Oral and maxillofacial surgeons may request Items 63621, 63671 and 63712 for scanning of the temporomandibular joint.

A MRI or Magnetic Resonance Angiography (MRA) service may be claimed for one of the three following purposes:

* Exclusion of a condition - where MRI or MRA (if performed) is used as the initial imaging modality for diagnosis;

* Further investigation of a condition- where MRI or MRA (if performed) is used as the secondary imaging modality when the diagnosis is uncertain or to assess the extent or severity of the condition;

* Monitoring of a condition - where MRI or MRA (if performed) is used following confirmed diagnosis to assess progress of a condition following treatment.

For the 'further investigation of' or 'monitoring of' purposes the initial imaging modality could have been MRI or any other diagnostic imaging modality.

DIL.3 Number of eligible services

Items have been placed in subgroups with limits on the number of services eligible for a Medicare benefit as follows:

* Subgroups 1, 2, 3, 4, 9, 10, 11, 12, 13, 14, 17, 18, 19, 22, 25, 27, 28 and 29, only one benefit for each item can be claimed in a 12 month period;

* Subgroups 5, 6, 21, 23 and 24 only two benefits for each item can be claimed in a 12 month period; and

* Subgroups 7, 8, 15, 16, 20, 26 and 30 which do not have a restriction on the number of eligible services.

DIL.4 Eligible services

Group I5 items, apply only to an MRI or MRA service performed:

(a) on referral by a recognised specialist or consultant physician, where the request for the scan specifically identifies in writing the clinical indication for the scan;
(b) under the professional supervision of an eligible provider; and
(c) with eligible equipment.

DIL.5 Specialist or consultant physician

Specialist or consultant physician means a medical practitioner recognised for the purposes of the Health Insurance Act 1973 as a specialist or consultant physician in a particular specialty.

DIL.6 Professional supervision

Group I5 items must be performed as follows:
(a) under the professional supervision of an eligible provider who is available to monitor and influence the conduct and diagnostic quality of the examination, including, if necessary, by personal attendance on the patient; or
(b) if the above paragraph is not complied with
- in an emergency; or
- because of medical necessity - in a remote or rural location.

DIL.7 Eligible providers

In Group I5, an eligible provider is a specialist in diagnostic radiology who satisfies the Health Insurance Commission (HIC) that:
(a) he or she is a participant in the Royal Australasian College of Radiologists' Quality and Accreditation Program; and
(b) the equipment he or she proposes to use for providing services of the kind mentioned in Group I5 is eligible equipment.

DIL.8 Eligible equipment

An eligible service must be provided within a medical practice, or the radiology department of a hospital, that offers a comprehensive range of alternative diagnostic imaging procedures. A minimum of diagnostic x-ray, ultrasound and computed tomography (CT) is needed to meet this requirement.

As from 1 November 1999, for a medical practice or hospital located in a metropolitan area, the equipment must:

(a) have been installed in a medical practice, or hospital, in Australia before 7.30 pm on 12 May 1998, Eastern Standard Time; or
(b) if uninstalled at that time on that day — have been purchased or leased under a contract, in writing (that did not contain an option to cancel), before 10 February 1998; or
(c) be replacement equipment for equipment mentioned in paragraph (a) or (b).

There is an exemption to protect patients requiring MRI scans in non-metropolitan areas. For a medical practice or hospital located in a non-metropolitan area:

(a) the equipment must have been installed in a medical practice, or hospital, in Australia before 7.30 pm on 12 May 1998, Eastern Standard Time; or
(b) if the equipment was uninstalled at the time and on the day mentioned in paragraph (a) — it must:

(i) have been purchased or leased under a contract, in writing (that did not contain an option to cancel) before that time on that day; and

(ii) on or before 18 October 1999 — be in use for services for which a Medicare benefit is claimed; or

(c) be replacement equipment for equipment mentioned in paragraph (a) or (b).

Irrespective of location:

- The Commission must have been given on or before 11 October 1999 a statutory declaration in relation to the equipment, and (if the unit was not installed by 7.30pm on 12 May 1998, Eastern Standard Time) a copy of the contract, as required by the regulations; and
- once equipment is replaced the original equipment ceases to be eligible equipment.

metropolitan area includes any location within any of the Sydney, Melbourne, Brisbane, Adelaide, Perth, Greater Hobart, Darwin or Canberra major statistical divisions, as defined in the Australian Standard Geographical Classification 1999 published by the Australian Bureau of Statistics (publication number 1216.0 of 1999).

Information about eligible MRI sites or eligibility requirements may be obtained from the Provider Liaison Section at the Health Insurance Commission on 132 150.

DIL.9 Eligible Provider Declaration

The specialist must give the HIC a statutory declaration:
(a) stating that he or she is enrolled in the RACR Quality and Accreditation Program;
(b) specifying the location of the MRI equipment;
(c) specifying the kinds of diagnostic imaging procedures offered at that location;
(d) stating the date of installation of the equipment (and time of installation if this occurred on the 12 May 1998); and
(e) if the equipment had not been installed before 7.30 pm on 12 May 1998 (Eastern Standard Time), the specialist must also give the HIC a copy of the contract for the purchase or lease of the equipment.

In addition, the HIC may request further supporting documentation or information. Specialists are advised to contact the Provider Liaison Section at the Health Insurance Commission on 132 150 prior to lodging a declaration.

DIL.10 General Medical Services Table - Anaesthetic item 18013

Item 18013 which relates to anaesthesia performed in connection with MRI services has been amended to cover anaesthesia performed in connection with any of items 63000 to 63946.

DIL.11 New Applications of MRI

New clinical applications of MRI not listed in this Schedule will require consideration by the Medicare Services Advisory Committee (MSAC) prior to inclusion in the Schedule. To contact MSAC write to:

The Secretary
Medicare Services Advisory Committee
MDP 107
GPO Box 9848
Canberra ACT 2601
Email msac.secretariat@health.gov.au
Fax: 61-2-6289 8799

GROUP I1 - ULTRASOUND

SUBGROUP 1 - GENERAL

55028	HEAD, ultrasound scan of, performed by, or on behalf of, a medical practitioner where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $99.90	**Benefit:** 75% = $74.95	85% = $84.95
55029	HEAD, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $34.65	**Benefit:** 75% = $26.00	85% = $29.50
55030	ORBITAL CONTENTS, ultrasound scan of, performed by, or on behalf of, a medical practitioner where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $99.90	**Benefit:** 75% = $74.95	85% = $84.95
55031	ORBITAL CONTENTS, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $34.65	**Benefit:** 75% = $26.00	85% = $29.50
55032	NECK, 1 or more structures of, ultrasound scan of, performed by, or on behalf of, a medical practitioner where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $99.90	**Benefit:** 75% = $74.95	85% = $84.95
55033	NECK, 1 or more structures of, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $34.65	**Benefit:** 75% = $26.00	85% = $29.50
‡ 55036	ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service described in item 55600 or item 55603, performed by, or on behalf of, a medical practitioner where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; (b) the referring medical practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member; and (c) the service is not performed with item 55038, 55044 or 55731 on the same patient within 24 hours (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $101.95	**Benefit:** 75% = $76.50	85% = $86.70
‡ 55037	ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $34.65	**Benefit:** 75% = $26.00	85% = $29.50
‡ 55038	URINARY TRACT, ultrasound scan of but not being a service associated with the service described in item 55600 or item 55603, performed by, or on behalf of, a medical practitioner where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member; and (c) the service is not performed with item 55036, 55044 or 55731 on the same patient within 24 hours (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $99.90	**Benefit:** 75% = $74.95	85% = $84.95

‡ 55039	URINARY TRACT, ultrasound scan of, but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $34.65	**Benefit:** 75% = $26.00	85% = $29.50
‡ 55044	PELVIS, male, ultrasound scan of, by any or all approaches, but not being a service associated with the service described in item 55600 or item 55603, performed by, or on behalf of, a medical practitioner where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; (b) the referring medical practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member; and (c) the service is not performed with item 55036 or 55038 on the same patient within 24 hours (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $101.95	**Benefit:** 75% = $76.50	85% = $86.70
‡ 55045	PELVIS, male, ultrasound scan of, by any or all approaches, but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $34.65	**Benefit:** 75% = $26.00	85% = $29.50
55048	SCROTUM, ultrasound scan of, performed by, or on behalf of, a medical practitioner where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $100.30	**Benefit:** 75% = $75.25	85% = $85.30
55049	SCROTUM, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $34.65	**Benefit:** 75% = $26.00	85% = $29.50
55054	ULTRASONIC CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this Group applies (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $99.90	**Benefit:** 75% = $74.95	85% = $84.95

55070	BREAST, one, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50
55073	BREAST, one, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR) **Fee:** $31.20 **Benefit:** 75% = $23.40 85% = $26.55
55076	BREASTS, both, ultrasound scan of, performed by or on behalf of a medical practitioner where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95
55079	BREASTS, both, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50
	SUBGROUP 2 - CARDIAC
‡ 55112	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3 of this Group applies (R) **Fee:** $257.65 **Benefit:** 75% = $193.25 85% = $219.05
† 55116	EXERCISE STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before exercise (baseline) from at least three acoustic windows and matching recordings from the same windows at, or immediately after, peak exercise. Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R) **Fee:** $257.65 **Benefit:** 75% = $193.25 85% = $219.05
† 55117	PHARMACOLOGICAL STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before drug infusion (baseline) from at least three acoustic windows and matching recordings from the same windows at least twice during drug infusion, including a recording at the peak drug dose or immediately after, peak exercise. Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R) **Fee:** $257.65 **Benefit:** 75% = $193.25 85% = $219.05
‡ 55118	HEART, 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL EXAMINATION of, from at least two levels, and in more than one plane at each level, with: (a) pulsed wave Doppler examination; (b) real time colour flow mapping; and (c) recordings on video tape or digital medium; and not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3 of this Group applies (R) (Anaes. 17708 = 6B + 2T) **Fee:** $257.05 **Benefit:** 75% = $192.80 85% = $218.50
‡ 55130	INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac surgery incorporating sequential assessment of cardiac function before and after the surgical procedure (R) (Anaes. 17710 = 6B + 4T) **Fee:** $372.20 **Benefit:** 75% = $279.15 85% = $321.30
	SUBGROUP 3 - VASCULAR
55238	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb OR of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $169.45 **Benefit:** 75% = $127.10 85% = $144.05

55240	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb OR of arteries and bypass grafts in the lower limb, below the inguinal ligament, including a service referred to in item 11603, 11606 or 11609, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this group applies - 1 examination and report (R) **Fee:** $197.00 **Benefit:** 75% = $147.75 85% = $167.45
55242	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb OR of arteries and bypass grafts in the lower limb, below the inguinal ligament, including a service referred to in item 11612, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $218.50 **Benefit:** 75% = $163.90 85% = $185.75
55244	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $169.45 **Benefit:** 75% = $127.10 85% = $144.05
55245	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, including a service referred to in item 11603, 11606 or 11609, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $197.00 **Benefit:** 75% = $147.75 85% = $167.45
55246	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $169.45 **Benefit:** 75% = $127.10 85% = $144.05
55247	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, including a service referred to in item 11603, 11606 or 11609, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $197.00 **Benefit:** 75% = $147.75 85% = $167.45
55248	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limb OR of arteries and bypass grafts in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $169.45 **Benefit:** 75% = $127.10 85% = $144.05
55250	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limb OR of arteries and bypass grafts in the upper limb, including a service referred to in item 11603, 11606 or 11609, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $197.00 **Benefit:** 75% = $147.75 85% = $167.45
55252	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $169.45 **Benefit:** 75% = $127.10 85% = $144.05
55254	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limb, including a service referred to in item 11603, 11606 or 11609, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $197.00 **Benefit:** 75% = $147.75 85% = $167.45
55256	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limbs OR of arteries and bypass grafts in the lower limbs, below the inguinal ligament, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this group applies - 1 examination and report (R) **Fee:** $169.45 **Benefit:** 75% = $127.10 85% = $144.05

55258	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limbs OR of arteries and bypass grafts in the lower limbs, below the inguinal ligament, including a service referred to in item 11603, 11606 or 11609, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $197.00 **Benefit:** 75% = $147.75 85% = $167.45
55260	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limbs OR of arteries and bypass grafts in the lower limbs, below the inguinal ligament, including a service referred to in item 11612, not being a service associated with a service to which an item in Subgroups 1 (with exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $218.50 **Benefit:** 75% = $163.90 85% = $185.75
55262	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limbs, below the inguinal ligament, for acute venous thrombosis, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $169.45 **Benefit:** 75% = $127.10 85% = $144.05
55263	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, including a service referred to in item 11603, 11606 or 11609, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $197.00 **Benefit:** 75% = $147.75 85% = $167.45
55264	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limbs, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $169.45 **Benefit:** 75% = $127.10 85% = $144.05
55265	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, including a service referred to in item 11603, 11606 or 11609, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $197.00 **Benefit:** 75% = $147.75 85% = $167.45
55266	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limbs OR of arteries and bypass grafts in the upper limbs, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $169.45 **Benefit:** 75% = $127.10 85% = $144.05
55268	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limbs OR of arteries and bypass grafts in the upper limbs, including a service referred to in item 11603, 11606 or 11609, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $197.00 **Benefit:** 75% = $147.75 85% = $167.45
55270	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limbs, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $169.45 **Benefit:** 75% = $127.10 85% = $144.05
55272	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limbs, including a service referred to in item 11603, 11606 or 11609, not being a service associated with a service to which an item in Subgroups 1 (with the exception o f item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $197.00 **Benefit:** 75% = $147.75 85% = $167.45
55274	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of extra-cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri-orbital Doppler examination, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Groups applies - 1 examination and report (R) **Fee:** $169.45 **Benefit:** 75% = $127.10 85% = $144.05

55276	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-abdominal, aorta and iliac arteries or inferior vena cava and iliac veins OR of intra-abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, for an examination of not less than 45 minutes duration, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $169.45 **Benefit:** 75% = $127.10 85% = $144.05
55277	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, for an examination of between 25 and 45 minutes duration, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $109.40 **Benefit:** 75% = $82.05 85% = $93.00
55278	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of renal or visceral vessels OR of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, for an examination of not less than 45 minutes duration, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $169.45 **Benefit:** 75% = $127.10 85% = $144.05
55279	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of renal or visceral vessels OR of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, for an examination of between 25 and 45 minutes duration, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $109.40 **Benefit:** 75% = $82.05 85% = $93.00
55280	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-cranial vessels, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) **Fee:** $169.45 **Benefit:** 75% = $127.10 85% = $144.05
55282	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal artery of the penis following intracavernosal administration of a vasoactive agent, performed during the period of pharmacological activity of the injected agent, to confirm a diagnosis of vasular aetiology for impotence, where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - examination and report (R) **Fee:** $169.45 **Benefit:** 75% = $127.10 85% = $144.05
55284	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal tissue of the penis to confirm a diagnosis and, where indicated, assess the progress and management of: (a) priapism; or (b) fibrosis of any type; or (c) fracture of the tunica; or (d) arteriovenous malformations; where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Groups applies - 1 examination and report (R) **Fee:** $169.45 **Benefit:** 75% = $127.10 85% = $144.05

	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed (and the area scanned where one of the examinations was of the kind referred to in item 55280) under this item. - TWO examinations of the kind referred to in items 55238 to 55280 inclusive except for an examination of the kind referred to in the items shown in the blocks below, where only one examination can be provided from the items in any one block:- block (a) - item 55238, 55240,55242,55256,55258 and 55260; block (b) - item 55244, 55245, 55246, 55247, 55262, 55263, 55264 and 55265; block (c) - item 55248, 55250, 55266 and 55268; block (d) - item 55252, 55254, 55270 and 55272; block (e) - item 55276, 55277, 55278 and 55279; not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054), or 4 of this Group applies - examination and report (R)
55288	**Fee:** $298.65 **Benefit:** 75% = $224.00 85% = $253.90
	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed (and the area scanned where one of the examinations was of the kind referred to in item 55280) under this item. THREE examinations of the kind referred to in items 55238 to 55280 inclusive except for an examination of the kind referred to in the items shown in the blocks below, where only one examination can be provided from the items in any one block:- block (a) - item 55238, 55240, 55242,55256, 55258 and 55260; block (b) - item 55244, 55245, 55246, 55247, 55262, 55263, 55264 and 55265; block (c) - item 55248, 55250, 55266 and 55268; block (d) - item 55252, 55254, 55270 and 55272; block (e) - item 55276, 55277, 55278 and 55279, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054), or 4 of this Group applies - examination and report (R)
55290	**Fee:** $298.65 **Benefit:** 75% = $224.00 85% = $253.90
	SUBGROUP 4 - UROLOGICAL
	PROSTATE, bladder base and urethra, transrectal ultrasound scan of, where performed: (a) personally by a medical practitioner (not being the medical practitioner who assessed the patient as specified in (c)) using a transducer probe or probes that: (i) have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i)examined the patient in the 60 days prior to the scan; and (ii)recommended the scan for the management of the patient's current prostatic disease (R)
55600	**Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95
	PROSTATE, bladder base and urethra, transrectal ultrasound scan of, where performed: (a) personally by a medical practitioner who undertook the assessment referred to in (c) using a transducer probe or probes that: (i) have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequecies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i)examined the patient in the 60 days prior to the scan; and (ii)recommended the scan for the management of the patient's current prostatic disease (R)
55603	**Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95

SUBGROUP 5 - OBSTETRIC AND GYNAECOLOGICAL

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner, where:

(a) the patient is referred by a medical practitioner; and
(b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member; and
(e) one or more of the following conditions are present:
- (i) hyperemesis gravidarum;
- (ii) diabetes mellitus;
- (iii) hypertension;
- (iv) toxaemia of pregnancy;
- (v) liver or renal disease;
- (vi) autoimmune disease;
- (vii) cardiac disease;
- (viii) alloimmunisation;
- (ix) maternal infection;
- (x) inflammatory bowel disease;
- (xi) bowel stoma;
- (xii) abdominal wall scarring;
- (xiii) previous spinal or pelvic trauma or disease;
- (xiv) drug dependency;
- (xv) thrombophilia;
- (xvi) significant maternal obesity;
- (xvii) advanced maternal age;
- (xviii) abdominal pain or mass;
- (xix) uncertain dates;
- (xx) high risk pregnancy;
- (xxi) previous post dates delivery;
- (xxii) previous caesarean section;
- (xxiii) poor obstetric history;
- (xxiv) suspicion of ectopic pregnancy;
- (xxv) risk of miscarriage;
- (xxvi) diminished symptoms of pregnancy;
- (xxvii) suspected or known cervical incompetence;
- (xxviii) suspected or known uterine abnormality;
- (xxix) pregnancy after assisted reproduction;
- (xxx) risk of fetal abnormality (R)

‡ 55700 **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where:
(a) the patient is not referred by a medical practitioner; and
(b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) one or more of the following conditions are present:
- (i) hyperemesis gravidarum;
- (ii) diabetes mellitus;
- (iii) hypertension;
- (iv) toxaemia of pregnancy;
- (v) liver or renal disease;
- (vi) autoimmune disease;
- (vii) cardiac disease;
- (viii) alloimmunisation;
- (ix) maternal infection;
- (x) inflammatory bowel disease;
- (xi) bowel stoma;
- (xii) abdominal wall scarring;
- (xiii) previous spinal or pelvic trauma or disease;
- (xiv) drug dependency;
- (xv) thrombophilia;
- (xvi) significant maternal obesity;
- (xvii) advanced maternal age;
- (xviii) abdominal pain or mass;
- (xix) uncertain dates;
- (xx) high risk pregnancy;
- (xxi) previous post dates delivery;
- (xxii) previous caesarean section;
- (xxiii) poor obstetric history;
- (xxiv) suspicion of ectopic pregnancy;
- (xxv) risk of miscarriage;
- (xxvi) diminished symptoms of pregnancy;
- (xxvii) suspected or known cervical imcompetence;
- (xxviii) suspected or known uterine abnormality;
- (xxix) pregnancy after assisted reproduction;
- (xxx) risk of fetal abnormality (NR)

‡ 55703 **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75

‡ 55704	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner, where: (a) the patient is referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member; and (e) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (R) **Fee:** $70.00 **Benefit:** 75% = $52.50 85% = $59.50

‡ 55705	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) one or more of the following conditions are present: (i) hyperemesis gravidarum (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical imcompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (NR) **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75
55706	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner, where: (a) the patient is referred by a medical practitioner; and (b) the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member; and (e) the service is not performed in the same pregnancy as item 55709 (R) **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00
55709	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the service is not performed in the same pregnancy as item 55706 (NR) **Fee:** $38.00 **Benefit:** 75% = $28.50 85% = $32.30

55712	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $115.00 **Benefit:** 75% = $86.25 85% = $97.75
55715	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (NR) **Fee:** $40.00 **Benefit:** 75% = $30.00 85% = $34.00

‡ 55718	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, performed by or on behalf of a medical practitioner where: (a) the patient is referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member; and (e) the service is not performed in the same pregnancy as item 55723; and (f) one or more of the following conditions are present: (i) known or suspected fetal abnormality or fetal cardiac arrhythmia; (ii) fetal anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous fetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced fetal movements; (xv) suspected fetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) fetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxaemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxi) bowel stoma; (xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (R) **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00
55721	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of by any or all approaches, performed by or on behalf of a medical practitioner, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $115.00 **Benefit:** 75% = $86.25 85% = $97.75

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:

(a) the patient is not referred by a medical practitioner; and
(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) the service is not performed in the same pregnancy as item 55718; and
(e) one or more of the following conditions are present:
- (i) known or suspected fetal abnormality or fetal cardiac arrhythmia;
- (ii) fetal anatomy (late booking or incomplete mid-trimester scan);
- (iii) malpresentation;
- (iv) cervical assessment;
- (v) clinical suspicion of amniotic fluid abnormality;
- (vi) clinical suspicion of placental or umbilical cord abnormality;
- (vii) previous complicated delivery;
- (viii) uterine scar assessment;
- (ix) uterine fibroid;
- (x) previous fetal death in utero or neonatal death;
- (xi) antepartum haemorrhage;
- (xii) clinical suspicion of intrauterine growth retardation;
- (xiii) clinical suspicion of macrosomia;
- (xiv) reduced fetal movements;
- (xv) suspected fetal death;
- (xvi) abnormal cardiotocography;
- (xvii) prolonged pregnancy;
- (xviii) premature labour;
- (xix) fetal infection;
- (xx) pregnancy after assisted reproduction;
- (xxi) trauma;
- (xxii) diabetes mellitus;
- (xxiii) hypertension;
- (xxiv) toxaemia of pregnancy;
- (xxv) liver or renal disease;
- (xxvi) autoimmune disease;
- (xxvii) cardiac disease;
- (xxviii) alloimmunisation;
- (xxix) maternal infection;
- (xxx) inflammatory bowel disease;
- (xxxi) bowel stoma;
- (xxxii) abdominal wall scarring;
- (xxxiii) previous spinal or pelvic trauma or disease;
- (xxxiv) drug dependency;
- (xxxv) thrombophilia;
- (xxxvi) significant maternal obesity;
- (xxxvii) advanced maternal age;
- (xxxviii) abdominal pain or mass (NR)

‡ 55723 **Fee:** $38.00 **Benefit:** 75% = $28.50 85% = $32.30

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricans and Gynaecologists, where:

(a) the patient is not referred by a medical practitioner; and
(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (NR)

55725 **Fee:** $40.00 **Benefit:** 75% = $30.00 85% = $34.00

	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member; and (e) it can be demonstrated that a clinical condition other than a condition mentioned in paragraph (f) of item 55718 or paragraph (e) of item 55723 is present (R) *(See para DIH. of explanatory notes to this Category)*		
55728	**Fee:** $100.00	**Benefit:** 75% = $75.00	85% = $85.00
* 55729	MEASUREMENT OF UMBILICAL BLOOD FLOW using pulsed wave or continuous wave Doppler techniques after the 26th week of gestation where the patient is referred by a medical practitioner for this procedure and where there is reason to suspect intrauterine growth retardation or a significant risk of foetal death, not being a service associated with a service to which an item in this Group applies - examination and report (R) **Fee:** $27.25	**Benefit:** 75% = $20.45	85% = $23.20
55731	PELVIS, FEMALE, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member; and (d) the service is not performed with item 55036 or 55038 on the same patient within 24 hours (R) **Fee:** $98.00	**Benefit:** 75% = $73.50	85% = $83.30
55733	PELVIS, FEMALE, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR) **Fee:** $35.00	**Benefit:** 75% = $26.25	85% = $29.75
55736	PELVIS, FEMALE, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, performed by or on behalf of a medical practitioner where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of medical practitioners of which the first mentioned practitioner is a member; and (d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R) **Fee:** $127.00	**Benefit:** 75% = $95.25	85% = $107.95
55739	PELVIS, FEMALE, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (NR) **Fee:** $57.00	**Benefit:** 75% = $42.75	85% = $48.45
† 55759	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner, where: (a) the patient is referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the first mentioned practitioner is a member; and (f) the service is not performed in conjunction with item 55706, 55709, 55712, or 55715 during the same pregnancy (R) **Fee:** $150.00	**Benefit:** 75% = $112.50	85% = $127.50

† 55762	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies (NR) **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00
† 55764	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner, where: (a) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the first mentioned practitioner is a member; and (f) further examination is clinically indicated in the same pregnancy to which item 55759 or 55762 has been performed; and (g) not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy (R) **Fee:** $160.00 **Benefit:** 75% = $120.00 85% = $136.00
† 55766	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner, who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; (e) further examination is clinically indicated in the same pregnancy to which item 55759, or 55762 has been performed; and (f) not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy (NR) **Fee:** $65.00 **Benefit:** 75% = $48.75 85% = $55.25
† 55768	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, performed by or on behalf of a medical practitioner, where: (a) dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) the ultrasound confirms a multiple pregnancy; and (c) the patient is referred by a medical practitioner; and (d) the service is not performed in the same pregnancy as item 55770; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55723, 55725 or 55728 during the same pregnancy (R) **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50
† 55770	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service n any 1 pregnancy), by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) the service is not performed in the same pregnancy as item 55768; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721, 55723, 55725 or 55278 during the same pregnancy (NR) **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00

† 55772	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55723, 55725 or 55728 during the same pregnancy (R) **Fee:** $160.00 **Benefit:** 75% = $120.00 85% = $136.00
† 55774	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721 55723, 55725 or 55728 during the same pregnancy (NR) **Fee:** $65.00 **Benefit:** 75% = $48.75 85% = $55.25
	SUBGROUP 6 - MUSCULOSKELETAL
† 55800	HAND OR WRIST, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95
† 55802	HAND OR WRIST, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50
† 55804	FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95
† 55806	FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50
† 55808	SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member. (R) **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95
† 55810	SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50
† 55812	CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95

† 55814	CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50
† 55816	HIP OR GROIN, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95
† 55818	HIP OR GROIN, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (c) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies: and (d) the patient is not referred by a medical practitioner (NR) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50
† 55820	PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (c) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95
† 55822	PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (f) the patient is not referred by a medical practitioner (NR) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50
† 55824	BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95
† 55826	BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50
† 55828	KNEE, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95
† 55830	KNEE, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50
† 55832	LOWER LEG, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95
† 55834	LOWER LEG, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50
† 55836	ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the services is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95

H 55838	ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50
H 55840	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95
H 55842	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50
H 55844	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) **Fee:** $80.00 **Benefit:** 75% = $60.00 85% = $68.00
H 55846	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, performed by or on behalf of a medical practitioner, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50
H 55848	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies, and not performed in conjunction with item 55054 (R) **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95
H 55850	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, where: (a) the referring practitioner has indicated on a referral for a musculoskeletal ultrasound that a ultrasound guided intervention be performed if clinically indicated; (b) the service is not performed in conjunction with items 55054, or 55800 to 55848, and (c) the referring practitioner is not a member of a group of practitioners of which the first mentioned practitioner is a member (R) **Fee:** $140.00 **Benefit:** 75% = $105.00 85% = $119.00

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:** $195.00	**Benefit:** 75% = $146.25	85% = $165.75
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:** $250.00	**Benefit:** 75% = $187.50	85% = $212.50
56010	COMPUTED TOMOGRAPHY - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) **Fee:** $252.10	**Benefit:** 75% = $189.10	85% = $214.30
56013	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) **Fee:** $250.00	**Benefit:** 75% = $187.50	85% = $212.50
56016	COMPUTED TOMOGRAPHY - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (K) **Fee:** $290.00	**Benefit:** 75% = $217.50	85% = $246.50
56022	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (K) **Fee:** $225.00	**Benefit:** 75% = $168.75	85% = $191.25
56028	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to intravenous contrast injection, when undertaken (R) (K) **Fee:** $336.80	**Benefit:** 75% = $252.60	85% = $286.30
56030	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (K) **Fee:** $300.00	**Benefit:** 75% = $225.00	85% = $255.00
56036	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (K) **Fee:** $375.00	**Benefit:** 75% = $281.25	85% = $324.10
56041	COMPUTED TOMOGRAPHY - scan of brain without intravenous contrast medium, not being a service to which item 57041 applies (R) (NK) **Fee:** $98.75	**Benefit:** 75% = $74.10	85% = $83.95
56047	COMPUTED TOMOGRAPHY - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57047 applies (R) (NK) **Fee:** $126.10	**Benefit:** 75% = $94.60	85% = $107.20
56050	COMPUTED TOMOGRAPHY - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) **Fee:** $128.15	**Benefit:** 75% = $96.15	85% = $108.95
56053	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) **Fee:** $128.15	**Benefit:** 75% = $96.15	85% = $108.95
56056	COMPUTED TOMOGRAPHY - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (NK) **Fee:** $155.40	**Benefit:** 75% = $116.55	85% = $132.10
56062	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (NK) **Fee:** $113.15	**Benefit:** 75% = $84.90	85% = $96.20
56068	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to intravenous contrast injection, when undertaken (R) (NK) **Fee:** $168.40	**Benefit:** 75% = $126.30	85% = $143.15

56070	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (NK) **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50
56076	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (NK) **Fee:** $187.50 **Benefit:** 75% = $140.65 85% = $159.40
	NECK
56101	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56801 applies (R) (K) **Fee:** $230.00 **Benefit:** 75% = $172.50 85% = $195.50
56107	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) - with intravenous contrast medium and with any scans of soft tissues of neck including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) prior to intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56807 applies (R) (K) **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.10
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:** $116.40 **Benefit:** 75% = $87.30 85% = $98.95
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:** $171.60 **Benefit:** 75% = $128.70 85% = $145.90
	SPINE
56210	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:** $240.00 **Benefit:** 75% = $180.00 85% = $204.00
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:** $351.35 **Benefit:** 75% = $263.55 85% = $300.45
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:** $326.20 **Benefit:** 75% = $244.65 85% = $277.30
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:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
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:** $177.50 **Benefit:** 75% = $133.15 85% = $150.90
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:** $164.80 **Benefit:** 75% = $123.60 85% = $140.10

	CHEST AND UPPER ABDOMEN
56301	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56801 or 57001 applies and not including a study performed to exclude coronary artery calcification (R) (K) **Fee:** $295.00 **Benefit:** 75% = $221.25 85% = $250.75
56307	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56807 or 57007 applies and not including a study performed to exclude coronary artery calcification (R) (K) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $349.10
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:** $149.50 **Benefit:** 75% = $112.15 85% = $127.10
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:** $202.00 **Benefit:** 75% = $151.50 85% = $171.70
	UPPER ABDOMEN
56401	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) without intravenous contrast medium, not being a service to which item 56301, 56501, 56801 or 57001 applies (R) (K) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
56407	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) with intravenous contrast medium and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56307, 56507, 56807 or 57007 applies (R) (K) **Fee:** $360.00 **Benefit:** 75% = $270.00 85% = $309.10
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:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
56412	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) with intravenous contrast medium and with any scans of pelvis (iliac crest to pubic symphysis) prior to intravenous contrast injection, when undertaken, not being a service to which item 56407 applies (R) (K) **Fee:** $360.00 **Benefit:** 75% = $270.00 85% = $309.10
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:** $126.80 **Benefit:** 75% = $95.10 85% = $107.80
56447	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) with intravenous contrast medium, and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56347, 56547, 56847 or 57047 applies (R) (NK) **Fee:** $181.45 **Benefit:** 75% = $136.10 85% = $154.25
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:** $126.80 **Benefit:** 75% = $95.10 85% = $107.80
56452	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) with intravenous contrast medium, and with any scans of pelvis (iliac crest to pubic symphysis) prior to intravenous contrast injection, when undertaken, not being a service to which item 56447 applies (R) (NK) **Fee:** $181.45 **Benefit:** 75% = $136.10 85% = $154.25
	UPPER ABDOMEN AND PELVIS
56501	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:** $385.00 **Benefit:** 75% = $288.75 85% = $334.10

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:** $480.00	**Benefit:** 75% = $360.00	85% = $429.10
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:** $193.10	**Benefit:** 75% = $144.85	85% = $164.15
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:** $243.75	**Benefit:** 75% = $182.85	85% = $207.20
	EXTREMITIES		
56619	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions without intravenous contrast medium, payable once only whether 1 or more attendances are required to complete the service (R) (K) *(See para DII. of explanatory notes to this Category)* **Fee:** $220.00	**Benefit:** 75% = $165.00	85% = $187.00
56625	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions with intravenous contrast medium and with any scans of extremities prior to intravenous contrast injection, when undertaken; only 1 benefit is payable whether 1 or more attendances are required to complete the service (R) (K) *(See para DII. of explanatory notes to this Category)* **Fee:** $334.65	**Benefit:** 75% = $251.00	85% = $284.50
56659	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions without intravenous contrast medium, payable once only whether 1 or more attendances are required to complete (R) (NK) *(See para DII. of explanatory notes to this Category)* **Fee:** $112.10	**Benefit:** 75% = $84.10	85% = $95.30
56665	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions with intravenous contrast medium, and with any scans of extremities prior to intravenous contrast injection, when undertaken; only 1 benefit is payable whether 1 or more attendances are required to complete the service (R) (NK) *(See para DII. of explanatory notes to this Category)* **Fee:** $167.35	**Benefit:** 75% = $125.55	85% = $142.25
	CHEST, ABDOMEN, PELVIS AND NECK		
56801	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium, not including a study performed to exclude coronary artery calcification (R) (K) **Fee:** $466.55	**Benefit:** 75% = $349.95	85% = $415.65
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:** $560.00	**Benefit:** 75% = $420.00	85% = $509.10
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:** $233.30	**Benefit:** 75% = $175.00	85% = $198.35
56847	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification (R) (NK) **Fee:** $283.85	**Benefit:** 75% = $212.90	85% = $241.30
	BRAIN, CHEST AND UPPER ABDOMEN		
57001	COMPUTED TOMOGRAPHY - scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification (R) (K) **Fee:** $466.65	**Benefit:** 75% = $350.00	85% = $415.75

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:** $567.75 **Benefit:** 75% = $425.85 85% = $516.85
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:** $233.35 **Benefit:** 75% = $175.05 85% = $198.35
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:** $283.90 **Benefit:** 75% = $212.95 85% = $241.35
	PELVIMETRY
57201	COMPUTED TOMOGRAPHY - PELVIMETRY (R) (K) **Fee:** $155.20 **Benefit:** 75% = $116.40 85% = $131.95
57247	COMPUTED TOMOGRAPHY - PELVIMETRY (R) (NK) **Fee:** $77.60 **Benefit:** 75% = $58.20 85% = $66.00
	INTERVENTIONAL TECHNIQUES
57341	COMPUTED TOMOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (K) **Fee:** $470.00 **Benefit:** 75% = $352.50 85% = $419.10
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:** $242.00 **Benefit:** 75% = $181.50 85% = $205.70
	SPIRAL ANGIOGRAPHY
‡ 57350	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months (R) (K) **Fee:** $510.00 **Benefit:** 75% = $382.50 85% = $459.10
‡ 57355	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months (R) (NK) **Fee:** $264.15 **Benefit:** 75% = $198.15 85% = $224.55

	GROUP I3 - DIAGNOSTIC RADIOLOGY		
	SUBGROUP 1 - RADIOGRAPHIC EXAMINATION OF EXTREMITIES AND REPORT		
57506	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (NR) **Fee:** $28.05	**Benefit:** 75% = $21.05	85% = $23.85
57509	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (R) **Fee:** $37.50	**Benefit:** 75% = $28.15	85% = $31.90
57512	HAND, WRIST AND FOREARM, OR FOREARM AND ELBOW, OR ELBOW AND HUMERUS (NR) **Fee:** $38.15	**Benefit:** 75% = $28.65	85% = $32.45
57515	HAND, WRIST AND FOREARM, OR FOREARM AND ELBOW, OR ELBOW AND HUMERUS (R) **Fee:** $50.90	**Benefit:** 75% = $38.20	85% = $43.30
57518	FOOT, ANKLE, LEG, KNEE OR FEMUR (NR) **Fee:** $30.65	**Benefit:** 75% = $23.00	85% = $26.10
57521	FOOT, ANKLE, LEG, KNEE OR FEMUR (R) **Fee:** $40.90	**Benefit:** 75% = $30.70	85% = $34.80
57524	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (NR) **Fee:** $46.55	**Benefit:** 75% = $34.95	85% = $39.60
57527	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (R) **Fee:** $62.00	**Benefit:** 75% = $46.50	85% = $52.70
	SUBGROUP 2 - RADIOGRAPHIC EXAMINATION OF SHOULDER OR PELVIS AND REPORT		
57700	SHOULDER OR SCAPULA (NR) **Fee:** $38.15	**Benefit:** 75% = $28.65	85% = $32.45
57703	SHOULDER OR SCAPULA (R) **Fee:** $50.90	**Benefit:** 75% = $38.20	85% = $43.30
57706	CLAVICLE (NR) **Fee:** $30.65	**Benefit:** 75% = $23.00	85% = $26.10
57709	CLAVICLE (R) **Fee:** $40.90	**Benefit:** 75% = $30.70	85% = $34.80
57712	HIP JOINT (R) **Fee:** $44.45	**Benefit:** 75% = $33.35	85% = $37.80
57715	PELVIC GIRDLE (R) **Fee:** $57.45	**Benefit:** 75% = $43.10	85% = $48.85
57721	FEMUR, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R) **Fee:** $93.55	**Benefit:** 75% = $70.20	85% = $79.55
	SUBGROUP 3 - RADIOGRAPHIC EXAMINATION OF HEAD AND REPORT		
57901	SKULL, not in association with item 57902 (R) **Fee:** $60.80	**Benefit:** 75% = $45.60	85% = $51.70
57902	CEPHALOMETRY, not in association with item 57901 (R) **Fee:** $60.80	**Benefit:** 75% = $45.60	85% = $51.70
57903	SINUSES (R) **Fee:** $44.55	**Benefit:** 75% = $33.45	85% = $37.90
57906	MASTOIDS (R) **Fee:** $60.80	**Benefit:** 75% = $45.60	85% = $51.70
57909	PETROUS TEMPORAL BONES (R) **Fee:** $60.80	**Benefit:** 75% = $45.60	85% = $51.70

57912	FACIAL BONES orbit, maxilla or malar, any or all (R) **Fee:** $44.45	**Benefit:** 75% = $33.35	85% = $37.80
57915	MANDIBLE, not by orthopantomography technique (R) **Fee:** $44.45	**Benefit:** 75% = $33.35	85% = $37.80
57918	SALIVARY CALCULUS (R) **Fee:** $44.45	**Benefit:** 75% = $33.35	85% = $37.80
57921	NOSE (R) **Fee:** $44.45	**Benefit:** 75% = $33.35	85% = $37.80
57924	EYE (R) **Fee:** $44.45	**Benefit:** 75% = $33.35	85% = $37.80
57927	TEMPOROMANDIBULAR JOINTS (R) **Fee:** $46.80	**Benefit:** 75% = $35.10	85% = $39.80
57930	TEETH SINGLE AREA (R) **Fee:** $31.00	**Benefit:** 75% = $23.25	85% = $26.35
57933	TEETH FULL MOUTH (R) **Fee:** $73.75	**Benefit:** 75% = $55.35	85% = $62.70
57936	TEETH, ORTHOPANTOMOGRAPHY (R) **Fee:** $44.65	**Benefit:** 75% = $33.50	85% = $38.00
57939	PALATOPHARYNGEAL STUDIES with fluoroscopic screening (R) **Fee:** $60.80	**Benefit:** 75% = $45.60	85% = $51.70
57942	PALATOPHARYNGEAL STUDIES without fluoroscopic screening (R) **Fee:** $46.80	**Benefit:** 75% = $35.10	85% = $39.80
57945	LARYNX, LATERAL AIRWAYS AND SOFT TISSUES OF THE NECK, not being a service associated with a service to which item 57939 or 57942 applies (R) **Fee:** $40.90	**Benefit:** 75% = $30.70	85% = $34.80
	SUBGROUP 4 - RADIOGRAPHIC EXAMINATION OF SPINE AND REPORT		
58100	SPINE CERVICAL (R) **Fee:** $63.30	**Benefit:** 75% = $47.50	85% = $53.85
58103	SPINE THORACIC (R) **Fee:** $51.95	**Benefit:** 75% = $39.00	85% = $44.20
58106	SPINE LUMBOSACRAL (R) **Fee:** $72.55	**Benefit:** 75% = $54.45	85% = $61.70
58109	SPINE SACROCOCCYGEAL (R) **Fee:** $44.30	**Benefit:** 75% = $33.25	85% = $37.70
58112	SPINE 2 REGIONS (R) **Fee:** $91.65	**Benefit:** 75% = $68.75	85% = $77.95
58115	SPINE 3 OR MORE REGIONS (R) **Fee:** $125.30	**Benefit:** 75% = $94.00	85% = $106.55
	SUBGROUP 5 - BONE AGE STUDY AND SKELETAL SURVEYS AND REPORT		
58300	BONE AGE STUDY (R) **Fee:** $37.80	**Benefit:** 75% = $28.35	85% = $32.15
58306	SKELETAL SURVEY (R) **Fee:** $84.25	**Benefit:** 75% = $63.20	85% = $71.65

	SUBGROUP 6 - RADIOGRAPHIC EXAMINATION OF THORACIC REGION AND REPORT		
58500	CHEST (lung fields) by direct radiography (NR) **Fee:** $33.30	**Benefit:** 75% = $25.00	85% = $28.35
58503	CHEST (lung fields) by direct radiography (R) **Fee:** $44.45	**Benefit:** 75% = $33.35	85% = $37.80
58506	CHEST (lung fields) by direct radiography with fluoroscopic screening (R) **Fee:** $57.30	**Benefit:** 75% = $43.00	85% = $48.75
58509	THORACIC INLET OR TRACHEA (R) **Fee:** $37.50	**Benefit:** 75% = $28.15	85% = $31.90
58521	LEFT RIBS, RIGHT RIBS OR STERNUM (R) **Fee:** $40.90	**Benefit:** 75% = $30.70	85% = $34.80
58524	LEFT AND RIGHT RIBS, LEFT RIBS AND STERNUM, OR RIGHT RIBS AND STERNUM (R) **Fee:** $53.25	**Benefit:** 75% = $39.95	85% = $45.30
58527	LEFT RIBS, RIGHT RIBS AND STERNUM (R) **Fee:** $65.45	**Benefit:** 75% = $49.10	85% = $55.65
	SUBGROUP 7 - RADIOGRAPHIC EXAMINATION OF URINARY TRACT AND REPORT		
58700	PLAIN RENAL ONLY (R) **Fee:** $43.40	**Benefit:** 75% = $32.55	85% = $36.90
58706	INTRAVENOUS PYELOGRAPHY, with or without preliminary plain films and with or without tomography - examination and report (R) **Fee:** $148.85	**Benefit:** 75% = $111.65	85% = $126.55
58715	ANTEGRADE OR RETROGRADE PYELOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - 1 side - examination and report (R) **Fee:** $142.85	**Benefit:** 75% = $107.15	85% = $121.45
58718	RETROGRADE CYSTOGRAPHY OR RETROGRADE URETHROGRAPHY with or without preliminary plain films and with preparation and contrast injection - examination and report (R) (Anaes. 17705 = 3B + 2T) **Fee:** $118.90	**Benefit:** 75% = $89.20	85% = $101.10
58721	RETROGRADE MICTURATING CYSTOURETHROGRAPHY, with preparation and contrast injection - examination and report (R) (Anaes. 17705 = 3B + 2T) **Fee:** $130.30	**Benefit:** 75% = $97.75	85% = $110.80
	SUBGROUP 8 - RADIOGRAPHIC EXAMINATION OF ALIMENTARY TRACT AND BILIARY SYSTEM AND REPORT		
58900	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58912, 58915 or 58924 applies (NR) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $33.65	**Benefit:** 75% = $25.25	85% = $28.65
58903	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58912, 58915 or 58924 applies (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $44.85	**Benefit:** 75% = $33.65	85% = $38.15
58909	BARIUM or other opaque meal of 1 or more of PHARYNX, OESOPHAGUS, STOMACH OR ABDOMEN, with or without preliminary plain films of pharynx, chest or duodenum, not being a service associated with a service to which item 57939 or 57942 or 57945 applies - examination and report (R) **Fee:** $84.80	**Benefit:** 75% = $63.60	85% = $72.10
58912	BARIUM or other opaque meal OF OESOPHAGUS, STOMACH, DUODENUM AND FOLLOW THROUGH TO COLON, with or without screening of chest, with or without preliminary plain film (R) **Fee:** $103.95	**Benefit:** 75% = $78.00	85% = $88.40
58915	BARIUM or other opaque meal, SMALL BOWEL SERIES ONLY, with or without preliminary plain film (R) **Fee:** $74.40	**Benefit:** 75% = $55.80	85% = $63.25

58916	SMALL BOWEL ENEMA, barium or other opaque study of the small bowel, including DUODENAL INTUBATION, with or without preliminary plain films, not being a service associated with a service to which item 30488 applies - examination and report (R) (Anaes. 17707 = 5B + 2T) **Fee:** $130.55 **Benefit:** 75% = $97.95 85% = $111.00
58921	OPAQUE ENEMA, with or without air contrast study and with or without preliminary plain films - examination and report (R) **Fee:** $127.50 **Benefit:** 75% = $95.65 85% = $108.40
58924	GRAHAM'S TEST (cholecystography), with preliminary plain films and with or without tomography - examination and report (R) **Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35
58927	CHOLEGRAPHY DIRECT, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 30439 applies - examination and report (R) **Fee:** $72.05 **Benefit:** 75% = $54.05 85% = $61.25
58933	CHOLEGRAPHY, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection - examination and report (R) **Fee:** $193.80 **Benefit:** 75% = $145.35 85% = $164.75
58936	CHOLEGRAPHY, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography - examination and report (R) **Fee:** $184.70 **Benefit:** 75% = $138.55 85% = $157.00
58939	DEFAECOGRAM (R) **Fee:** $131.30 **Benefit:** 75% = $98.50 85% = $111.65
	SUBGROUP 9 - RADIOGRAPHIC EXAMINATION FOR LOCALISATION OF FOREIGN BODIES AND REPORT
59103	FOREIGN BODY, LOCALISATION OF AND REPORT, not being a service to which another item in this Group applies (R) **Derived Fee:** The fee for radiographic examination of the area and report plus an amount of $21.30
	SUBGROUP 10 - RADIOGRAPHIC EXAMINATION OF BREASTS AND REPORT
59300 S	*(Note: These items are intended for use in the investigation of a clinical abnormality of the breast/s and NOT for individual, group or opportunistic screening of asymptomatic patients)* RADIOGRAPHIC EXAMINATION OF BOTH BREASTS, (with or without thermography) and report if: (a) the patient is referred with a specific request for this procedure; and (b) there is reason to suspect the presence of malignancy in the breasts because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $82.00 **Benefit:** 75% = $61.50 85% = $69.70
59303 S	RADIOGRAPHIC EXAMINATION OF 1 BREAST, (with or without thermography) and report if: (a) the patient is referred with a specific request for this procedure; and (b) there is reason to suspect the presence of malignancy in the breasts because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $49.45 **Benefit:** 75% = $37.10 85% = $42.05
59306	MAMMARY DUCTOGRAM (galactography) - 1 breast (R) **Fee:** $94.55 **Benefit:** 75% = $70.95 85% = $80.40
59309	MAMMARY DUCTOGRAM (galactography) - 2 breasts (R) **Fee:** $189.10 **Benefit:** 75% = $141.85 85% = $160.75
59312	RADIOGRAPHIC EXAMINATION OF BOTH BREASTS, in conjunction with a surgical procedure on each breast, using interventional techniques - examination and report (R) **Fee:** $82.00 **Benefit:** 75% = $61.50 85% = $69.70
59314	RADIOGRAPHIC EXAMINATION OF 1 BREAST, in conjunction with a surgical procedure using interventional techniques - examination and report (R) **Fee:** $49.45 **Benefit:** 75% = $37.10 85% = $42.05

59318	RADIOGRAPHIC EXAMINATION OF EXCISED BREAST TISSUE to confirm satisfactory excision of 1 or more lesions in 1 breast or both following pre-operative localisation in conjunction with a service under item 30361 - examination and report (R) **Fee:** $44.35 **Benefit:** 75% = $33.30 85% = $37.70
	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:** $84.25 **Benefit:** 75% = $63.20 85% = $71.65
	SUBGROUP 12 - RADIOGRAPHIC EXAMINATION WITH OPAQUE OR CONTRAST MEDIA AND REPORT
59700	DISCOGRAPHY, each disc, with or without preliminary plain films and with preparation and contrast injection - examination and report (R) (Anaes. 17707 = 5B + 2T) **Fee:** $91.00 **Benefit:** 75% = $68.25 85% = $77.35

59703	DACRYOCYSTOGRAPHY, 1 side, with or without preliminary plain film and with preparation and contrast injection - examination and report (R) **Fee:** $71.55	**Benefit:** 75% = $53.70	85% = $60.85
59712	HYSTEROSALPINGOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - examination and report (R) (Anaes. 17705 = 3B + 2T) **Fee:** $107.20	**Benefit:** 75% = $80.40	85% = $91.15
59715	BRONCHOGRAPHY, 1 side, with or without preliminary plain films and with preparation and contrast injection - examination and report (R) (Anaes. 17709 = 6B + 3T) **Fee:** $135.30	**Benefit:** 75% = $101.50	85% = $115.05
59718	PHLEBOGRAPHY, 1 side, with or without preliminary plain films and with preparation and contrast injection - examination and report (R) (Anaes. 17708 = 5B + 3T) **Fee:** $126.95	**Benefit:** 75% = $95.25	85% = $107.95
59724	MYELOGRAPHY, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 56219 applies - examination and report (R) (Anaes. 17712 = 7B + 5T) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $213.45	**Benefit:** 75% = $160.10	85% = $181.45
59733	SIALOGRAPHY, 1 side, with preparation and contrast injection, not being a service associated with a service to which item 57918 applies - examination and report (R) **Fee:** $101.50	**Benefit:** 75% = $76.15	85% = $86.30
59736	VASOEPIDIDYMOGRAPHY, 1 side, for other than an investigation for reversal of previous sterilisation - examination and report (R) **Fee:** $58.45	**Benefit:** 75% = $43.85	85% = $49.70
59739	SINOGRAM OR FISTULOGRAM, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection - examination and report (R) **Fee:** $69.50	**Benefit:** 75% = $52.15	85% = $59.10
59751	ARTHROGRAPHY, each joint, excluding the facet (zygapophyseal) joints of the spine, single or double contrast study, with or without preliminary plain films and with preparation and contrast injection - examination and report (R) **Fee:** $131.15	**Benefit:** 75% = $98.40	85% = $111.50
59754	LYMPHANGIOGRAPHY, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection - examination and report(R) **Fee:** $206.75	**Benefit:** 75% = $155.10	85% = $175.75
59760	PERITONEOGRAM (herniography) with or without contrast medium including preparation - performed on a person over 14 years of age (R) **Fee:** $108.55	**Benefit:** 75% = $81.45	85% = $92.30
59763	AIR INSUFFLATION during video - fluoroscopic imaging including associated consultation (R) **Fee:** $126.20	**Benefit:** 75% = $94.65	85% = $107.30
	SUBGROUP 13 - ANGIOGRAPHY AND REPORT		
	BY FILM OR OTHER TECHNIQUE		
59900	SERIAL ANGIOCARDIOGRAPHY (rapid cassette changing) each series (R) (Anaes. 17711 = 7B + 4T) **Fee:** $87.55	**Benefit:** 75% = $65.70	85% = $74.45
59903	SERIAL ANGIOCARDIOGRAPHY (SINGLE PLANE) each series (R) (Anaes. 17711 = 7B + 4T) **Fee:** $120.60	**Benefit:** 75% = $90.45	85% = $102.55
59906	SERIAL ANGIOCARDIOGRAPHY (BIPLANE) each series (R) (Anaes. 17711 = 7B + 4T) **Fee:** $120.60	**Benefit:** 75% = $90.45	85% = $102.55
59912	SELECTIVE CORONARY ARTERIOGRAPHY (R) **Fee:** $321.25	**Benefit:** 75% = $240.95	85% = $273.10
59915	CEREBRAL ANGIOGRAPHY 1 side (R) **Fee:** $81.95	**Benefit:** 75% = $61.50	85% = $69.70

59918	ARTERIOGRAPHY, PERIPHERAL 1 side (R) **Fee:** $103.95	**Benefit:** 75% = $78.00	85% = $88.40
59921	AORTOGRAPHY (R) **Fee:** $103.95	**Benefit:** 75% = $78.00	85% = $88.40
59924	SELECTIVE ARTERIOGRAPHY per injection and film or data acquisition run (R) **Fee:** $103.95	**Benefit:** 75% = $78.00	85% = $88.40
59970	ANGIOGRAPHY AND/OR DIGITAL SUBTRACTION ANGIOGRAPHY with fluoroscopy and image acquisition using a mobile image intensifier, 1 or more regions including any preliminary plain films, preparation and contrast injection (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $158.65	**Benefit:** 75% = $119.00	85% = $134.90
	BY DIGITAL SUBTRACTION TECHNIQUE		
60000	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 1 to 3 data acquisition runs (R) **Fee:** $531.60	**Benefit:** 75% = $398.70	85% = $480.70
60003	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 4 to 6 data acquisition runs (R) **Fee:** $779.60	**Benefit:** 75% = $584.70	85% = $728.70
60006	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 7 to 9 data acquisition runs (R) **Fee:** $1,108.60	**Benefit:** 75% = $831.45	85% = $1,057.70
60009	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 10 or more data acquisition runs (R) **Fee:** $1,297.30	**Benefit:** 75% = $973.00	85% = $1,246.40
60012	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 1 to 3 data acquisition runs (R) **Fee:** $531.60	**Benefit:** 75% = $398.70	85% = $480.70
60015	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 4 to 6 data acquisition runs (R) **Fee:** $779.60	**Benefit:** 75% = $584.70	85% = $728.70
60018	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 7 to 9 data acquisition runs (R) **Fee:** $1,108.60	**Benefit:** 75% = $831.45	85% = $1,057.70
60021	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 10 or more data acquisition runs (R) **Fee:** $1,297.30	**Benefit:** 75% = $973.00	85% = $1,246.40
60024	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 1 to 3 data acquisition runs (R) **Fee:** $531.60	**Benefit:** 75% = $398.70	85% = $480.70
60027	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 4 to 6 data acquisition runs (R) **Fee:** $779.60	**Benefit:** 75% = $584.70	85% = $728.70
60030	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 7 to 9 data acquisition runs (R) **Fee:** $1,108.60	**Benefit:** 75% = $831.45	85% = $1,057.70
60033	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 10 or more data acquisition runs (R) **Fee:** $1,297.30	**Benefit:** 75% = $973.00	85% = $1,246.40
60036	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 1 to 3 data acquisition runs (R) **Fee:** $531.60	**Benefit:** 75% = $398.70	85% = $480.70
60039	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 4 to 6 data acquisition runs (R) **Fee:** $779.60	**Benefit:** 75% = $584.70	85% = $728.70
60042	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 7 to 9 data acquisition runs (R) **Fee:** $1,108.60	**Benefit:** 75% = $831.45	85% = $1,057.70
60045	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 10 or more data acquisition runs (R) **Fee:** $1,297.30	**Benefit:** 75% = $973.00	85% = $1,246.40

60048	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 1 to 3 data acquisition runs (R) **Fee:** $531.60	**Benefit:** 75% = $398.70	85% = $480.70
60051	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 4 to 6 data acquisition runs (R) **Fee:** $779.60	**Benefit:** 75% = $584.70	85% = $728.70
60054	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 7 to 9 data acquisition runs (R) **Fee:** $1,108.60	**Benefit:** 75% = $831.45	85% = $1,057.70
60057	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 10 or more data acquisition runs (R) **Fee:** $1,297.30	**Benefit:** 75% = $973.00	85% = $1,246.40
60060	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 1 to 3 data acquisition runs (R) **Fee:** $531.60	**Benefit:** 75% = $398.70	85% = $480.70
60063	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 4 to 6 data acquisition runs (R) **Fee:** $779.60	**Benefit:** 75% = $584.70	85% = $728.70
60066	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 7 to 9 data acquisition runs (R) **Fee:** $1,108.60	**Benefit:** 75% = $831.45	85% = $1,057.70
60069	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 10 or more data acquisition runs (R) **Fee:** $1,297.30	**Benefit:** 75% = $973.00	85% = $1,246.40
60072	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 1 vessel (NR) **Fee:** $45.35	**Benefit:** 75% = $34.05	85% = $38.55
60075	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 2 vessels (NR) **Fee:** $90.60	**Benefit:** 75% = $67.95	85% = $77.05
60078	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 3 or more vessels (NR) **Fee:** $135.95	**Benefit:** 75% = $102.00	85% = $115.60
	SUBGROUP 14 - TOMOGRAPHY AND REPORT		
60100	TOMOGRAPHY OF ANY REGION AND REPORT (R) **Fee:** $57.30	**Benefit:** 75% = $43.00	85% = $48.75
	SUBGROUP 15 - FLUOROSCOPIC EXAMINATION AND REPORT		
60500	FLUOROSCOPY, with general anaesthesia (not being a service associated with a radiographic examination) (R) (Anaes. 17707 = 5B + 2T) **Fee:** $40.90	**Benefit:** 75% = $30.70	85% = $34.80
60503	FLUOROSCOPY, without general anaesthesia (not being a service associated with a radiographic examination)(R) **Fee:** $28.05	**Benefit:** 75% = $21.05	85% = $23.85
60506	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service associated with a service to which another item in this Table applies (R) **Fee:** $60.10	**Benefit:** 75% = $45.10	85% = $51.10
60509	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this Table applies (R) **Fee:** $93.20	**Benefit:** 75% = $69.90	85% = $79.25
	SUBGROUP 16 - PREPARATION FOR RADIOLOGICAL PROCEDURE		
60903	CEREBRAL ANGIOGRAPHY, 1 side percutaneous, catheter or open exposure, when used in association with a service to which items 59900, 59903,59906, 59912, 59915, 59918, 59921, 59924 or 59970 applies, not being a service associated with a service to which items 60000 to 60078 inclusive apply (NR) (Anaes. 17710 = 5B + 5T) **Fee:** $120.80	**Benefit:** 75% = $90.60	85% = $102.70

60915	AORTOGRAPHY, when used in association with a service to which items 59900, 59903, 59906, 59912, 59915, 59918 59921, 59924 or 59970 applies, not being a service associated with a service to which items 60000 to 60078 inclusive apply (NR) (Anaes. 17709 = 5B + 4T) **Fee:** $66.55	**Benefit:** 75% = $49.95	85% = $56.60
60918	ARTERIOGRAPHY (peripheral) or PHLEBOGRAPHY 1 vessel, when used in association with a service to which items 59900, 59903, 59906, 59912, 59915, 59918, 59921 or 59924 applies, not being a service associated with a service to which items 60000 to 60078 inclusive apply (NR) (Anaes. 17708 = 5B + 3T) **Fee:** $49.65	**Benefit:** 75% = $37.25	85% = $42.25
60927	SELECTIVE ARTERIOGRAM or PHLEBOGRAM, when used in association with a service to which items 59900, 59903, 59906, 59912, 59915, 59918, 59921 or 59924 applies, not being a service associated with a service to which items 60000 to 60078 inclusive apply (NR) (Anaes. 17708 = 5B + 3T) **Fee:** $40.05	**Benefit:** 75% = $30.05	85% = $34.05
	SUBGROUP 17 - INTERVENTIONAL TECHNIQUES		
61109	FLUOROSCOPY in an ANGIOGRAPHY SUITE with image intensification, in conjunction with a surgical procedure, using interventional techniques, not being a service associated with a service to which another item in this Table applies (R) **Fee:** $244.05	**Benefit:** 75% = $183.05	85% = $207.45

GROUP I4 - NUCLEAR MEDICINE IMAGING

NOTE

Benefits for a nuclear medicine scanning service are only payable when the preliminary examination of the patient, estimation and administration of the dosage and the performance of the scan, are undertaken by a medical specialist, or on behalf of the medical specialist in the specialist's presence, and the compilation of the report is undertaken by the medical specialist. Additional benefits will only be attracted for a specialist or consultant physician attendance under Category 1 of the Schedule where there is a request for a full medical examination accompanied by a letter or note of referral.

61302	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - planar imaging (R) **Fee:** $391.25	**Benefit:** 75% = $293.45	85% = $340.35
61303	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - with single photon emission tomography and with planar imaging when undertaken (R) **Fee:** $492.75	**Benefit:** 75% = $369.60	85% = $441.85
61306	COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - planar imaging (R) **Fee:** $618.60	**Benefit:** 75% = $463.95	85% = $567.70
61307	COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - with single photon emission tomography and with planar imaging when undertaken (R) **Fee:** $727.75	**Benefit:** 75% = $545.85	85% = $676.85
61310	MYOCARDIAL INFARCT-AVID-STUDY, with planar imaging and single photon emission tomography, OR planar imaging or single photon emission tomography (R) **Fee:** $320.15	**Benefit:** 75% = $240.15	85% = $272.15
61313	GATED CARDIAC BLOOD POOL STUDY, (equilibrium), with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) **Fee:** $264.45	**Benefit:** 75% = $198.35	85% = $224.80
61314	GATED CARDIAC BLOOD POOL STUDY, and first pass blood flow or cardiac shunt study, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) **Fee:** $366.10	**Benefit:** 75% = $274.60	85% = $315.20
61316	GATED CARDIAC BLOOD POOL STUDY, with intervention, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) **Fee:** $332.20	**Benefit:** 75% = $249.15	85% = $282.40
61317	GATED CARDIAC BLOOD POOL STUDY, with intervention and first pass blood flow study or cardiac shunt study, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) **Fee:** $429.15	**Benefit:** 75% = $321.90	85% = $378.25
61320	CARDIAC FIRST PASS BLOOD FLOW STUDY OR CARDIAC SHUNT STUDY, not being a service to which another item in this Group applies (R) **Fee:** $199.55	**Benefit:** 75% = $149.70	85% = $169.65
61328	LUNG PERFUSION STUDY, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) **Fee:** $189.40	**Benefit:** 75% = $142.05	85% = $161.00
61340	LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) **Fee:** $220.55	**Benefit:** 75% = $165.45	85% = $187.50
61348	LUNG PERFUSION STUDY AND LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) **Fee:** $386.45	**Benefit:** 75% = $289.85	85% = $335.55
61352	LIVER AND SPLEEN STUDY (colloid) - planar imaging (R) **Fee:** $226.05	**Benefit:** 75% = $169.55	85% = $192.15
61353	LIVER AND SPLEEN STUDY (colloid), with single photon emission tomography and with planar imaging when undertaken (R) **Fee:** $336.95	**Benefit:** 75% = $252.75	85% = $286.45

61356	RED BLOOD CELL SPLEEN OR LIVER STUDY, including single photon emission tomography when undertaken (R) **Fee:** $342.35	**Benefit:** 75% = $256.80	85% = $291.45
61360	HEPATOBILIARY STUDY, including morphine administration or pre-treatment with cholecystokinin (CCK) when undertaken (R) **Fee:** $351.60	**Benefit:** 75% = $263.70	85% = $300.70
61361	HEPATOBILIARY STUDY with formal quantification following baseline imaging, using an infusion of cholecystokinin (CCK) (R) **Fee:** $402.20	**Benefit:** 75% = $301.65	85% = $351.30
61364	BOWEL HAEMORRHAGE STUDY (R) **Fee:** $433.15	**Benefit:** 75% = $324.90	85% = $382.25
61368	MECKEL'S DIVERTICULUM STUDY (R) **Fee:** $194.45	**Benefit:** 75% = $145.85	85% = $165.30
61369	INDIUM-LABELLED OCTREOTIDE STUDY - including single photon emission tomography when undertaken, where: (a) there is a suspected gastro-entero-pancreatic endocrine tumour, based on biochemical evidence, with negative or equivocal conventional imaging; or (b) a surgically amenable gastro-entero-pancreatic endocrine tumour has been identified based on conventional techniques, in order to exclude additional disease sites. (Ministerial Determination)(R) **Fee:** $1,757.00	**Benefit:** 75% = $1,317.75	85% = $1,706.10
61372	SALIVARY STUDY (R) **Fee:** $194.45	**Benefit:** 75% = $145.85	85% = $165.30
61373	GASTRO-OESOPHAGEAL REFLUX STUDY, including delayed imaging on a separate occasion when undertaken (R) **Fee:** $426.85	**Benefit:** 75% = $320.15	85% = $375.95
61376	OESOPHAGEAL CLEARANCE STUDY (R) **Fee:** $125.00	**Benefit:** 75% = $93.75	85% = $106.25
61381	GASTRIC EMPTYING STUDY, using single tracer (R) **Fee:** $500.65	**Benefit:** 75% = $375.50	85% = $449.75
61383	COMBINED SOLID AND LIQUID GASTRIC EMPTYING STUDY using dual isotope technique or the same isotope on separate days (R) **Fee:** $544.80	**Benefit:** 75% = $408.60	85% = $493.90
61384	RADIONUCLIDE COLONIC TRANSIT STUDY (R) **Fee:** $599.45	**Benefit:** 75% = $449.60	85% = $548.55
61386	RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R) **Fee:** $289.80	**Benefit:** 75% = $217.35	85% = $246.35
61387	RENAL CORTICAL STUDY, with single photon emission tomography and planar quantification (R) **Fee:** $375.45	**Benefit:** 75% = $281.60	85% = $324.55
61389	SINGLE RENAL STUDY with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R) **Fee:** $323.00	**Benefit:** 75% = $242.25	85% = $274.55
61390	RENAL STUDY with diuretic administration following a baseline study (R) **Fee:** $357.40	**Benefit:** 75% = $268.05	85% = $306.50
61393	COMBINED EXAMINATION INVOLVING A RENAL STUDY following angiotensin converting enzyme (ACE) inhibitor provocation and a baseline study, in either order and related to a single referral episode (R) **Fee:** $527.80	**Benefit:** 75% = $395.85	85% = $476.90
61397	CYSTOURETEROGRAM (R) **Fee:** $215.20	**Benefit:** 75% = $161.40	85% = $182.95
61401	TESTICULAR STUDY (R) **Fee:** $141.45	**Benefit:** 75% = $106.10	85% = $120.25
61402	CEREBRAL PERFUSION STUDY, with single photon emission tomogrophy and with planar imaging when undertaken (R) **Fee:** $527.40	**Benefit:** 75% = $395.55	85% = $476.50

61405	BRAIN STUDY WITH BLOOD BRAIN BARRIER AGENT, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) **Fee:** $301.60	**Benefit:** 75% = $226.20	85% = $256.40
61409	CEREBRO-SPINAL FLUID TRANSPORT STUDY, with imaging on 2 or more separate occasions (R) **Fee:** $761.40	**Benefit:** 75% = $571.05	85% = $710.50
61413	CEREBRO-SPINAL FLUID SHUNT PATENCY STUDY (R) **Fee:** $196.95	**Benefit:** 75% = $147.75	85% = $167.45
61417	DYNAMIC BLOOD FLOW STUDY OR REGIONAL BLOOD VOLUME QUANTITATIVE STUDY, not being a service associated with a service to which another item in this Group applies (R) **Fee:** $103.55	**Benefit:** 75% = $77.70	85% = $88.05
61421	BONE STUDY - whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) **Fee:** $418.20	**Benefit:** 75% = $313.65	85% = $367.30
61425	BONE STUDY - whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) **Fee:** $523.60	**Benefit:** 75% = $392.70	85% = $472.70
61426	WHOLE BODY STUDY using iodine (R) **Fee:** $483.60	**Benefit:** 75% = $362.70	85% = $432.70
61429	WHOLE BODY STUDY using gallium (R) **Fee:** $473.30	**Benefit:** 75% = $355.00	85% = $422.40
61430	WHOLE BODY STUDY using gallium, with single photon emission tomography (R) **Fee:** $574.80	**Benefit:** 75% = $431.10	85% = $523.90
61433	WHOLE BODY STUDY using cells labelled with technetium (R) **Fee:** $433.15	**Benefit:** 75% = $324.90	85% = $382.25
61434	WHOLE BODY STUDY using cells labelled with technetium, with single photon emission tomography (R) **Fee:** $536.40	**Benefit:** 75% = $402.30	85% = $485.50
61437	WHOLE BODY STUDY using thallium (R) **Fee:** $473.10	**Benefit:** 75% = $354.85	85% = $422.20
61438	WHOLE BODY STUDY using thallium, with single photon emission tomography (R) **Fee:** $586.60	**Benefit:** 75% = $439.95	85% = $535.70
61441	BONE MARROW STUDY - whole body using technetium labelled bone marrow agents (R) **Fee:** $426.85	**Benefit:** 75% = $320.15	85% = $375.95
61442	WHOLE BODY STUDY, using gallium - with single photon emission tomography of 2 or more body regions acquired separately (R) **Fee:** $655.75	**Benefit:** 75% = $491.85	85% = $604.85
61445	BONE MARROW STUDY - localised using technetium labelled agent (R) **Fee:** $250.00	**Benefit:** 75% = $187.50	85% = $212.50
61446	LOCALISED BONE OR JOINT STUDY, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (R) **Fee:** $290.75	**Benefit:** 75% = $218.10	85% = $247.15
61449	LOCALISED BONE OR JOINT STUDY and single photon emission tomography, including when undertaken, blood flow, blood pool and imaging on a separate occasion (R) **Fee:** $397.70	**Benefit:** 75% = $298.30	85% = $346.80
61450	LOCALISED STUDY using gallium (R) **Fee:** $346.50	**Benefit:** 75% = $259.90	85% = $295.60
61453	LOCALISED STUDY using gallium, with single photon emission tomography (R) **Fee:** $448.60	**Benefit:** 75% = $336.45	85% = $397.70

61454	LOCALISED STUDY using cells labelled with technetium (R) **Fee:** $303.40	**Benefit:** 75% = $227.55	85% = $257.90
61457	LOCALISED STUDY using cells labelled with technetium, with single photon emission tomography (R) **Fee:** $410.10	**Benefit:** 75% = $307.60	85% = $359.20
61458	LOCALISED STUDY using thallium (R) **Fee:** $345.95	**Benefit:** 75% = $259.50	85% = $295.05
61461	LOCALISED STUDY using thallium, with single photon emission tomography (R) **Fee:** $460.10	**Benefit:** 75% = $345.10	85% = $409.20
61462	REPEAT PLANAR AND SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING, OR REPEAT PLANAR IMAGING OR SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING on an occasion subsequent to the performance of any one of items 61364, 61426, 61429, 61430, 61442, 61450, 61453 or 61469, where there is no additional administration of radiopharmaceutical and where the previous radionuclide scan was abnormal or equivocal. (R) **Derived Fee:** The fee for the nuclear medicine investigation plus an amount of $113.55		
61465	VENOGRAPHY (R) **Fee:** $231.45	**Benefit:** 75% = $173.60	85% = $196.75
61469	LYMPHOSCINTIGRAPHY (R) **Fee:** $303.40	**Benefit:** 75% = $227.55	85% = $257.90
61473	THYROID STUDY including uptake measurement when undertaken (R) **Fee:** $152.85	**Benefit:** 75% = $114.65	85% = $129.95
61480	PARATHYROID STUDY, planar imaging and single photon emission tomography when undertaken (R) **Fee:** $337.20	**Benefit:** 75% = $252.90	85% = $286.65
61484	ADRENAL STUDY, with imaging on 2 or more separate occasions (R) **Fee:** $767.80	**Benefit:** 75% = $575.85	85% = $716.90
61485	ADRENAL STUDY, with imaging on 2 or more occasions and renal localisation and single photon emission tomography when undertaken (R) **Fee:** $871.00	**Benefit:** 75% = $653.25	85% = $820.10
61495	TEAR DUCT STUDY (R) **Fee:** $194.45	**Benefit:** 75% = $145.85	85% = $165.30
61499	PARTICLE PERFUSION STUDY (intra-arterial) or Le Veen shunt study (R) **Fee:** $220.55	**Benefit:** 75% = $165.45	85% = $187.50

GROUP I5 - MAGNETIC RESONANCE IMAGING

SUBGROUP 1 - SCAN OF HEAD - FOR THE EXCLUSION OF SPECIFIED CONDITONS

NOTE: Benefits are payable for each service included in Subgroup 1 on one occasion only in a 12 month period

MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of head** for the exclusion of:

	- tumour of the brain or meninges (R)		
63000	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- skull base or orbital tumour (R)		
63003	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- acoustic neuroma (R)		
63006	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- pituitary tumour (R)		
63009	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- inflammation of brain or meninges (R)		
63012	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- toxic or metabolic or ischaemic encephalopathy (R)		
63015	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- demyelinating disease of the brain (R)		
63018	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- congenital malformation of brain or meninges (R)		
63021	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- venous sinus thrombosis (R)		
63024	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10

SUBGROUP 2 - SCAN OF HEAD AND CERVICAL SPINE - FOR THE EXCLUSION OF SPECIFIED CONDITIONS

NOTE: Benefits are payable for each service included by Subgroup 2 on one occasion only in a 12 month period

MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of head and cervical spine** for the exclusion of:

	- tumour of the central nervous system or meninges (R)		
63050	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- inflammation of the central nervous system or meninges (R)		
63053	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- demyelinating disease of the central nervous system (R)		
63056	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- congenital malformation of the central nervous system or meninges (R)		
63059	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- syrinx (congenital or acquired) (R)		
63062	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10

	SUBGROUP 3 - SCAN OF HEAD - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS		
	NOTE: Benefits are payable for each service included by Subgroup 3 on one occasion only in a 12 month period MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of head** for further investigation of:		
63100	- tumour of the brain or meninges (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63103	- skull base or orbital tumour (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63106	- acoustic neuroma (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63109	- pituitary tumour (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63112	- inflammation of the brain or meninges (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63115	- toxic or metabolic or ischaemic encephalopathy (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63118	- demyelinating disease of the brain (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63121	- congenital malformation of the brain or meninges (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63124	- head trauma (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63127	- epilepsy (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63130	- stroke (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63133	- venous sinus thrombosis (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	SUBGROUP 4 - SCAN OF HEAD AND CERVICAL SPINE - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS		
	NOTE: Benefits are payable for each service included by Subgroup 4 on one occasion only in a 12 month period MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of head and cervical spine** for further investigation of:		
63150	- tumour of the central nervous system or meninges (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63153	- inflammation of the central nervous system or meninges (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63156	- demyelinating disease of the central nervous system (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63159	- congenital malformation of the central nervous system or meninges (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10

	- syrinx (congenital or acquired) (R)		
63162	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10

SUBGROUP 5 - SCAN OF HEAD - FOR MONITORING OF SPECIFIED CONDITIONS

NOTE: Benefits are payable for each service included by Subgroup 5 on two occasions only in a 12 month period

MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of head** for monitoring of:

	- acoustic neuroma (R)		
63200	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- pituitary tumour (R)		
63203	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- demyelinating disease of the brain (R)		
63206	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- congenital malformation of brain or meninges (R)		
63209	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- head trauma (R)		
63212	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- epilepsy (R)		
63215	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- stroke (R)		
63218	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- toxic or metabolic or ischaemic encephalopathy (R)		
63221	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10

SUBGROUP 6 - SCAN OF HEAD AND CERVICAL SPINE - FOR MONITORING OF SPECIFIED CONDITIONS

NOTE: Benefits are payable for each service included by Subgroup 6 on two occasions only in a 12 month period

MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of head and cervical spine** for monitoring of:

	- demyelinating disease of the central nervous system (R)		
63250	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- congenital malformation of the central nervous system or meninges (R)		
63253	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	-syrinx (congenital or acquired) (R)		
63256	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10

SUBGROUP 7 - SCAN OF HEAD - FOR MONITORING OF SPECIFIED CONDITIONS

MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of head** for monitoring of:

	- tumour of the brain or meninges (R)		
63270	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10

	- skull base or orbital tumour (R)		
63273	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- inflammation of brain or meninges (R)		
63276	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- venous sinus thrombosis (R)		
63279	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	SUBGROUP 8 - SCAN OF HEAD AND CERVICAL SPINE - FOR MONITORING OF SPECIFIED CONDITIONS		
	MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of head and cervical spine** for monitoring of:		
	- tumour of the central nervous system or meninges (R)		
63290	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- inflammation of the central nervous system or meninges (R)		
63293	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	SUBGROUP 9 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR THE EXCLUSION OF A SPECIFIED CONDITION		
	NOTE: Benefits are payable for each service included by Subgroup 9 on one occasion only in a 12 month period		
	MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of one region or two contiguous regions of the spine** for the exclusion of:		
	- infection (R)		
63300	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- tumour (R)		
63303	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- demyelinating disease (R)		
63306	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- congenital malformation of the spinal cord or the cauda equina or the meninges (R)		
63309	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- myelopathy (R)		
63312	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- syrinx (congenital or acquired) (R)		
63315	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	SUBGROUP 10 - SCAN OF SPINE - THREE CONTIGUOUS OR TWO NON CONTIGUOUS REGIONS - FOR THE EXCLUSION OF SPECIFIED CONDITIONS		
	NOTE: Benefits are payable for each service included by Subgroup 10 on one occasion only in a 12 month period		
	MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of three contiguous regions or two non contiguous regions of the spine** for the exclusion of:		
	- infection (R)		
63350	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	- tumour (R)		
63353	**Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10

63356	- demyelinating disease (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63359	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63362	- myelopathy (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63365	- syrinx (congenital or acquired) (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	SUBGROUP 11 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS		
	NOTE: Benefits are payable for each service included by Subgroup 11 on one occasion only in a 12 month period MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of one region or two contiguous regions of the spine** for further investigation of:		
63400	- infection (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63403	- tumour (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63406	- demyelinating disease (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63409	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63412	- myelopathy (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63415	- syrinx (congenital or acquired) (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63418	- cervical radiculopathy (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63421	- sciatica (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63424	- spinal canal stenosis (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63427	- previous spinal surgery (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63430	- trauma (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10

	SUBGROUP 12 - SCAN OF SPINE - THREE CONTIGUOUS OR TWO NON CONTIGUOUS REGIONS - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 12 on one occasion only in a 12 month period MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of three contiguous regions or two non contiguous regions of the spine** for further investigation of:
63450	- infection (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63453	- tumour (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63456	- demyelinating disease (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63459	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63462	- myelopathy (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63465	- syrinx (congenital or acquired) (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63468	- cervical radiculopathy (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63471	- sciatica (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63474	- spinal canal stenosis (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63477	- previous spinal surgery (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63480	- trauma (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
	SUBGROUP 13 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR MONITORING OF SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 13 on one occasion only in a 12 month period MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of one region or two contiguous regions of the spine** for monitoring of:
63500	- demyelinating disease (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63503	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63506	- myelopathy (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63509	- syrinx (congenital or acquired) (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10

63512	- cervical radiculopathy (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63515	- sciatica (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63518	- spinal canal stenosis (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63521	- previous spinal surgery (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63524	- trauma (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10

SUBGROUP 14 - SCAN OF SPINE - THREE CONTIGUOUS OR TWO NON CONTIGUOUS REGIONS - FOR MONITORING OF SPECIFIED CONDITIONS

NOTE: Benefits are payable for each service included by Subgroup 14 on one occasion only in a 12 month period

MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of three contiguous regions or two non contiguous regions of the spine** for monitoring of:

63550	- demyelinating disease (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63553	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63556	- myelopathy (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63559	- syrinx (congenital or acquired) (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63562	- cervical radiculopathy (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63565	- sciatica (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63568	- spinal canal stenosis (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63571	- previous spinal surgery (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63574	- trauma (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10

SUBGROUP 15 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR MONITORING OF SPECIFIED CONDITIONS

MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of one region or two contiguous regions of the spine** for monitoring of:

63580	- infection (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63583	- tumour (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10

	SUBGROUP 16 - SCAN OF SPINE - THREE CONTIGUOUS OR TWO NON CONTIGUOUS REGIONS - FOR MONITORING OF SPECIFIED CONDITIONS		
	MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of three contiguous regions or two non contiguous regions of the spine** for monitoring of:		
63590	- infection (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63593	- tumour (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	SUBGROUP 17 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR THE EXCLUSION OF SPECIFIED CONDITIONS		
	NOTE: Benefits are payable for each service included by Subgroup 17 on one occasion only in a 12 month period MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of musculoskeletal system** for the exclusion of:		
63600	- tumour arising in bone or other connective tissue (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63603	- infection arising in bone or other connective tissue (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63606	- osteonecrosis (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63609	- derangement of hip or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63612	- derangement of shoulder or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63615	- derangement of knee or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63618	- derangement of ankle or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63621	- derangement of temporomandibular joint or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63624	- derangement of wrist or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63627	- derangement of elbow or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	SUBGROUP 18 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS		
	NOTE: Benefits are payable for each service included by Subgroup 18 on one occasion only in a 12 month period MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of musculoskeletal system** for further investigation of:		
63650	- tumour arising in bone or other connective tissue (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10

63653	- infection arising in bone or other connective tissue (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63656	- osteonecrosis (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63659	- derangement of hip or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63662	- derangement of shoulder or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63665	- derangement of knee or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63668	- derangement of ankle or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63671	- derangement of temporomandibular joint or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63674	- derangement of wrist or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63677	- derangement of elbow or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63680	- post-inflammatory or post-traumatic physeal fusion in a person under 16 years of age (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	SUBGROUP 19 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR MONITORING OF SPECIFIED CONDITIONS		
63700	**NOTE: Benefits are payable for each service included by Subgroup 19 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of musculoskeletal system** for monitoring of: - derangement of hip or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63703	- derangement of shoulder or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63706	- derangement of knee or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63709	- derangement of ankle or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63712	- derangement of temporomandibular joint or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63715	- derangement of wrist or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63718	- derangement of elbow or its supporting structures (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63721	- post-inflammatory or post-traumatic physeal fusion in a person under 16 years of age (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10

	SUBGROUP 20 - SCAN OF MUSCULOSKELATAL SYSTEM - FOR MONITORING OF SPECIFIED CONDITIONS		
	MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of musculoskeletal system** for monitoring of:		
63736	- osteonecrosis (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63739	- tumour arising in bone or other connective tissue (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63742	- infection arising in bone or other connective tissue (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	SUBGROUP 21 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR FURTHER INVESTIGATION OR MONITORING OF SPECIFIED CONDITIONS		
	NOTE: Benefits are payable for each service included by Subgroup 21 on two occasions only in a 12 month period		
	MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of musculoskeletal system** for further investigation or monitoring of:		
63745	- Gaucher disease (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	SUBGROUP 22 - SCAN OF CARDIOVASCULAR SYSTEM - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS		
	NOTE: Benefits are payable for each service included by Subgroup 22 on one occasion only in a 12 month period		
	MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of cardiovascular system** for further investigation of:		
63750	- congenital disease of the heart or a great vessel (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63753	- tumour of the heart or a great vessel (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63756	- abnormality of thoracic aorta (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
	SUBGROUP 23 - SCAN OF CARDIOVASCULAR SYSTEM - FOR MONITORING OF SPECIFIED CONDITIONS		
	NOTE: Benefits are payable for each service included by Subgroup 23 on two occasions only in a 12 month period		
	MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of cardiovascular system** for monitoring of:		
63800	- congenital disease of the heart or a great vessel (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10
63803	- tumour of the heart or a great vessel (R) **Fee:** $475.00	**Benefit:** 75% = $356.25	85% = $424.10

	- abnormality of the thoracic aorta (R)
63806	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
	SUBGROUP 24 - MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR THE EXCLUSION OF OR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 24 on two occasions only in a 12 month period
	MAGNETIC RESONANCE ANGIOGRAPHY with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of cardiovascular system** for exclusion of or further investigation of:
	- stroke (R)
63850	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
	- carotid or vertebral artery dissection (R)
63853	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
	- intracranial aneurysm (R)
63856	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
	- intracranial arteriovenous malformation (R)
63859	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
	- venous sinus thrombosis (R)
63862	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
	- vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R)
63865	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
	- obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R)
63868	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
	SUBGROUP 25 - MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
	NOTE: Benefits are payable for each service included by Subgroup 25 on one occasion only in a 12 month period
	MAGNETIC RESONANCE ANGIOGRAPHY with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of cardiovascular system of a person under the age of 16 years** for further investigation of:
	- the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (R)
63870	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
	SUBGROUP 26 - MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR MONITORING OF SPECIFIED CONDITIONS
	MAGNETIC RESONANCE ANGIOGRAPHY with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of cardiovascular system** for monitoring of:
	- carotid or vertebral artery dissection (R)
63880	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
	- venous sinus thrombosis (R)
63883	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10

	SUBGROUP 27 - SCAN OF BODY - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
	NOTE: Benefits are payable for each service included by Subgroup 27 on one occasion only in a 12 month period
	MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of the body of a person under the age of 16 years** for further investigation of:
63900	- pelvic or abdominal mass (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63903	- mediastinal mass (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63906	- congenital uterine or anorectal abnormality (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63909	- Gaucher disease (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
	SUBGROUP 28 - SCAN OF BODY - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS
	NOTE: Benefits are payable for the each service included by item 63920 on one occasion only in a 12 month period
	MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of the body** for further investigation of:
63920	- adrenal mass in a patient with a malignancy which is otherwise resectable (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
	SUBGROUP 29 - SCAN OF BODY - FOR MONITORING OF SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
	NOTE: Benefits are payable for the each service included by item 63930 on one occasion only in a 12 month period
	MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of the body of a person under the age of 16 years** for monitoring of:
63930	- congenital uterine or anorectal abnormality (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
	SUBGROUP 30 - SCAN OF BODY - FOR MONITORING OF SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
	MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of the body of a person under the age of 16 years** for monitoring of:
63940	- mediastinal mass (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63943	- pelvic or abdominal mass (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10
63946	- Gaucher disease (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.10

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***Payable on attendance basis**

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PATHOLOGY SERVICES

CATEGORY 6

PLEASE NOTE:

The information contained in this Category relates specifically to the Pathology Services Arrangements under Medicare. More comprehensive information on the Medicare Benefits Schedule book and the Medicare Arrangements are contained in the INTRODUCTION and the GENERAL EXPLANATORY NOTES to this book, which should be read in conjunction with this Category.

CATEGORY 6 - PATHOLOGY SERVICES

OUTLINE OF ARRANGEMENTS

SCHEDULE OF SERVICES

OUTLINE OF ARRANGEMENTS

PA. PATHOLOGY SERVICES IN RELATION TO MEDICARE BENEFITS

PA.1 Basic Requirements

PA.1.1 *Determination of Necessity of Service*

The treating practitioner must determine that the pathology service is necessary.

PA.1.2 *Request for Service*

The service may only be provided:

(i) in response to a request from the treating practitioner or from another Approved Pathology Practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days); or

(ii) if determined to be necessary by an Approved Pathology Practitioner who is treating the patient.

PA.1.3 *Provision of Service*

The following conditions relate to provision of services:

(i) the service has to be provided by or on behalf of an Approved Pathology Practitioner;

(ii) the service has to be provided in a pathology laboratory accredited for that kind of service;

(iii) the proprietor of the laboratory where the service is performed must be an Approved Pathology Authority;

(iv) the Approved Pathology Practitioner providing the service must either be the proprietor of the laboratory or party to an agreement, either by way of contract of employment or otherwise, with the proprietor of the laboratory in which the service is provided; and

(v) no benefit will be payable for services provided by an Approved Pathology Practitioner on behalf of an Approved Pathology Authority if they are not performed in the laboratories of that particular Approved Pathology Authority.

PA.1.4 *Therapeutic Goods Act 1989*

For any service listed in the MBS to be eligible for a Medicare rebate, the service must be rendered in accordance with the provisions of the relevant Commonwealth and State and Territory laws. Approved Pathology Practitioners have the responsibility to ensure that the supply of medicines or medical devices used in the provision of pathology services is strictly in accordance with the provisions of the *Therapeutic Goods Act 1989*.

PA.2 Exceptions to Basic Requirements

PA.2.1 *Prescribed Pathology Services*

A prescribed pathology service is a service included in Group P9 of the Pathology Services Table. Group P9 contains 11 services which may be performed by a medical practitioner in his or her own surgery on his or her own patients.

Additionally, benefit is payable only where the service is determined to be necessary by the medical practitioner rendering the service, or is in response to a request by a member of a group of practitioners to which that practitioner belongs (see PO.2 for the definition of a "group of practitioners").

PA.2.2 *Services Where Request Not Required*

A written request is not required for -

(i) a prescribed pathology service rendered by or on behalf of a medical practitioner upon his or her own patients;

(ii) a pathologist-determinable service. (A pathologist-determinable service is a pathology service determined to be necessary by an Approved Pathology Practitioner in respect of a person who is the patient of that Approved Pathology Practitioner and which is rendered by or on behalf of that Approved Pathology Practitioner. Further information on additional pathology tests not covered by a request is provided at PB.3.)

PA.3 Circumstances Where Medicare Benefits Not Attracted

PA.3.1 *Services Rendered by Disqualified Practitioner*

Medicare benefits are not payable for pathology services if at the time the service is rendered, the person, by or on whose behalf the service is rendered, is a person in relation to whom a determination is in force in relation to that class of services. That is, where an Approved Pathology Practitioner has breached an undertaking, and a determination has been made that Medicare benefits should not be paid during a specified period (of up to five years) in respect of specified pathology services rendered by the practitioner.

Note: An Approved Pathology Practitioner may be disqualified for reasons other than a breach of undertaking.

PA.3.2 *Certain Pathology Tests Do Not Attract Medicare Benefits*

Certain tests of public health significance do not qualify for payment of Medicare benefits. Examples of services in this category are:

- examination by animal inoculation;
- Guthrie test for phenylketonuria;
- neonatal screening for hypothyroidism (T4/TSH estimation);
- neonatal screening for Cystic Fibrosis;
- neonatal screening for Galactosemia;
- pathology services used with the intention of monitoring the performance enhancing effects of any substance;
- pathology tests carried out on specimens collected from persons occupationally exposed to sexual transmission of disease where the purpose of the collection of specimens is for testing in accordance with conditions determined by the health authority of the State or Territory in which the service is performed; and
- the detection of the presence of human immunodeficiency virus (HIV) except quantitation as specified in items 69378, 69381 and 69382.

In addition to the above, certain other tests do not qualify for payment of Medicare benefits. These include:

- cytotoxic food testing;
- pathology services performed for the purposes of tissue audit;
- pathology services performed for the purposes of control estimation, repeat tests (eg. for confirmation of earlier tests on the same specimen, etc);
- preparation of autogenous vaccines;
- tissue banking and preparation procedures;
- pathology services which are performed routinely in association with the termination of pregnancy without there being any indication for the necessity of the services. However, benefits will be paid for the following pathology tests:item 65060 - haemoglobin estimation;
  item 65090 - blood grouping ABO and Rh (D antigen);
  item 65096 - examination of serum for Rh and other blood group antibodies; and
- pathology services performed on stillborn babies or cadavers.

PB. REQUESTS

PB.1 Responsibilities of Treating/Requesting Practitioners

PB.1.1 *Form of Request*

A treating practitioner may request a pathology service either orally or in writing but oral requests must be confirmed in writing within fourteen days from the day when the oral request was made.

Pathology request forms and combined pathology request/offer to assign forms which are prepared by the pathologists and distributed to requesting practitioners must be approved by the Health Insurance Commission (see PB.2). Written pathology requests from treating practitioners that are not on a form prepared and distributed by a pathologist do not need to be approved. However, all written requests for pathology services should contain the following particulars:

(i) the individual pathology services, or recognised groups of pathology tests to be rendered (see section PQ of these notes for the list of acceptable terms and abbreviations). The description must be sufficient to enable the item in which the service is specified to be identified;

(ii) the requesting practitioner's signature and date of request;

(iii) the surname, initials of given names, practice address and provider number of the requesting practitioner;

(iv) the patient's name and address;

(v) details of the hospital status of the patient, as follows (for benefit rate assessment). That is, whether the patient was or will be, at the time of the service or when the specimen is obtained:

(a) a private patient in a private hospital, or approved day hospital facility;

(b) a private patient in a recognised hospital;

(c) a Medicare patient in a recognised hospital;

(d) an outpatient of a recognised hospital;

(vi) details of the person to whom the request is directed. A pathology request can be directed to an Approved Pathology Practitioner or an Approved Pathology Authority. If the request is directed to an Approved Pathology Authority, the form must show the full name and address of the Approved Pathology Authority. If the request is directed to an Approved Pathology Practitioner, the form must show the surname, initials or given names and place of practice of the Approved Pathology Practitioner to whom the request is addressed.

PB.1.2 ***Offence Not to Confirm an Oral Request***

A requesting practitioner who, without reasonable excuse, does not confirm in writing an oral request within fourteen days of making the oral request is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding $1000, and the request is deemed never to have been made.

PB.2 Responsibilities of Approved Pathology Practitioners

PB.2.1 ***Form of Request***

There is no official "request in writing" form, and the requesting practitioner's own stationery, or pre-printed forms supplied by Approved Pathology Practitioners/Authorities are acceptable, provided there are no check lists or "tick-a-box" lists of individual tests or groups of pathology services on the forms. However, pre-printed request forms issued by Approved Pathology Practitioners/Authorities for use by requesting practitioners must be approved by the Health Insurance Commission. Forms submitted for approval should be accompanied by other information or documentation such as that contained in notes for guidance, cover sheets, etc., provided to requesting practitioners.

PB.2.2 ***Offence to Provide Unapproved Request Forms***

An Approved Pathology Practitioner or Approved Pathology Authority who, without reasonable excuse, provides (directly or indirectly) to practitioners request forms which are not approved by the Health Insurance Commission, is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding $1000.

PB.2.3 ***Request to Approved Pathology Authority***

It is acceptable for a request to be made to an Approved Pathology Authority who is the proprietor or one of the proprietors of a laboratory instead of making the request to the Approved Pathology Practitioner who renders the service or on whose behalf the service is rendered.

PB.2.4 ***Holding, Retention, Recording and Production of Request Forms***

Approved Pathology Practitioners must hold a request in writing for all services requested by any other practitioner before billing patients.
An Approved Pathology Practitioner is required to retain written requests/confirmation of requests for pathology services for 18 months from the day when the service was rendered. This also applies to requests which an Approved Pathology Practitioner receives of which only some tests are referred to another Approved Pathology Practitioner (the first Approved

Pathology Practitioner would retain the request for 18 months). If all tests were referred, the second pathologist would retain the original request.

If the written request or written confirmation has been recorded on film or other magnetic medium approved by the Minister for Health and Aged Care, for the purposes of storage and subsequent retrieval, the record so made shall be deemed to be a retention of the request or confirmation. The production or reproduction of such a record shall be deemed to be a production of the written request or written confirmation.

An Approved Pathology Practitioner is required to produce, on request from an officer of the Health Insurance Commission, no later than the end of the day following the request from the officer, a written request or written confirmation retained pursuant to the above paragraphs. The officer is authorised to make and retain copies of or take and retain extracts from written requests or written confirmations.

PB.2.5 ***Offences in Relation to Retaining and Producing Request Forms***

The following offences are punishable upon conviction by a fine not exceeding $1000:

(i) an Approved Pathology Practitioner who, without reasonable excuse, does not keep request forms for 18 months;

(ii) an Approved Pathology Practitioner who, without reasonable excuse, does not produce a request form to an officer of the Health Insurance Commission before the end of the day following the day of the officer's request.

PB.2.6 ***Referral From An Approved Pathology Practitioner To Another Approved Pathology Practitioner***

Where an Approved Pathology Practitioner refers some or all services requested to another Approved Pathology Practitioner not associated with the same Approved Pathology Authority the following apply:

(i) where all the services are referred, the first Approved Pathology Practitioner should forward the original request to the second Approved Pathology Practitioner, and the document bearing the patient's assignment voucher so that the second Approved Pathology Authority can direct-bill Medicare;

(ii) where some of the services which are listed in different items in the Schedule are referred, the first Approved Pathology Practitioner must issue his/her own request in writing listing the tests to be performed, and when necessary, forward a photocopy of the patient's assignment voucher so that the second Approved Pathology Authority can direct-bill Medicare;

in addition to the details of the first Approved Pathology Practitioner, the second Approved Pathology Practitioner must show on the account/receipt/assignment form:

(a) name and provider number of the original requesting practitioner; and

(b) date of original request;

(iii) under the item coning rules (which limit benefits for multiple services) only one Medicare benefit is payable for services included in coned items except for estimations covered by Rule 6 entitled "designated pathology services". The exemption allows payment of more than one Medicare benefit where various components of the one item number from the same request e.g. drug assays (item 66611) are performed by two Approved Pathology Authorities.

Although the provisions concerning designated pathology services in Rule 6 permit similar services (e.g. hormone estimations) to be performed by 2 or more laboratories, with different Approved Pathology Authorities, the sum of the Medicare benefit payable for services provided by the laboratories concerned will not exceed the maximum amount payable under the item coning rules when a single laboratory performs all the estimations.

Notes:

(i) the patient should be billed by each Approved Pathology Practitioner only for those services rendered by or on his/her behalf;

(ii) photocopies of requests are not acceptable;

(iii) in the case of "designated pathology services" (i.e. items 66620, 66713, 66737 and 69402 only)

a patient episode initiation fee (PEI) is payable for the services provided by the laboratory which receives the original request and performs one or more of the estimations. However, no PEI is payable for services provided by the other laboratory which performs the remainder of the estimations. A "specimen referred fee" is payable instead. One Approved Pathology Practitioner cannot claim both a PEI and a "specimen referred fee" in relation to the same patient episode.

PB.2.7 ***Offence Not To Confirm An Oral Request***

An Approved Pathology Practitioner who, without reasonable excuse, does not confirm in writing an oral request to another Approved Pathology Practitioner within fourteen days of making the oral request is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding $1000, and the request is deemed never to have been made.

PB.3 Pathology Tests Not Covered by Request

An Approved Pathology Practitioner, who has been requested to perform one or more pathology services, may consider it necessary, in the interest of the patient, that additional tests to those requested be carried out. The Approved Pathology Practitioner must discuss this need with the requesting practitioner, and if the requesting practitioner determines that additional tests are necessary, the Approved Pathology Practitioner must arrange with the requesting practitioner to forward an amended or second request for those services. The account will then be issued in the ordinary way and the additional services will attract benefits providing the Approved Pathology Practitioner is a recognised specialist pathologist.

PC. DETAILS REQUIRED ON ACCOUNTS, RECEIPTS OR ASSIGNMENT FORMS

PC.1 General

Medicare benefit is not payable in respect of a pathology service unless specified details are provided, by the practitioner rendering the service, on his or her account, receipt or assignment form.

PC.2 Approved Pathology Practitioners

In addition to holding a request in writing from the treating medical or dental practitioner or from another Approved Pathology Practitioner, the following additional details must be recorded on the account, receipt or assignment form of the Approved Pathology Practitioner providing the service:

(i) the surname and initials of the Approved Pathology Practitioner who performed the service and either his/her practice address or the provider number for the address;

(ii) the name of the person to whom the service was rendered;

(iii) the date on which the service was rendered;

(iv) the name of the requesting practitioner;

(v) the date on which the request was made;

(vi) the requesting practitioner's provider number;

(vii) a description of the pathology service in words which are derived from the item description in the Schedule and are of sufficient detail to identify the specific test in the Schedule that was rendered. Instead of such a full description, the abbreviations contained in the index and the group abbreviations listed at PQ.4 are acceptable alternatives (see PQ.1);

(viii) where the Approved Pathology Practitioner determines or provides a pathology service on his/her own patient, the account must be endorsed "sd"; and

(ix) provide collection centre identification number if the specimen was collected in a licensed collection centre (or approved pathology collection centre).

Where some services are referred from one Approved Pathology Practitioner to another Approved Pathology Practitioner, the request details to be shown on the second Approved Pathology Practitioner's account, receipt or assignment form must be identical to those of the original requesting practitioner including the date of request.

PC.3 Prescribed Pathology Services

For Prescribed Pathology Services (that is, pathology items in Group P9) the medical practitioner who renders the service must ensure his or her account, receipt or assignment form includes his or her name, address or provider number, the date of the service, and a description to clearly identify the service in the Schedule that was rendered.

If the service was determined necessary by another medical practitioner who is a member of the same group practice as the practitioner who rendered the service, the name of the requesting practitioner, sufficient to identify the practitioner from other practitioners in the same group practice with the same surname, must also be included together with the date on which the request was made.

PD. INBUILT MULTIPLE SERVICES RULE

PD.1 Description of Rule

The term "Inbuilt Multiple Services Rule" (Rule 3 of the Pathology Services Table) describes an arrangement which places limits on the benefits payable for items in the Pathology Services Table depending on the range of services performed during a single patient episode. A patient episode is defined in PO.4 of these notes.

PD.2 Exemptions

Under Rule 4 of the Pathology Services Table, exemptions to the multiple services rule have been granted for certain specified tests. In some circumstances tests which are repeated up to 4 times over a 24 hour period, or tests which are requested up to 6 times on a single request form and are performed within 6 months of the date of request may be eligible for separate Medicare benefits. The services to which the exemptions apply are listed under Rule 4.(1 and 2) and cover seriously or chronically ill patients who require particular tests under specified circumstances. In order to claim the exemptions, accounts should be endorsed "Rule 3 Exemption".

Where a practitioner seeks an exemption to the multiple services rule for a patient whose condition requires a series of pathology investigations at various times throughout any one day or over a longer period of time, and the services required are not exempted under Rule 4, an application for exemption can be made which is endorsed "S4B(3)". Some factors that the delegate of the Minister may take into consideration in approving an exemption are: the patient is seriously ill; there are distinct and separate collections and performances of tests; and the services involve substantial additional expenses for the Approved Pathology Practitioner. These, and other clinical details, should be supplied by the practitioner when seeking an S4B(3) exemption.

If Rule 3 exemptions are endorsed "S4B(3)", claim assessment could take longer as all S4B(3) claims are passed to the delegate for assessment. S4B(3) covers all exemptions to the multiple services rule but, where applicable, specific "Rule 3 exemption" endorsements will speed up the payment of claims. Rule 3 and S4B(3) exemptions cannot be used to overcome time based restrictions within items e.g. ".... each test to a maximum of 4 tests in a 12 month period".

PE. EPISODE CONE

PE.1 Description of Rule 19

The term "Episode Cone" describes an arrangement under which Medicare benefits payable in a patient episode for a set of pathology services, containing more than three items, ordered by a general practitioner for a non-hospitalised patient, will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. Further information on the episode coning arrangements is provided in PO.5 of these notes.

PE.2 Exemptions

Some items are not included in the count of the items performed when applying episode coning. The items which have been exempted from the cone include all the items in Groups P10 and P11, the Pap smear testing items (73053 and 73055) and the designated pathology services items (66620, 66713, 66737 and 69402).

PF. SCHEDULE FEES

PF.1 Single Level Fees

A single level Schedule fee as opposed to the previous SP and OP fee levels was introduced from 1 February 1992. The Schedule fee was set at 70% of the previous SP fee for all services except for a cytology item, a histopathology item and three high volume test items.

PF.2 Patient Episode Initiation Fees (PEIs)

Items in Groups P10 and P11 of the Pathology Services Table are only applicable to services performed:

(i) by or on behalf of an Approved Pathology Practitioner who is a recognised specialist pathologist; and

(ii) in private practice.

Accordingly, these fees are not payable for pathology services rendered by an Approved Pathology Practitioner, being a specialist pathologist when requested for a:

(i) privately referred out-patient of a recognised hospital;

(ii) private in-patient in a recognised hospital; or where

(a) any pathology equipment of a recognised hospital, or a laboratory included in a prescribed class of laboratories, is used; or

(b) any member of the staff of a recognised hospital, or a laboratory included in a prescribed class of laboratories, participates in the provision of the service in the course of his/her employment with that hospital or laboratory.

The patient episode initiation fees (PEIs) will be applicable on an episodic basis i.e. a claim may be made for the provision of pathology services requested by a practitioner in respect of one individual on the same day. For example, if a practitioner orders three pathology tests for a person on the one day, Medicare benefits will be payable for each of those tests but only one PEI will be applicable.

This Rule applies even when the treating practitioner has requested pathology tests from two or more Approved Pathology Practitioners. Thus a PEI will only be paid for the first account submitted unless an exemption listed in Rule 4 or 15.(7) applies or an exemption has been granted under "S4B(3)".

Under Rule 15.(7) two PEIs are payable in relation to the same patient episode where a referring practitioner refers two different specimens to two different Approved Pathology Authorities in the following circumstances:

- a tissue pathology specimen and any other non-tissue pathology specimen; or
- a cytopathology specimen and any other non-cytopathology specimen.

Rule 15.(8) also provides that only one PEI will be paid for the collection of specimens from a patient on one day in or by a single Approved Pathology Authority.

The patient episode initiation fees are two-tiered.

A higher fee will be payable for specimens collected in a licensed collection centre (or approved pathology collection centre), private hospital or day hospital facility where the patient is an in-patient. The specimen must be collected by an employee of the proprietor of the laboratory in which the pathology service will be rendered, or an Approved Pathology Practitioner associated with that laboratory.

A lower fee will be payable for specimens collected by the patient himself or herself or specimens collected by or on behalf of a treating practitioner.

PF.3 Patient Episode Initiation Fees for Certain Tissue Pathology and Cytology Items

Tissue Pathology items 72813, 72816, 72817, 72823, 72824, 72825, 72830 and 72836 and Cytology items 73053, 73055 and 73057 will be subject to a different patient episode initiation fee structure - items 73901 to 73905 refer.

PF.4 Hospital, Government etc Laboratories

The following laboratories have been prescribed for the purposes of payment of Medicare benefits as outlined in paragraphs PF.2 and PF.3:

(i) laboratories operated by the Commonwealth (these include Commonwealth health laboratories operated by the Department of Health and Aged Care as well as the laboratories operated by other Departments, e.g. the Departments of Defence and Veterans' Affairs operate laboratories from which pathology services are provided);

(ii) laboratories operated by a State Government or authority of a State (laboratories operated or associated with recognised hospitals are also included);

(iii) laboratories operated by the Northern Territory and the Australian Capital Territory; and

(iv) laboratories operated by Australian tertiary education institutions eg Universities.

PG. ASSIGNMENT OF MEDICARE BENEFITS

PG.1 Patient Assignment

In addition to the general arrangements relating to the assignment of benefits, as outlined at paragraph 7 of the "General Explanatory Notes" in Section 1 of this book, it should be noted that, where the treating practitioner requests pathology services but the patient does not physically attend the Approved Pathology Practitioner, the patient may complete an assignment voucher at the time of the visit to the requesting doctor offering to assign benefits for the Approved Pathology Practitioner's services.

If an Approved Pathology Practitioner refers some of the tests requested by the treating practitioner to another Approved Pathology Authority, he/she should provide the second Approved Pathology Authority with a photocopy of the patient's assignment voucher so that the second Approved Pathology Authority can also direct-bill Medicare.

PG.2 Approved Pathology Practitioner Eligibility

If a practitioner requests an Approved Pathology Practitioner to perform a necessary pathology service, that Approved Pathology Practitioner must personally perform the service or have it performed on his/her behalf in order to be eligible to receive benefits by way of assignment. If, however, the first Approved Pathology Practitioner arranges for the service to be rendered by a second Approved Pathology Practitioner with the same Approved Pathology Authority, the second Approved Pathology Practitioner and not the first, is eligible to receive an assignment of the Medicare benefit for the service in question.

PH. ACCREDITED PATHOLOGY LABORATORIES

PH.1 Need For Accreditation

A pathology service will not attract Medicare benefits unless that service is provided in a pathology laboratory which is accredited for that kind of service. Details of the administration of the pathology laboratory accreditation arrangements are set out below.

PH.2 Applying For Accreditation

To become an Accredited Pathology Laboratory it is necessary to lodge a completed application form with the Manager, Pathology Section, Health Insurance Commission, PO Box 1001, TUGGERANONG ACT 2901. The prescribed fees for Approved Pathology Laboratories are:

- $2500 for Category GX labs
- $2000 for Category GY labs
- $1500 for Category B labs
- $ 750 for Category M & S labs.

It is necessary for an application for inspection be made to an approved inspection agency. The National Association of Testing Authorities (NATA) has been chosen to act on the Commonwealth's behalf as the primary inspection agency. The

Royal Australian College of General Practitioners (RACGP) has also been appointed to inspect laboratories in Category M (general practitioner) in Victoria only.

The arrangements for laboratory categorisation changed on 1 January 2000. Information about the new laboratory categories and associated supervisory requirements can be found on the Department's internet site (http://www.health.gov.au). Alternatively, contact the Secretariat of the National Pathology Accreditation Advisory Council (see PH.6) on (02) 6289 6833 or email npaac@health.gov.au.

PH.3 Effective Period of Accreditation

Accreditation takes effect from the date of approval by the Minister for Health and Aged Care. The Minister has no power to backdate an approval. Transitional accreditation may be given pending full accreditation. An application and fee are required annually.

PH.4 Assessment of Applications for Accreditation

The principles of accreditation for pathology laboratories as determined by the Minister are used to assess applications for accreditation. These also require pathology laboratories to address National Pathology Accreditation Advisory Council standards. Copies of the principles and standards are available from the Secretariat, National Pathology Accreditation Advisory Council (see PH.6) on (02) 6289 6833 or email npaac@health.gov.au.

PH.5 Refusal of Accreditation and Right of Review

An applicant who has been notified of the intention to refuse accreditation may, within 28 days of being notified, provide further information to the Minister which may be taken into consideration prior to a final decision being made.

Applicants refused accreditation or any person affected by the decision have the right to appeal to the Administrative Appeals Tribunal.

PH.6 National Pathology Accreditation Advisory Council (NPAAC)

NPAAC was established in 1979. Its functions are to assist in the introduction and maintenance of uniform standards of practice in pathology services throughout Australia and to initiate and coordinate educational programs in relation to pathology practice. The agencies used to inspect laboratories on the Commonwealth's behalf are required to conduct inspections using the standards set down by NPAAC. For further information the NPAAC Secretariat can be contacted on (02) 6289 6833 or email npaac@health.gov.au.

PH.7 Change of Address/Location

Laboratories are accredited for the particular premises given on the application form. Where a laboratory is relocated to other premises, any previously issued approvals for that Accredited Pathology Laboratory lapse. Medicare benefits are not payable for any pathology services performed at the new location until a new application has been approved by the Minister for Health and Aged Care. Paragraph PH.2 sets out the method for applying for accreditation.

PH.8 Change of Ownership of a Laboratory

Part of the assessment of an application for an Accredited Pathology Laboratory relates to the Approved Pathology Authority status. Where the ownership, or some other material change occurs affecting the laboratory, the Minister for Health and Aged Care must be provided with those changed details. Medicare benefits will not be payable for any pathology services performed on any premises other than those premises for which approval has been given.

PH.9 Licensed Collection Centres (LCC)

To enable the payment of Medicare benefits for pathology services performed on pathology specimens collected in a collection centre, the centre must first be licensed. A licence can only be issued to a private Approved Pathology Authority who has been granted an allocation of units of entitlements for the current year.

In order to be issued with a licence, a private Approved Pathology Authority must submit a completed application form to the Health Insurance Commission giving details of the location of the premises, the owner, and the staff to be employed at the centre. Staff working at the centre must be employed by the Approved Pathology Authority.

Application forms and enquiries should be forwarded to the Manager, Pathology Section, Health Insurance Commission, PO Box 1001, TUGGERANONG ACT 2901.

New arrangements for specimen collection centres are expected to be introduced in the 2000/01financial year, replacing the LCC Scheme. Approved Pathology Authorities will be advised when the legislation for these new arrangements has been passed.

PI. APPROVED PATHOLOGY PRACTITIONERS

PI.1 Introduction

A pathology service will not attract Medicare benefits unless that service is provided by or on behalf of an Approved Pathology Practitioner. (Approved Pathology Practitioners must be registered medical practitioners.) Set out below is information which relates to Approved Pathology Practitioner requirements.

PI.2 Applying for Acceptance of the Approved Pathology Practitioner Undertaking

To apply for acceptance of an Approved Pathology Practitioner Undertaking, it is necessary to send:

(i) a completed application for acceptance of an Approved Pathology Practitioner Undertaking; and

(ii) a signed Approved Pathology Practitioner Undertaking to the Pathology Registration Co-ordinator, Health Insurance Commission, PO Box 9822 (in your capital city).

An application form, undertaking and associated literature can be obtained from the Pathology Registration Co-ordinator.

PI.2.1 *Payment of Acceptance Fee*

On receipt of advice that the Minister has accepted an undertaking, a cheque for $500 should be despatched to the Pathology Registration Co-ordinator. Applicants are required to pay this fee within 14 days of the notice being given (ie. the day the notice is sent).

As there is no discretion under the *Health Insurance Act 1973* to accept late payments, failure to pay the fee within the required time means that:

(i) acceptance of the undertaking will be revoked;

(ii) a new application must be completed;

(iii) acceptance of the new undertaking cannot be backdated; and

(iv) there will therefore be a period during which Medicare benefits cannot be paid.

PI.2.2 *Reminder Process*

In administering the Approved Pathology Authority and Approved Pathology Practitioner arrangements, the Health Insurance Commission provides reminders to ensure that:

(i) applicants whose undertaking are about to expire are aware of the consequences of late lodgement; and

(ii) where the 14 day period for payment of fees is about to expire and the fees have not been paid, that applicants are aware of the consequences of failure to pay on time.

PI.3 Undertakings

PI.3.1 *Consideration of Undertakings*

The Minister is unable to accept an undertaking from a person in respect of whom there is a determination in force that the person has breached the undertaking, or from a person who, if the undertaking were accepted, would be likely to carry on the business of a prescribed person or would enable a person to avoid the financial consequences of the disqualification (or likely disqualification) of that prescribed person. A 'prescribed person' includes, amongst other things, fully or partially disqualified persons (or persons likely to be so disqualified).

Similarly an undertaking cannot be accepted unless the Minister is satisfied that the person giving such undertaking is a fit and proper person to be an Approved Pathology Practitioner.

When an undertaking has been given, the Minister may require the person giving the undertaking to provide additional information within a fixed period of time and if the person does not comply the Minister may refuse to accept the undertaking.

PI.3.2 ***Refusal of Undertaking and Rights of Review***

Where the Minister refuses to accept an undertaking, for any of the reasons shown above, the Minister must notify the person of the decision. The notification must include advice of a right of internal review of the decision and a right of further appeal to the Administrative Appeals Tribunal if the internal review upholds the original decision to refuse the undertaking.

PI.3.3 ***Effective Period of Undertaking***

The following applies:

(i) Date of Effect - the earliest day from which the Minister or delegate can accept an undertaking is the day of the decision in respect of the undertaking. The day the undertaking is signed is to be the day it is actually signed and must not be backdated;

(ii) Period of Effect - in determining the period of effect of the undertaking the Minister shall, unless the Minister considers that special circumstances exist, determine that the period of effect shall be twelve months from the day on which the undertaking comes into force. There is a requirement for the Minister to notify persons giving undertakings of the period of time for which the undertaking is to have effect, and the notice is to advise persons whose interests are affected by the decision of their rights of appeal to the Administrative Appeals Tribunal against the Minister's decision;

(iii) Renewals - when an undertaking is given and accepted by the Minister while a former undertaking is current, the new undertaking does not take effect until the former undertaking ceases to be in force. When an undertaking is given while a former undertaking is current and the date on which the former undertaking is to expire passes without the Minister giving notice to accept or reject the new undertaking, the former undertaking remains in force until the Minister gives such notification. This provision does not apply when the renewal application is not received by the Health Insurance Commission until after the expiry of the existing undertaking. Under these circumstances there will be a period during which Medicare benefits cannot be paid unless the new application can be backdated to the expiry of the previous undertaking. This is a limited discretion for periods up to one month and special conditions apply; and

(iv) Cessation of Undertaking - the undertaking ceases to be in force if it is terminated, if the Minister revokes acceptance of the undertaking, or if the period of effect for the undertaking expires - whichever event first occurs.

An Approved Pathology Practitioner may terminate an undertaking at any time providing that the practitioner gives at least 30 days notice of his/her intention to do so.

PI.4 Obligations and Responsibilities of Approved Pathology Practitioners

The requirements of the legislation and the undertaking impose a number of obligations and responsibilities on Approved Pathology Practitioners and the Minister. The more complex of these not already dealt with are considered in PK, PL and PM dealing with Breaches of Undertakings, Excessive Pathology Services and Personal Supervision.

PJ. APPROVED PATHOLOGY AUTHORITIES

PJ.1 Introduction

A pathology service will not attract Medicare benefits unless the proprietor of the laboratory in which the pathology service is performed is an Approved Pathology Authority. Following is information which relates to Approved Pathology Authority requirements.

PJ.2 Applying for Acceptance of an Approved Pathology Authority Undertaking

To apply for acceptance of an Approved Pathology Authority Undertaking, it is necessary to send:

(i) a completed application for acceptance of an Approved Pathology Authority Undertaking; and

(ii) a signed Approved Pathology Authority Undertaking.

to the Pathology Registration Co-ordinator, Health Insurance Commission, PO Box 9822 (in your capital city). Application forms, undertakings and associated literature can be obtained from the Pathology Registration Co-ordinator.

The application and the undertaking should be completed by the proprietor of the laboratory/ies and where the proprietor is not a natural person (e.g. company or partnership), an authorised representative/s should complete the forms. This proprietor can be:

(i) a natural person;

(ii) partners (natural persons and/or companies) in a partnership;

(iii) a body corporate (i.e. a company); or

(iv) a government authority (e.g. a public hospital).

PJ.2.1 ***Payment of Acceptance Fee***

On receipt of advice that the Minister has accepted an undertaking, a cheque for $1,500 should be dispatched within 14 days or the undertaking will be cancelled and the whole process begun again with a consequent gap in the payment of benefits.

PJ.3 Undertakings

PJ.3.1 ***Consideration of Undertakings***

The Minister is unable to accept undertakings from a person in respect of whom there is a determination in force that the person has breached the undertaking, or from a person who, if the undertaking were accepted, would be likely to carry on the business of a prescribed person or would enable a person to avoid the financial consequences of the disqualification (or likely disqualification) of that prescribed person. A 'prescribed person' includes, inter alia, fully or partially disqualified persons (or persons likely to be so disqualified).

Similarly an undertaking cannot be accepted unless the Minister is satisfied that the person giving such undertaking is a fit and proper person to be an Approved Pathology Authority.

When an undertaking has been given the Minister may require the person giving the undertaking to provide additional information within a specified period of time and if the person does not comply the Minister may refuse to accept the undertaking.

PJ.3.2 ***Refusal of Undertaking and Rights of Review***

Where the Minister refuses to accept an undertaking, the Minister must notify the person of the decision. The notification must include advice of a right of internal review of the decision and a right of further appeal to the Administrative Appeals Tribunal if the internal review upholds the original decision to refuse the undertaking.

PJ.3.3 ***Effective Period of Undertaking***

The following applies:

(i) Date of Effect - the earliest day from which the Minister or delegate can accept an undertaking is the day of the decision in respect of the undertaking. The day the undertaking is signed is to be the day it is actually signed and must not be backdated;

(ii) Period of Effect - in determining the period of effect of the undertaking the Minister shall, unless the Minister considers that special circumstances exist, determine that the period of effect shall be twelve months from the day on which the undertaking comes into force. There is a requirement for the Minister to notify persons giving an undertaking of the period of time for which the undertaking is to have effect, and the notice is to advise persons whose interests are affected by the decision of their rights of appeal to the Administrative Appeals Tribunal against the Minister's decision;

(iii) Renewals - when an undertaking is given and accepted by the Minister while a former undertaking is current, the new undertaking does not take effect until the former undertaking ceases to be in force. When an undertaking is given while a former undertaking is current and the date on which the former undertaking is to expire passes without the Minister giving notice to accept or reject the new undertaking, the former undertaking remains in force until the Minister gives such notification. This provision does not apply when the renewal application is not received by the Health Insurance Commission until after the expiry of the existing undertaking. Under these circumstances there will be a period during which Medicare benefits cannot be paid unless the new application can be backdated to the expiry of the previous undertaking. This is a limited discretion for periods up to one month and special conditions apply; and

(iv) Cessation of Undertaking - the undertaking ceases to be in force if it is terminated, if the Minister revokes acceptance of the undertaking, or if the period of effect for the undertaking expires - whichever event first occurs.

An Approved Pathology Authority may terminate an undertaking at any time providing that at least 30 days notice of the intention to terminate the undertaking is given.

PJ.4 Obligations and Responsibilities of Approved Pathology Authorities

The requirements of the legislation and the undertaking impose a number of obligations and responsibilities on Approved Pathology Authorities and the Minister. The more complex of these which have not already been covered are considered in paragraphs PK and PL dealing with Breaches of Undertakings and Excessive Pathology Services.

PK. BREACHES OF UNDERTAKINGS

PK.1 Notice Required

Where the Minister has reasonable grounds for believing that an Approved Pathology Practitioner or an Approved Pathology Authority has breached the undertaking, the Minister is required to give notice in writing to the person explaining the grounds for that belief and inviting the person to put a submission to the Minister to show cause why no further action should be taken in the matter.

PK.2 Decisions by Minister

Where a person provides a submission, the Minister may decide to take no further action against the person. Alternatively the Minister may refer the matter to a Medicare Participation Review Committee, notifying the grounds for believing that the undertaking has been breached. If after 28 days no submission has been received from the person, the Minister must refer that matter to the Committee.

PK.3 Appeals

The Minister is empowered to suspend an undertaking where notice has been given to a Medicare Participation Review Committee of its possible breach, pending the outcome of the Committee's proceedings. The Minister must give notice in writing to the person who provided the undertaking of the determination to suspend it, and the notice shall inform the person of a right of appeal against the determination to the Administrative Appeals Tribunal. The Minister may also publish a notice of a determination in the Commonwealth Gazette. Rights of appeal to the Administrative Appeals Tribunal also exist in respect of any determination made by a Medicare Participation Review Committee.

PL. INITIATION OF EXCESSIVE PATHOLOGY SERVICES

PL.1 Notice Required

Where the Minister has reasonable grounds for believing that a person, of a specified class of persons, has initiated, or caused or permitted the initiation of excessive pathology services the Minister is required to give notice in writing to the person explaining the grounds for the belief and inviting the person to put a submission to the Minister to show cause why no further action should be taken in the matter.

PL.2 Classes of Persons

The classes of persons are:

(i) the practitioner who initiated the services;

(ii) the employer of the practitioner who caused or permitted the practitioner to initiate the services; or

(iii) an officer of the body corporate employing the practitioner who caused or permitted the practitioner to initiate the services.

PL.3 Decisions by Minister for Health and Aged Care

Where a person provides a submission, the Minister may decide to take no further action against the person. Alternatively, the Minister may refer the matter to a Professional Services Review (PSR) Committee, notifying the grounds for believing that excessive pathology services have been initiated. If after 28 days no submission has been received from the person, the Minister must refer the matter to the Committee. The Minister must give to the person notice in writing of the decision.

PL.4 Appeals

Unlike the procedures relating to breaches of undertaking there is no power given to the Minister to determine a penalty. The Minister's role is either deciding to take no further action or referring the matter to a PSR Committee. Accordingly, there are no rights of appeal to the Administrative Appeals Tribunal applicable to the above procedures. However, rights of appeal to the Administrative Appeals Tribunal exist in respect of any determination made by a Medicare Participation Review Committee.

PM. PERSONAL SUPERVISION

PM.1 Introduction

The *Health Insurance Act 1973* provides that the form of undertaking to be given by an Approved Pathology Practitioner may make provision for pathology services carried out under the personal supervision of the Approved Pathology Practitioner.

PM.2 Extract from Undertaking

The following is an extract from the Approved Pathology Practitioner (APP) undertaking:

"PART 1 - PERSONAL SUPERVISION

1) Subject to clause 2, I undertake that where a service is rendered on my behalf, I will accept personal responsibility for the rendering of that service under the following conditions of personal supervision -

a) Where a service is rendered on my behalf, I must usually be physically available in the laboratory during the rendering of that service.

b) I may be absent from the laboratory for brief periods where the absence is due to illness or other personal exigency, or involves activities which, in accordance with normal and accepted practice, relate to the provision of services by that laboratory. If such an absence occurs, and it does not exceed 7 consecutive days, then I will be regarded as continuing to personally supervise the rendering of services.

c) Where I am absent from the laboratory for more than 7 consecutive days, I must arrange for another approved pathology practitioner to personally supervise the rendering of services in the laboratory which would otherwise be rendered by me or on my behalf. Where such an arrangement is made, then I will be regarded as continuing to personally supervise the rendering of services.

d) For the purposes of the *Health Insurance Act 1973*, services will not be regarded as being rendered by me or on my behalf during any absence, for any reason, which occurs after I have already been absent for a total of 14 working days in any month that services are rendered.

e) If a service is being rendered on my behalf outside the normal hours of operation of the laboratory, I must be able to be contacted at the time that the service is being rendered by the person who is rendering the service. If required, I must be able to personally attend at the laboratory during the rendering of the service.

f) If a service is being rendered on my behalf by a person who is not -

i) a medical practitioner;

ii) a scientist; or

iii) a person having special qualifications or skills relevant to the service being rendered;

and no person in the above groups is physically present in the laboratory, then I must be physically present in the laboratory and closely supervise the rendering of the service.

g) I accept responsibility for taking all reasonable steps to ensure that in regard to services rendered by me or on my behalf:

i) all persons who render services are adequately trained;

ii) all services which are to be rendered in the laboratory are allocated to persons with appropriate qualifications and experience to render the services;

iii) the methods and procedures in operation in the laboratory for the purpose of rendering services are in accordance with proper and correct practices;

iv) for services rendered, proper quality control methods are established and reviewed to ensure their reliability and effectiveness; and

v) results of services and tests rendered are accurately recorded and reported.

PM.3 Notes on the Above

Part 1 of the APP Undertaking outlines the requirements for the personal supervision by an Approved Pathology Practitioner where a pathology service is rendered by another person on behalf of the APP. It should be noted that "on behalf of" does not relieve an Approved Pathology Practitioner of professional responsibility for the service or from being personally involved in the supervision of services in the laboratory.

PN. CHANGES TO THE PATHOLOGY SERVICES TABLE

PN.1 Health Insurance Regulations

The *Health Insurance Act 1973* allows the Minister for Health and Aged Care to determine an appropriate Pathology Services Table which is then prescribed by Regulation.

The Minister has established the Pathology Services Table Committee (PSTC) to assist in determining changes to the Table (except new medical services and technologies - see below). Any person or organisation seeking to make a submission to this Committee can contact the PSTC Secretariat on (02) 6289 7053 or e-mail address pstc@health.gov.au and/or write to: Director, Pathology Section, Department of Health and Aged Care, GPO Box 9848, CANBERRA ACT 2601.

Pathology submissions relating to new medical services and technologies should be forwarded to the Medicare Services Advisory Committee (MSAC). MSAC has been established to advise the Minister on the strength of evidence pertaining to new and emerging medical technologies and procedures in relation to their safety, effectiveness and cost effectiveness, and under what circumstances public funding should be supported.

Any person or organisation seeking to make a submission to MSAC can contact the MSAC Secretariat on (02) 6289 6811 or email address "msac.secretariat@health.gov.au" and/or write to: Director, Strategic Policy Section, Department of Health and Aged Care, GPO Box 9848, CANBERRA ACT 2601. The application form and guidelines for applying can also be obtained from MSAC's website - www.health.gov.au/haf/msac.

EXPLANATORY NOTES

PO. DEFINITIONS

PO.1 Excessive Pathology Service

This means a pathology service for which a Medicare benefit has become or may become payable and which is not reasonably necessary for the adequate medical or dental care of the patient concerned.

PO.2 Group of Practitioners

This means:

(i) a practitioner conducting a medical practice or a dental practice together with another practitioner, or other practitioners, participating (whether as employees or otherwise) in the provision of professional services as part of that practice; or

(ii) two or more practitioners conducting a medical practice or a dental practice as partners; or

(iii) those partners together with any other practitioner who participates (whether as an employee or otherwise) in the provision of professional services as part of that practice.

PO.3 Initiate

In relation to a pathology service this means to request the provision of pathology services for a patient.

PO.4 Patient Episode

A patient episode comprises a pathology service or services specified in one or more items which are provided for a single patient, the need for which was determined under subsection 16A(1) of the Act on the same day, whether they were provided by one or more approved pathology practitioners on one day or over several days and whether they are requested by one or more treating practitioners. Even if a treating practitioner writes separate request forms to cover the collection of specimens at different times, where the decision to collect the multiple specimens was made at the same time, the multiple tests are deemed to belong to the same patient episode. In addition, if more than one request is made, on the same or different days, for tests on the same specimen within 14 days, they are part of the same patient episode.

Rule 4 of the Pathology Services Table provides an exemption to the above and enables services requested on one day which are performed under strictly limited circumstances for seriously or chronically ill patients with certain specified conditions to each be classified as a patient episode. See PD.2 for further information on exemptions.

Rule 15.(8) also provides that only a single patient episode initiation fee will be payable for all the specimens collected on one day from one patient in or by one Approved Pathology Authority.

PO.5 Episode Cone

The episode cone is an arrangement, described in Rule 19, which effectively places an upper limit on the number of items for which Medicare benefits are payable in a patient episode. This cone only applies to services requested by general practitioners for their non-hospitalised patients. Pathology services requested for hospital in-patients, or ordered by specialists, are not subject to these coning arrangements.

When more than 3 items are requested by a general practitioner in a patient episode, the benefits payable will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. Rule 19 provides that for the two items with the highest Schedule fees, Medicare benefits will be payable for each item. The remaining items are regarded as one service for which the benefit payable will be equivalent to that for the item with the third highest Schedule fee. Where items have the same Schedule fee, their item numbers are used as an artificial means to rank them.

The episode cone will apply even when the pathology services in a patient episode are performed by 2 or more Approved Pathology Authorities, with the exception of the services listed below.

The following items are not included in the count of the items performed when applying the episode cone:

(i) all the items in Groups P10 and P11;

(ii) Pap smear testing (items 73053 and 73055); and

(iii) designated pathology services (items 66620, 66713, 66737 and 69402).

PO.6 Personal Supervision

This means that an Approved Pathology Practitioner will, to the fullest extent possible, be responsible for exercising an acceptable level of control over the rendering of pathology services. See PM.1 to PM.3 for a full description of the responsibilities involved in personal supervision.

PO.7 Prescribed Pathology Service

These are simple basic pathology services which are included in Group P9 and may be performed by a medical practitioner in the practitioner's surgery without the need to obtain Approved Pathology Authority, Approved Pathology Practitioner or Accredited Pathology Laboratory status.

PO.8 Proprietor of a Laboratory

This means in relation to a pathology laboratory the person, authority or body of persons having effective control of:

(i) the laboratory premises, whether or not the holder of an estate or interest in the premises;

(ii) the use of equipment used in the laboratory; and

(iii) the employment of staff in the laboratory.

PO.9 Specialist Pathologist

This means a medical practitioner recognised for the purposes of the *Health Insurance Act 1973* as a specialist in pathology (see 5.1 of the "General Explanatory Notes" in Section 1 of this book). The principal specialty of pathology includes a number of sectional specialties. Accordingly, a medical practitioner who is recognised as a specialist in a sectional specialty of pathology is recognised as a specialist pathologist for this purpose.

PO.10 Designated Pathology Service

This means a pathology service specified in items 66620, 66713, 66737 or 69402. Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some but not all the estimations in a coned item and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the rest, the service provided by the second practitioner is deemed to be the "designated pathology service". Thus the first practitioner claims under the appropriate item for the services which he/she provides while the second practitioner claims one of items 66620, 66713, 66737 or 69402. Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some, but not all estimations and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the remainder, the first Approved Pathology Practitioner can raise a "patient episode initiation fee". The second Approved Pathology Practitioner who receives the specimen can raise a "specimen referred fee".

PP. INTERPRETATION OF THE SCHEDULE

PP.1 Cholesterol and Triglyceride (Item 66521) and General Chemistry (Item 66500)

Where a cholesterol estimation or a triglyceride estimation or estimations for both cholesterol and triglycerides are performed (item 66521) in combination with 1 test from item 66500, the item to be claimed is 66524; item 66521 with 2 tests from item 66500, the item to be claimed is 66527; item 66521 with 3 tests from item 66500, the item to be claimed is 66530; item 66521 with 4 or more tests from item 66500, the item to be claimed is 66533. Item 66521 cannot be claimed separately if any tests from item 66500 are performed at the same time.

PP.2 Faecal Occult Blood (Item 66764 - 66770)

The fee for item 66764-66770 is only payable where both test methods described in the item have been performed.

PP.3 Tissue Pathology and Cytology (Items 72813 - 73060)

When services described in Group P5 need to be performed upon material which is submitted for cytology items listed in Group P6 only the fee for the P6 item can be claimed.

PP.4 Cervical and Vaginal Cytology (Items 73053 - 73057)

Item 73053 only applies to the cytological examination of cervical smears collected from women with no symptoms, signs or recent history suggestive of cervical neoplasia as part of routine, biennial examination for the detection of pre-cancerous or cancerous changes. This item also applies to smears repeated due to an unsatisfactory routine smear, or if there is inadequate information provided to use item 73055.

Cytological examinations carried out under item 73053 should be in accordance with the agreed National Policy on Screening for the Prevention of Cervical Cancer. This policy provides for:

(i) an examination interval of two years for women who have no symptoms or history suggestive of abnormal cervical cytology, commencing between the ages of 18 to 20 years, or one to two years after first sexual intercourse, whichever is later; and

(ii) cessation of cervical smears at 70 years for women who have had two normal results within the last five years. Women over 70 who have never been examined, or who request a cervical smear, should be examined.

This policy has been endorsed by the Royal Australian College of General Practitioners, the Royal Australian College of Obstetricians and Gynaecologists, The Royal College of Pathologists of Australasia, the Australian Cancer Society and the National Health and Medical Research Council.

The *Health Insurance Act 1973* excludes payment of Medicare benefits for health screening services except where Ministerial directions have been issued to enable benefits to be paid, such as the Papanicolaou test. As there is now an established policy which has the support of the relevant professional bodies, routine screening in accordance with the policy will be regarded as good medical practice.

The screening policy will not be used as a basis for determining eligibility for benefits. However, the policy will be used as a guide for reviewing practitioner profiles.

Item 73055 applies to cervical cytological examinations where the smear has been collected for the purpose of management, follow up or investigation of a previous abnormal cytology report, or collected from women with symptoms, signs or recent history suggestive of abnormal cervical cytology.

Items 73057 applies to all vaginal cytological examinations, whether for a routine examination or for the follow up or management of a previously detected abnormal smear.

For cervical smears, treating practitioners are asked to clearly identify on the request form to the pathologist, by item number, if the smear has been taken as a routine examination or for the management of a previously detected abnormality.

PP.5 Eosinophil Cationic Protein (Item 71095)

Item 71095 applies to children aged less than 12 years who cannot be reliably monitored by spirometry or flowmeter readings.

PP.6 Lithium

A test for the quantitation of lithium is claimable under item 66611 - 'quantitation of a drug being used therapeutically'.

PP.7 Antibiotics/Antimicrobial Chemotherapeutic Agents

A test for the quantitation of antibiotics/antimicrobial chemotherapeutic agents is claimable under item 66611 - 'quantitation of a drug being used therapeutically'.

PQ. ABBREVIATIONS, GROUPS OF TESTS

PQ.1 Abbreviations

As stated at PC.2 of the Outline, details that must be recorded on accounts, receipts or assignment forms of an Approved Pathology Practitioner/Authority include a description of the pathology service that is of sufficient detail to identify the specific service rendered. The lists of abbreviations for group tests are contained in PQ.4. The lists of abbreviations for individual tests are contained in the Index to this Section. The abbreviations are provided to allow users to identify and refer to particular pathology services, or particular groups of pathology services, more accurately and conveniently.

The above requirements may be used for billing purposes but treating practitioners requesting pathology services are encouraged to use the approved abbreviations. In this regard treating practitioners should note that:

- pathology services cannot be self determined by a rendering pathologist responding to a request. This places the onus for medical necessity on the treating practitioner who, in normal circumstances would, if he or she was unclear in deciding the appropriate test for a clinical situation, consult a pathologist for assistance; and
- Approved Pathology Practitioners/Authorities undertake not to issue accounts etc unless the pathology service was rendered in response to an unambiguous request.

PQ.2 Tests not Listed

Tests which are not listed in the Pathology Services Table do not attract Medicare benefits. As explained at PN.1 of the Outline, changes to the Pathology Services Table can only be made by the Minister for Health and Aged Care.

PQ.3 Audit of Claims

The Health Insurance Commission is undertaking routine audits of claims for pathology benefits against requested services to ensure compliance with the provisions of the *Health Insurance Act 1973*.

PQ.4 Groups of Tests

For the purposes of recording a description of the pathology service on accounts etc, an Approved Pathology Practitioner /Authority may use group abbreviations or group descriptions for the following specified groups of tests. These groups consist of two or more tests within the same item.

Treating practitioners are encouraged to use these group abbreviations or group descriptions where appropriate.

For ease of identification of group tests, it is recommended that practitioners use the following abbreviations. Tests requested individually may attract Medicare benefits.

Group	Estimations Included in Group	Group Abbreviation	Item Numbers
Cardiac enzymes	Lactate dehydrogenase (LDH), aspartate aminotransferase (AST) and creatine kinase (CK)	CE	66506
Coagulation studies	Prothrombin time, activated partial thrombo-plastin time and two or more of the following tests- fibrinogen, thrombin clotting time, fibrinogen degradation products, fibrin monomer, D-dimer factor XIII screening tests	COAG	65129
Electrolytes	Sodium (NA) potassium (K) chloride (CL) and bicarbonate (HCO3)	E	66509
Full Blood Examination	Erythrocyte count Haematocrit Haemoglobin Platelet count Red cell count Leucocyte count Manual or instrument generated differential Morphological assessment of blood film where appropriate	FBE, FBC, CBC	65070
Lipid studies	Cholesterol (CHOL) and triglycerides (TRIG)	FATS	66521

Liver function tests	Alkaline phosphatase (ALP), alanine aminotransferase (ALT), aspartate aminotransferase (AST), albumin (ALB), bilirubin (BIL), gamma glutamyl transpeptidase (GGT), lactate dehydrogenase (LDH), and protein (PROT).	LFT	66515
Syphilis serology	Rapid plasma reagin test (RPR), or venereal disease research laboratory test (VDRL), and treponema pallidum haemagglutin test (TPHA), or fluorescent treponemal antibody-absorption test (FTA)	STS	69387
Urea, electrolytes, creatinine	Urea, electrolytes, creatinine	U&E	66515

PR. COMPLEXITY LEVELS FOR HISTOPATHOLOGY ITEMS

PR.1 Complexity Levels

A new set of histopathology items was developed in March 1997, based on complexity and relative resource use, which better reflected the range of procedures performed and incorporated differential fees. The set included eight items (72813, 72816, 72817, 72823, 72824, 72825, 72830 and 72836) which were defined in terms of complexity level and number of specimens.

Only one of these histopathology examination items can be claimed in a patient episode.

The remaining items (72846, 72847, 72851, 72852, 72855 and 72856) are add-on items, covering immunohistochemistry, electron microscopy and frozen sections, which can be claimed in addition to the main item when ordered by the requesting practitioner.

A new item for enzyme histochemistry of skeletal muscle (72844) was developed in November 1998.

Immunohistochemistry items 72846 and 72847 and immunocytochemistry items 73059 and 73060 will become Pathologist-determinable services for tissue examination items 72813 to 72836 and cytology items 73045 to 73051 respectively during early 2000/01.

The list of complexity levels by type of specimen are contained at the back of this Section.

PX. PATHOLOGY SERVICES TABLE

PX.1 Rules for the Interpretation of the Pathology Services Table

1. (1) In this table

patient episode means:

(a) a pathology service or pathology services (other than a pathology service to which paragraph 1 (1) (b) refers) provided for a single patient whose need for the service or services was determined under section 16A of the Act:

(i) on the same day; or

(ii) if more than 1 test is performed on the 1 specimen within 14 days - on the same or different days;

whether the services:

(iii) are requested by 1 or more practitioners; or
(iv) are described in a single item or in more than 1 item; or
(v) are rendered by 1 approved pathology practitioner or more than 1 approved pathology practitioner; or
(vi) are rendered on the same or different days; or

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

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 the 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 pathology service described in item 66500 and 66584, if:
(a) 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
(b) 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

(c) 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

(d) the account for the service is endorsed 'Rule 3 Exemption'.

4. (2) Rule 3 does not apply to any of the following pathology services:

(a) estimation of prothrombin time (INR) in respect of a patient undergoing anticoagulant therapy;

(b) quantitative estimation of lithium in respect of a patient undergoing lithium therapy;

(c) a service described in item 65070 in relation to a patient undergoing chemotherapy for neoplastic disease or immunosuppressant therapy;

(d) a service described in item 65070 in relation to clozaril, ticlopidine hydrochloride, methotrexate, gold, sulfasalazine or penicillamine therapy of a patient;

(e) a service described in item 66500 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;

(g) quantitative estimation of albumin and calcium in relation to therapy of a patient with vitamin D, its metabolites or analogues;

if:

(h) under a request for a service, other than a request for a service described in paragraph (a), no more than 6 tests are requested; and

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

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

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

5. (1) For an item in Group P1 (Haematology):

(a) if pathology services of a kind referred to in item 65090 or 65093 are rendered for a patient during a period when the patient is in hospital, the item applies only to the first pathology service of that kind rendered for the patient during the period; and

(b) if:

(i) tests (except tests mentioned in item 65099, 65102, 65105 and 65108) are carried out in relation to a patient episode; and

(ii) specimen material from the patient episode is stored; and

(iii) in response to a request made within 14 days of the patient episode, further tests (except tests mentioned in item 65099, 65102, 65105 and 65108) are carried out on the stored material;

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

5. (2) Benefits for items 65102 and 65108 are payable only if a minimum of 6 units are issued for the patient's care in any 1 day.

5.(3) For items 65099 and 65102:

compatibility tests by crossmatch means that, in addition to all the tests described in paragraphs (a) and (b) of the item, donor red cells from each unit must have been tested directly against the serum of the patient by 1 or more accepted crossmatching techniques.

Certain items not to apply to a service referred by one pathology practitioner to another

6. (1) In this rule:

designated pathology service means a pathology service in respect of tests relating to a single patient episode that are:

(a) tests of the kind described in item 66611; or

(b) tests of the kind described in item 66695; or

(c) tests of the kind described in item 66722; or

(d) tests of the kind described in item 69384.

6. (2) This rule applies in respect of a designated pathology service where:

(a) an approved pathology practitioner (***practitioner A)*** in an approved pathology authority:

(i) has been requested to render the designated pathology service; and

(ii) is unable, because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority, to render 1 or more (but not all) of the tests included in the service; and

(iii) requests an approved pathology practitioner (***practitioner B)*** in another approved pathology authority to render the test or tests that practitioner A is unable to render; and

(iv) renders each test included in the service, other than the test or tests in respect of which the request mentioned in subparagraph (iii) is made: and

(b) the tests mentioned in subparagraph (a) (iv) that practitioner A renders are not tests constituting a service described in item 66617, 66710, 66734 or 69399.

6. (3) If this rule applies in respect of a designated pathology service:

(a) item 66611, 66614, 66695, 66698, 66701, 66704, 66707, 66722, 66725, 66728, 66731, 69384, 69387, 69390, 69393 or 69396 (as the case requires) applies in respect of the test or tests rendered by practitioner A; and

(b) where practitioner B renders a service under a request referred to in subparagraph (2) (a) (iii) - subject to subrule (4), the amount specified in item 66620, 66713, 66737 or 69402 (as the case requires) is payable for each test that the service comprises.

6. (4) For paragraph (3) (b), the maximum number of tests to which item 66620, 66713, 66737 or 69402 applies is:

(a) for item 66620:

3 - **X**; or

(b) for item 66713, 66737 or 69402:

6 - **X**;

where **X** is the number of tests rendered by practitioner A in relation to the designated pathology service in respect of which the request mentioned in that paragraph is made.

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

Items not to be split

7. Except as stated in rule 6, the amount specified in an item is payable only to one approved pathology practitioner in respect of a single patient episode.

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

8. For 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.

Item 66536

9. The amount specified in item 66536 is not payable in respect of a pathology service described in the item unless at least one of the following paragraphs applies:

(a) if the HDL cholesterol or apolipoprotein B/A1 ratio of the patient is requested to be determined because the patient has a serum cholesterol level >5.5 mmol/L - the determination is performed on the sample that the serum cholesterol level determination for the patient was performed;

(b) if the HDL cholesterol or apolipoprotein B/A1 ratio of the patient is requested to be determined because the patient has a fasting serum triglyceride level >2.0 mmol/L - the determination is performed on the sample that the serum triglyceride level determination for the patient was performed;

(c) the pathologist who renders the service has a written statement from the medical practitioner who requested the service that the patient is on a lipid lowering drug.

Thyroid function testing

10. (1) For item 66719:

abnormal level of TSH means a level of TSH that is outside the normal reference range in respect of the particular method of assay used to determine the level.

10. (2) Except where paragraph (a) of item 66719 is satisfied, the amount specified in the item is not payable in respect of a pathology service described in the item unless the pathologist who renders the service has a written statement from the medical practitioner who requested the service that satisfies subrule (3).

10. (3) The written statement from the medical practitioner must indicate:

(a) that the tests are required for a particular purpose, being a purpose specified in paragraph (b) of item 66719; or
(b) that the medical practitioner who requested the tests suspects the patient has pituitary dysfunction; or
(c) that the patient is on drugs that interfere with thyroid hormone metabolism or function.

Meaning of "serial examinations or cultures"

11. For an item in Group P3 (Microbiology):

(a) ***serial examinations or cultures*** means a series of examinations or cultures requested on 1 occasion whether or not:
  (i) the materials are received on different days by the approved pathology practitioner; or
  (ii) the examinations or cultures were requested on 1 or more request forms by the treating practitioner; and
(b) if:
  (i) tests are carried out in relation to a patient episode; and
  (ii) specimen material from the patient episode is stored; and
  (iii) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;

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

Investigation for hepatitis and syphilis serology

12. (1) A medicare benefit is not payable in respect of more than one of items 69414, 69417, 69420, 69423, 69426, 69429, 69432, 69435, 69438, 69447, 69450, 69453, 69456, 69459, 69462, 69465 and 69468 in a patient episode.

12.(2) For items 69459 and 69468, ***currently elevated transaminase level*** means a level of alanine aminotransferase or aspartate aminotransferase above the normal reference range in respect of the particular method of assay used to determine the level, as disclosed by a test carried out on a sample taken for the investigation or on a sample taken within the previous 7 days.

Tests in Group P4 (Immunology) relating to antibodies

13. For items in Group P4 (Immunology), in items 71119, 71121, 71123 and 71125, if:

(a) tests are carried out in relation to a patient episode; and
(b) specimen material from the patient episode is stored; and
(c) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;

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

Tests on biopsy material - Group P5 (Tissue pathology) and Group P6 (Cytology)

14. (1) For items in Group P5 (Tissue pathology):

(a) ***biopsy material*** means all tissue (other than a bone marrow biopsy) received by the Approved Pathology Practitioner:
  (i) from a medical procedure or group of medical procedures performed on a patient at the same time; or
  (ii) after being expelled spontaneously from a patient.

(b) ***cytology*** means microscopic examination of 1 or more stained preparations of cells separated naturally or artificially from their normal environment by methods recognised as adequate to demonstrate their structure to a degree sufficient to enable an opinion to be formed about whether they are likely to be normal, abnormal but benign, or abnormal and malignant but, in accordance with customary laboratory practice, does not include examination of a blood film and a bone marrow aspirate; and

(c) ***separately identified specimen*** means an individual specimen collected, identified so that it is clearly distinguished from any other specimen, and sent for testing by or on behalf of the treating practitioner responsible for the procedure in which the specimen was taken.

14. (2) For Groups P5 and P6 of the pathology services table, services in Group P6 include any services described in Group P5 on the material submitted for a test in Group P6.

14. (3) For subrule (2), any sample submitted for cytology from which a cell block is prepared does not qualify for a Group P5 item.

14.(4) If more than 1 of the services mentioned in items 72813, 72816, 72817, 72823, 72824, 72825, 72830 and 72836 are performed in a single patient episode, a medicare benefit is payable only for the item performed that has the highest schedule fee.

14.(5) If more than 1 histopathological examinations are performed on separate specimens, of different complexity levels, from a single patient episode, a medicare benefit is payable only for the examination that has the highest schedule fee.

14.(6) In items 72813, 72816, 72817, 72823, 72824, 72825, 72830 and 72836 a reference to a ***complexity level*** is a reference to the level given to a specimen type mentioned in Part 4 of this Table.

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

15. (1) For 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.

15. (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.

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

15. (4) An item in Group P10 or P11 does not apply to a pathology service unless at least 1 item in Groups P1 to P8 also applies to the service.

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

15. (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.

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

(a) services referred to in 1 or more items in Group P5 and 1 or more of Groups P1, P2, P3, P4, P6, P7 and P8 are rendered by an approved pathology practitioner in the laboratory of another approved pathology authority; and

(b) services referred to in 1 or more items in Group P6 and 1 or more of Groups P1, P2, P3, P4, P5, P7 and P8 are rendered by another approved pathology practitioner in another approved pathology authority;

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

15. (8) If more than one specimen is collected from a person on the same day for the provision of pathology services:

(a) in accordance with more than 1 request; and

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

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

15. (9) The amount specified in item 73921 is payable only once in respect of a single patient episode.

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

16. 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 practitioner who claimed item 73921 in respect of the patient episode.

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

17. (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.

17. (2) An approved pathology Authority is ***related to*** another approved pathology authority for subrule (1) if:

(a) both approved pathology authorities are employed (including employed under contract) by the same person, whether or not the person is also an approved pathology authority; or

(b) either of the approved pathology authorities is employed (including employed under contract) by the other; or

(c) both approved pathology authorities are corporations and are related corporations within the meaning of the Corporations 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).

17. (3) An item in Group P11 does not apply to a referral if the following common tests are referred either singly or in combination (except if the following items are referred in combination with other items not similarly specified): 65060, 65070, 65120, 66500, 66503, 66506, 66509, 66512, 66515, 66521, 66524, 66527, 66530, 66533, 66536, 66596, 69300, 69303, 69333 or 73527.

Abbreviations

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

18. (2) The names of services or drugs not listed in Part 3 of this table must be written in full.

Certain pathology services to be treated as 1 service

19. (1) In this rule:

general practitioner means a medical practitioner who:

(a) is not a consultant physician in any specialty; and

(b) is not a specialist in any specialty;

set of pathology services means a group of pathology services:

(a) that consists of services that are described in at least 4 different items; and

(b) all of which are requested in a single patient episode; and

(c) each of which relates to a patient who is not an admitted patient of a hospital; and

(d) none of which is referred to:

(i) in item 66620, 66713, 66737, 69402, 73053 or 73055; or

(ii) in an item in Group P10 (Patient episode initiation) or Group P11 (Specimen referred).

19. (2) If a general practitioner requests a set of pathology services, the pathology services in the set are to be treated as individual pathology services in accordance with this rule.

19. (3) If the fee specified in 1 item that describes any of the services in the set of pathology services is higher than the fees specified in the other items that describe the services in the set:

(a) the pathology service described in the first-mentioned item is to be treated as 1 pathology service; and

(b) either:

(i) the pathology service in the set that is described in the item that specifies the second-highest fee is to be treated as 1 pathology service; or

(ii) if 2 or more items that describe any of those services specify the second-highest fee - the pathology service described in the item that specifies the second-highest fee, and has the lowest item number, is to be treated as 1 pathology service; and

(c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.

19. (4) If the fees specified in 2 or more items that describe any of the services in the set of pathology services are the same, and higher than the fees specified in the other items that describe the services in the set:

(a) the pathology service in the set that is described in the item that specifies the highest fee, and has the lowest item number, is to be treated as 1 pathology service; and

(b) the pathology service in the set that is described in the item that specifies the highest fee, and has the second-lowest item number, is to be treated as 1 pathology service; and

(c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.

19. (5) If pathology services are to be treated as one pathology service under paragraph (3) (c) or (4) (c), the fee for the one pathology service is the highest fee specified in any of the items that describe the pathology services that are to be treated as the 1 pathology service.

Hepatitis C viral RNA testing

20. For item 69444:

Hepatitis C sero-positive, for a patient, means 2 different assays of Hepatitis C antibodies are positive.

serological status is uncertain, for a patient, means any result where 2 different assays of Hepatitis C antibodies are inconclusive.

Haemochromatosis testing

21. For item 66794:

elevated serum ferritin for a patient, means a level of ferritin above the normal reference range in respect of the particular method of assay used to determine the level.

Serum B12 and red cell folate testing

22.

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

(2) A medicare benefit is not payable for a service described in item 66599 if the service was provided as part of the same patient episode as a service described in item 66602.

Nutritional and toxicity testing

23

(1) A medicare benefit is not payable for more than 3 episodes of services described in items 66669, 66670, 66672 or 66673, or any combination of those items, in a 6 month period.

GROUP P1 - HAEMATOLOGY

65060	Haemoglobin, erythrocyte sedimentation rate, blood viscosity - 1 or more tests **Fee:** $7.70	**Benefit:** 75% = $5.80	85% = $6.55
65066	Examination of: (a) a blood film by special stains to demonstrate Heinz bodies, parasites or iron; or (b) a blood film by enzyme cytochemistry for neutrophil alkaline phosphatase, alpha-naphthyl acetate esterase or chloroacetate esterase; or (c) a blood film using any other special staining methods including periodic acid Schiff and Sudan Black; or (d) a urinary sediment for haemosiderin including a service described in item 65072 **Fee:** $10.25	**Benefit:** 75% = $7.70	85% = $8.75
† 65070	Erythrocyte count, haematocrit, haemoglobin, calculation or measurement of red cell index or indices, platelet count, leucocyte count and manual or instrument generated differential count - not being a service where haemoglobin only is requested - 1 or more instrument generated set of results from a single sample; and (if performed) (a) a morphological assessment of a blood film; (b) any service in item 65060 or 65072 **Fee:** $16.70	**Benefit:** 75% = $12.55	85% = $14.20
65072	Examination for reticulocytes including a reticulocyte count by any method 1 or more tests in any episode **Fee:** $10.00	**Benefit:** 75% = $7.50	85% = $8.50
65075	Haemolysis or metabolic enzymes - assessment by: (a) erythrocyte autohaemolysis test; or (b) erythrocyte osmotic fragility test; or (c) sugar water test; or (d) G-6-P D (qualitative or quantitative) test; or (e) pyruvate kinase (qualitative or quantitative) test; or (f) acid haemolysis test; or (g) quantitation of muramidase in serum or urine; or (h) Donath Landsteiner antibody test; or (i) other erythrocyte metabolic enzyme tests 1 or more tests **Fee:** $51.30	**Benefit:** 75% = $38.50	85% = $43.65
65078	Tests for the diagnosis of thalassaemia when indicated on the basis of an abnormal full blood examination or by the clinical need for family studies, consisting of haemoglobin electrophoresis or chromatography and at least 2 of: (a) examination for HbH; or (b) quantitation of HbA2; or (c) quantitation of HbF; including (if performed) any service described in item 65060 or 65070 **Fee:** $89.00	**Benefit:** 75% = $66.75	85% = $75.65
65081	Tests for the investigation of haemoglobinopathy (including S, C, D, E), other than thalassaemia, when indicated on the basis of an abnormal full blood examination or by the clinical need for family studies, consisting of haemoglobin electrophoresis or chromatography and at least 1 of: (a) heat denaturation test; or (b) isopropanol precipitation test; or (c) tests for the presence of haemoglobin S; or (d) quantitation of any haemoglobin fraction (including S, C, D, E); including (if performed) any service described in item 65060, 65070 or 65078 **Fee:** $95.30	**Benefit:** 75% = $71.50	85% = $81.05
65084	Bone marrow trephine biopsy - histopathological examination of sections of bone marrow and examination of aspirated material (including clot sections where necessary), including (if performed): (a) special stains or immunohistochemical techniques (if any); and (b) any test described in item 65060, 65066 or 65070 **Fee:** $163.70	**Benefit:** 75% = $122.80	85% = $139.15
65087	Bone marrow - examination of aspirated material (including clot sections where necessary), including (if performed): (a) special stains or immunohistochemical techniques (if any); and (b) any test described in item 65060, 65066 or 65070 **Fee:** $82.00	**Benefit:** 75% = $61.50	85% = $69.70

65090	Blood grouping (including back-grouping if performed) - ABO and Rh (D antigen) **Fee:** $10.90	**Benefit:** 75% = $8.20	85% = $9.30
65093	Blood grouping - Rh phenotypes, Kell system, Duffy system, M and N factors or any other blood group system - 1 or more systems, including item 65090 (if performed) **Fee:** $21.70	**Benefit:** 75% = $16.30	85% = $18.45
65096	Blood grouping (including back-grouping if performed), and examination of serum for Rh and other blood group antibodies, including: (a) identification and quantitation of any antibodies detected; and (b) (if performed) any test described in item 65060 or 65070 **Fee:** $40.40	**Benefit:** 75% = $30.30	85% = $34.35
65099	Compatibility tests by crossmatch - all tests performed on any one day for up to 6 units, including: (a) all grouping checks of the patient and donor; and (b) examination for antibodies, and if necessary identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090 or 65096 (Item is subject to rule 5) **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50
65102	Compatibility tests by crossmatch - all tests performed on any one day in excess of 6 units, including: (a) all grouping checks of the patient and donor; and (b) examination for antibodies, and if necessary identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090, 65096, 65099 or 65105 (Item is subject to rule 5) **Fee:** $165.00	**Benefit:** 75% = $123.75	85% = $140.25
65105	Compatibility testing using at least a 3 cell panel and issue of red cells for transfusion - all tests performed on any one day for up to 6 units, including: (a) all grouping checks of the patient and donor; and (b) examination for antibodies and, if necessary, identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090 or 65096 (Item is subject to rule 5) **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50
65108	Compatibility testing using at least a 3 cell panel and issue of red cells for transfusion - all tests performed on any one day in excess of 6 units, including: (a) all grouping checks of the patient and donor; and (b) examination for antibodies and, if necessary, identification of any antibodies detected; and (c) (if performed) any tests described in item 65060, 65070, 65090, 65096, 65099 or 65105 (Item is subject to rule 5) **Fee:** $165.00	**Benefit:** 75% = $123.75	85% = $140.25
65111	Examination of serum for blood group antibodies (including identification and, if necessary, quantitation of any antibodies detected) **Fee:** $22.90	**Benefit:** 75% = $17.20	85% = $19.50
65114	1 or more of the following tests: (a) direct Coombs (antiglobulin) test; (b) qualitative or quantitative test for cold agglutinins or heterophil antibodies **Fee:** $8.95	**Benefit:** 75% = $6.75	85% = $7.65
65117	1 or more of the following tests: (a) qualitative spectroscopic examination of blood for chemically altered haemoglobins; (b) detection of methaemalbumin (Schumm's test) **Fee:** $20.00	**Benefit:** 75% = $15.00	85% = $17.00
65120	Prothrombin time (including INR where appropriate), activated partial thromboplastin time, thrombin time (including test for the presence of heparin), test for factor XIII deficiency (qualitative), Echis test, Stypven test, reptilase time, fibrinogen, or 1 of fibrinogen degradation products, fibrin monomer or D-dimer - 1 test **Fee:** $13.65	**Benefit:** 75% = $10.25	85% = $11.65
65123	2 tests described in item 65120 **Fee:** $20.00	**Benefit:** 75% = $15.00	85% = $17.00
65126	3 tests described in item 65120 **Fee:** $27.50	**Benefit:** 75% = $20.65	85% = $23.40

65129	4 or more tests described in item 65120 **Fee:** $35.00	**Benefit:** 75% = $26.25	85% = $29.75
‡ 65132	Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency, lupus anticoagulant, activated protein C resistance – if the request for the test specifically identifies in writing a history of venous thromboembolism - quantitation by 1 or more techniques - 1 test **Fee:** $25.00	**Benefit:** 75% = $18.75	85% = $21.25
65133	2 tests described in item 65132 **Fee:** $48.00	**Benefit:** 75% = $36.00	85% = $40.80
65134	3 tests described in item 65132 **Fee:** $71.00	**Benefit:** 75% = $53.25	85% = $60.35
65135	4 tests described in item 65132 **Fee:** $94.00	**Benefit:** 75% = $70.50	85% = $79.90
65136	5 tests described in item 65132 **Fee:** $117.00	**Benefit:** 75% = $87.75	85% = $99.45
‡ 65137	Test for the presence of lupus anticoagulant not being a service associated with any service to which items 65132, 65133, 65134, 65135 and 65136 apply **Fee:** $25.00	**Benefit:** 75% = $18.75	85% = $21.25
65139	Quantitation of plasminogen - 1 test **Fee:** $25.00	**Benefit:** 75% = $18.75	85% = $21.25
65140	Quantitation of euglobulin clot lysis time - 1 test **Fee:** $25.00	**Benefit:** 75% = $18.75	85% = $21.25
‡ 65142	Confirmation or clarification of an abnormal or indeterminate result from a test described in item 65132, by testing a specimen collected on a different day - 1 or more tests **Fee:** $25.00	**Benefit:** 75% = $18.75	85% = $21.25
65144	Platelet aggregation in response to ADP, collagen, 5HT, ristocetin or other substances; or heparin, low molecular weight heparins, heparinoid or other drugs - 1 or more tests **Fee:** $55.80	**Benefit:** 75% = $41.85	85% = $47.45
65147	Quantitation of anti-Xa activity when monitoring is required for a patient receiving a low molecular weight heparin or heparinoid - 1 test **Fee:** $37.40	**Benefit:** 75% = $28.05	85% = $31.80
65150	Quantitation of von Willebrand factor antigen, von Willebrand factor activity (ristocetin cofactor assay), von Willebrand factor collagen binding activity, factor II, factor V, factor VII, factor VIII, factor IX, factor X, factor XI, factor XII, factor XIII, Fletcher factor, Fitzgerald factor, circulating coagulation factor inhibitors other than by Bethesda assay - 1 test **Fee:** $70.00	**Benefit:** 75% = $52.50	85% = $59.50
65153	2 tests described in item 65150 **Fee:** $140.00	**Benefit:** 75% = $105.00	85% = $119.00
65156	3 or more tests described in item 65150 **Fee:** $210.00	**Benefit:** 75% = $157.50	85% = $178.50
65159	Quantitation of circulating coagulation factor inhibitors by Bethesda assay - 1 test **Fee:** $70.00	**Benefit:** 75% = $52.50	85% = $59.50
65162	Examination of a maternal blood film for the presence of fetal red blood cells (Kleihauer test) **Fee:** $10.25	**Benefit:** 75% = $7.70	85% = $8.75
65165	Detection and quantitation of fetal red blood cells in the maternal circulation by detection of red cell surface antigens using flow cytometric methods including (if performed) any test described in item 65070 or 65162 **Fee:** $34.00	**Benefit:** 75% = $25.50	85% = $28.90
65168	Characterisation of the genotype of a patient for Factor V Leiden gene mutation, or detection of other relevant mutations in the investigation of proven venous thrombosis or pulmonary embolism - 1 or more tests **Fee:** $36.00	**Benefit:** 75% = $27.00	85% = $30.60

65171	Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency or activated protein C resistance in a first degree relative of a person who has a proven defect of any of the above - 1 or more tests **Fee:** $25.00	**Benefit:** 75% = $18.75	85% = $21.25
65174	Characterisation of the genotype of a person who is a first degree relative of a person who has been proven to have 1 or more abnormal genotypes under item 65168 - 1 or more tests **Fee:** $36.00	**Benefit:** 75% = $27.00	85% = $30.60
	GROUP P2 - CHEMICAL		
66500	Quantitation in serum, plasma, urine or other body fluid (except amniotic fluid), by any method except reagent tablet or reagent strip (with or without reflectance meter or electrophoresis) of: acetoacetate, acid phosphatase, alanine aminotransferase, albumin, alkaline phosphatase, ammonia, amylase, aspartate aminotransferase, beta-hydroxybutyrate, bicarbonate, bilirubin (total), bilirubin (any fractions), C-reactive protein, calcium (total or corrected for albumin), chloride, creatine kinase, creatinine, gamma glutamyl transferase, globulin, glucose, lactate, lactate dehydrogenase, lipase, magnesium, phosphate, potassium, pyruvate, sodium, total protein, urate or urea - 1 test **Fee:** $9.50	**Benefit:** 75% = $7.15	85% = $8.10
66503	2 tests described in item 66500 **Fee:** $11.50	**Benefit:** 75% = $8.65	85% = $9.80
66506	3 tests described in item 66500 **Fee:** $13.50	**Benefit:** 75% = $10.15	85% = $11.50
66509	4 tests described in item 66500 **Fee:** $15.50	**Benefit:** 75% = $11.65	85% = $13.20
66512	5 tests described in item 66500 **Fee:** $17.50	**Benefit:** 75% = $13.15	85% = $14.90
66515	6 or more tests described in item 66500 **Fee:** $19.50	**Benefit:** 75% = $14.65	85% = $16.60
66518	Investigation of cardiac or skeletal muscle damage by measurement of creatine kinase isoenzymes (by any method), troponin or myoglobin in plasma or serum - 1 or more tests in a 24 hour period **Fee:** $19.80	**Benefit:** 75% = $14.85	85% = $16.85
66521	Quantitation (except by reagent strip with or without reflectance meter or electrophoresis) of cholesterol or triglycerides or both in serum, plasma, urine or other body fluid *(See para PP. of explanatory notes to this Category)* **Fee:** $11.40	**Benefit:** 75% = $8.55	85% = $9.70
66524	A service described in item 66521 and 1 test described in item 66500 **Fee:** $13.50	**Benefit:** 75% = $10.15	85% = $11.50
66527	A service described in item 66521 and 2 tests described in item 66500 **Fee:** $15.50	**Benefit:** 75% = $11.65	85% = $13.20
66530	A service described in item 66521 and 3 tests described in item 66500 **Fee:** $17.50	**Benefit:** 75% = $13.15	85% = $14.90
66533	A service described in item 66521 and 4 or more tests described in item 66500 **Fee:** $19.50	**Benefit:** 75% = $14.65	85% = $16.60
‡ 66536	Quantitation of HDL cholesterol or apolipoprotein B/A1 ratio in a patient who: (a) has a serum cholesterol level >5.5mmol/L; or (b) has a fasting serum triglyceride level > 2.0 mmol/L; or (c) is on a lipid lowering drug prescribed by a medical practitioner; or (d) has a serum cholesterol level >4.0 mmol/L and has a history of ischaemic heart disease; each episode to a maximum of 4 episodes in a 12 month period (Item is subject to rule 9) **Fee:** $11.40	**Benefit:** 75% = $8.55	85% = $9.70
66539	Electrophoresis of serum for demonstration of lipoprotein subclasses, if the cholesterol is >6.5 mmol/L and triglyceride >4.0 mmol/L or in the diagnosis of types III and IV hyperlipidaema - each episode to a maximum of 2 episodes in a 12 month period **Fee:** $30.20	**Benefit:** 75% = $22.65	85% = $25.70

66542	Oral glucose tolerance test for the diagnosis of diabetes mellitus that includes: (a) administration of glucose; and (b) at least 2 measurements of blood glucose; and (c) (if performed) any test described in item 66695 **Fee:** $18.70	**Benefit:** 75% = $14.05	85% = $15.90
66545	Oral glucose challenge test in pregnancy for the detection of gestational diabetes that includes: (a) administration of glucose; and (b) 1 or 2 measurements of blood glucose; and (c) (if performed) any test in item 66695 (if performed) **Fee:** $15.60	**Benefit:** 75% = $11.70	85% = $13.30
66548	Oral glucose tolerance test in pregnancy for the diagnosis of gestational diabetes that includes: (a) administration of glucose; and (b) at least 3 measurements of blood glucose; and (c) (if performed) any test in item 66695 (if performed) **Fee:** $19.70	**Benefit:** 75% = $14.80	85% = $16.75
66551	Quantitation of glycosylated haemoglobin performed in the management of established diabetes - each test to a maximum of 4 tests in a 12 month period **Fee:** $16.60	**Benefit:** 75% = $12.45	85% = $14.15
66554	Quantitation of glycosylated haemoglobin performed in the management of pre-existing diabetes where the patient is pregnant - each test to a maximum of 6 tests in a 12 month period which includes the whole pregnancy, including a service in item 66551 (if performed) **Fee:** $16.60	**Benefit:** 75% = $12.45	85% = $14.15
66557	Quantitation of fructosamine performed in the management of established diabetes - each test to a maximum of 4 tests in a 12 month period **Fee:** $9.55	**Benefit:** 75% = $7.20	85% = $8.15
‡ 66560	Microalbumin - quantitation in urine **Fee:** $19.90	**Benefit:** 75% = $14.95	85% = $16.95
66563	Osmolality, estimation by osmometer, in serum or in urine - 1 or more tests **Fee:** $24.35	**Benefit:** 75% = $18.30	85% = $20.70
66566	Quantitation of: (a) blood gases (including pO_2, oxygen saturation and pCO_2); and (b) bicarbonate and pH; including any other measurement (eg. haemoglobin, potassium or ionised calcium) or calculation performed on the same specimen - 1 or more tests on 1 specimen **Fee:** $33.25	**Benefit:** 75% = $24.95	85% = $28.30
66569	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 2 specimens performed within any 1 day **Fee:** $42.05	**Benefit:** 75% = $31.55	85% = $35.75
66572	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 3 specimens performed within any 1 day **Fee:** $50.85	**Benefit:** 75% = $38.15	85% = $43.25
66575	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 4 specimens performed within any 1 day **Fee:** $59.65	**Benefit:** 75% = $44.75	85% = $50.75
66578	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 5 specimens performed within any 1 day **Fee:** $68.45	**Benefit:** 75% = $51.35	85% = $58.20
66581	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 6 or more specimens performed within any 1 day **Fee:** $77.25	**Benefit:** 75% = $57.95	85% = $65.70
66584	Quantitation of ionised calcium (except if performed as part of item 66566) - 1 test **Fee:** $9.55	**Benefit:** 75% = $7.20	85% = $8.15
66587	Urine acidification test for the diagnosis of renal tubular acidosis including the administration of an acid load, and pH measurements on 4 or more urine specimens and at least 1 blood specimen **Fee:** $46.90	**Benefit:** 75% = $35.20	85% = $39.90

66590	Calculus, analysis of 1 or more **Fee:** $30.20	**Benefit:** 75% = $22.65	85% = $25.70
66593	Ferritin - quantitation, except if requested as part of iron studies **Fee:** $18.80	**Benefit:** 75% = $14.10	85% = $16.00
66596	Iron studies, consisting of quantitation of: (a) serum iron; and (b) transferrin or iron binding capacity; and (c) ferritin **Fee:** $34.10	**Benefit:** 75% = $25.60	85% = $29.00
66599	Serum B12 or red cell folate and, if required, serum folate (Item is subject to rule 22) **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 22) **Fee:** $44.45	**Benefit:** 75% = $33.35	85% = $37.80
66605	Vitamins - quantitation of vitamins A, B1, B2, B3, B6, C and E in blood, urine or other body fluid - 1 or more tests within a 6 month period **Fee:** $30.20	**Benefit:** 75% = $22.65	85% = $25.70
66608	Vitamin D or D fractions - 1 or more tests **Fee:** $41.70	**Benefit:** 75% = $31.30	85% = $35.45
66611	Quantitation, not elsewhere described in this Table by any method or methods, in blood or other body fluid, of a drug being used therapeutically by the patient from whom the specimen was taken - 1 test (This fee applies where 1 laboratory performs the only test specified on the request form or performs 1 test and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) *(See para PP. of explanatory notes to this Category)* **Fee:** $20.45	**Benefit:** 75% = $15.35	85% = $17.40
66614	2 tests described in item 66611 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $32.60	**Benefit:** 75% = $24.45	85% = $27.75
66617	3 or more tests described in item 66611 (Item is subject to rule 6) **Fee:** $44.80	**Benefit:** 75% = $33.60	85% = $38.10
66620	Tests described in item 66611, if rendered under a request referred to in subparagraph (2) (a) (iii) of rule 6 - each test to a maximum of 2 tests (Item is subject to rule 6) **Fee:** $12.20	**Benefit:** 75% = $9.15	85% = $10.40
66623	All qualitative and quantitative tests on blood, urine or other body fluid for: (a) a drug or drugs of abuse (including illegal drugs and legally available drugs taken other than in appropriate dosage); or (b) ingested or absorbed toxic chemicals; including a service described in item 66611, 66614 or 66617 (if performed), but excluding: (c) the surveillance of sports people and athletes for performance improving substances; and (d) the monitoring of patients participating in a drug abuse treatment program **Fee:** $41.00	**Benefit:** 75% = $30.75	85% = $34.85
66626	Detection or quantitation or both (not including the detection of nicotine and metabolites in smoking withdrawal programs) of a drug, or drugs, of abuse or a therapeutic drug, on a sample collected from a patient: (a) participating in a drug abuse treatment program; or (b) being monitored for drug effects; but excluding (c) the surveillance of sports people and athletes for performance improving substances; including all tests on blood, urine or other body fluid - each episode, to a maximum of 21 episodes in a 12 month period **Fee:** $23.80	**Benefit:** 75% = $17.85	85% = $20.25

66629	Beta-2-microglobulin - quantitation in serum, urine or other body fluids - 1 or more tests **Fee:** $19.90 **Benefit:** 75% = $14.95 85% = $16.95
66632	Caeruloplasmin, haptoglobins, or prealbumin – quantitation in serum, urine or other body fluids – 1 or more tests **Fee:** $19.90 **Benefit:** 75% = $14.9585% = $16.95
66635	Alpha-1-antitrypsin - quantitation in serum, urine or other body fluid - 1 or more tests **Fee:** $19.90 **Benefit:** 75% = $14.95 85% = $16.95
66638	Isoelectric focussing or similar methods for determination of alpha-1-antitrypsin phenotype in serum - 1 or more tests **Fee:** $28.80 **Benefit:** 75% = $21.60 85% = $24.50
66641	Electrophoresis of serum or other body fluid to demonstrate: (a) the isoenzymes of lactate dehydrogenase; or (b) the isoenzymes of alkaline phosphatase; including the preliminary quantitation of total relevant enzyme activity 1 or more tests **Fee:** $28.80 **Benefit:** 75% = $21.60 85% = $24.50
66644	C-1 esterase inhibitor - quantitation **Fee:** $19.90 **Benefit:** 75% = $14.95 85% = $16.95
66647	C-1 esterase inhibitor - functional assay **Fee:** $44.50 **Benefit:** 75% = $33.40 85% = $37.85
66650	Alpha-fetoprotein, CA-15.3 antigen (CA15.3), CA-125 antigen (CA125), CA-19.9 antigen (CA19.9), cancer associated serum antigen (CASA), carcinoembryonic antigen (CEA), human chorionic gonadotrophin (HCG), mammary serum antigen (MSA), thyroglobulin in serum or other body fluid, in the monitoring of malignancy or in the detection or monitoring of gestational trophoblastic disease - quantitation - 1 test **Fee:** $24.00 **Benefit:** 75% = $18.00 85% = $20.40
66653	2 or more tests described in item 66650 **Fee:** $44.00 **Benefit:** 75% = $33.00 85% = $37.40
66656	Prostate specific antigen or prostate acid phosphatase - quantitation in the confirmation or monitoring of malignancy - 1 test **Fee:** $19.90 **Benefit:** 75% = $14.95 85% = $16.95
66659	2 tests described in item 66656 **Fee:** $36.65 **Benefit:** 75% = $27.50 85% = $31.20
66662	Quantitation of hormone receptors on proven primary breast or ovarian carcinoma or a metastasis from a breast or ovarian carcinoma or a subsequent lesion in the breast - 1 or more tests **Fee:** $78.90 **Benefit:** 75% = $59.20 85% = $67.10
66665	Lead quantitation in blood or urine (other than for occupational health screening purposes) to a maximum of 3 tests in a 6 month period - each test **Fee:** $30.20 **Benefit:** 75% = $22.65 85% = $25.70
† 66667	Quantitation of serum zinc in a patient receiving intravenous alimentation - each test **Fee:** $30.20 **Benefit:** 75% = $22.65 85% = $25.70
† 66669	Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid or tissue - 1 test to a maximum of 3 episodes in a 6 month period (Item is subject to rule 23) **Fee:** $30.20 **Benefit:** 75% = $22.65 85% = $25.70
† 66670	Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid or tissue - 2 or more tests to a maximum of 3 episodes in a 6 month period (Item is subject to rule 23) **Fee:** $51.75 **Benefit:** 75% = $38.80 85% = $44.00
66671	Quantitation of serum aluminium in a patient in a renal dialysis program - each test **Fee:** $36.40 **Benefit:** 75% = $27.30 85% = $30.95
† 66672	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 1 test to a maximum of 3 episodes in a 6 month period (Item is subject to rule 23) **Fee:** $30.20 **Benefit:** 75% = $22.65 85% = $25.70

† 66673	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 2 or more tests to a maximum of 3 episodes in a 6 month period (Item is subject to rule 23) **Fee:** $51.75 **Benefit:** 75% = $38.80 85% = $44.00
66674	Quantitation of: (a) faecal fat; or (b) breath hydrogen in response to loading with disaccharides; 1 or more tests within a 28 day period **Fee:** $39.45 **Benefit:** 75% = $29.60 85% = $33.55
66677	Test for tryptic activity in faeces in the investigation of diarrhoea of longer than 4 weeks duration in children under 6 years old **Fee:** $11.00 **Benefit:** 75% = $8.25 85% = $9.35
66680	Quantitation of disaccharidases and other enzymes in intestinal tissue - 1 or more tests **Fee:** $73.45 **Benefit:** 75% = $55.10 85% = $62.45
66683	Enzymes quantitation in solid tissue or tissues other than blood elements or intestinal tissue - 1 or more tests **Fee:** $73.45 **Benefit:** 75% = $55.10 85% = $62.45
66686	Performance of 1 or more of the following procedures: (a) growth hormone suppression by glucose loading; (b) growth hormone stimulation by exercise; (c) dexamethasone suppression test; (d) sweat collection by iontophoresis for chloride analysis; (e) pharmacological stimulation of growth hormone **Fee:** $50.00 **Benefit:** 75% = $37.50 85% = $42.50
66689	Personal performance by a recognised pathologist of 1 of the following procedures: (a) gonadotrophin releasing hormone stimulation test; (b) synacthen stimulation test; (c) glucagon stimulation test with C-peptide measurement; (d) pentagastrin or calcium stimulation of thyrocalcitonin release; (e) secretin or calcium stimulation of gastrin release; (f) insulin hypoglycaemia; (g) arginine infusion; (h) thyrotrophin releasing hormone (TRH) test **Fee:** $80.00 **Benefit:** 75% = $60.00 85% = $68.00
66692	Personal performance by a recognised pathologist of 2 or more tests described in item 66689 **Fee:** $140.00 **Benefit:** 75% = $105.00 85% = $119.00
66695	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(IGF-1), free or total testosterone, urine steroid fraction or fractions, vasoactive intestinal peptide, vasopressin (antidiuretic hormone) - 1 test **Fee:** $31.30 **Benefit:** 75% = $23.50 85% = $26.65
66698	2 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $44.00 **Benefit:** 75% = $33.00 85% = $37.40
66701	3 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 tests specified on the request form or performs 3 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $57.00 **Benefit:** 75% = $42.75 85% = $48.45
66704	4 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 tests specified on the request form or performs 4 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $70.00 **Benefit:** 75% = $52.50 85% = $59.50

	5 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 tests specified on the request form or performs 5 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)		
66707	**Fee:** $83.00	**Benefit:** 75% = $62.25	85% = $70.55
	6 or more tests described in item 66695 (Item is subject to rule 6)		
66710	**Fee:** $96.00	**Benefit:** 75% = $72.00	85% = $81.60
	Tests described in item 66695, if rendered under a request referred to in subparagraph (2)(a)(iii) of rule 6 - each test to a maximum of 5 tests (Item is subject to rule 6)		
66713	**Fee:** $13.00	**Benefit:** 75% = $9.75	85% = $11.05
	TSH quantitation		
66716	**Fee:** $30.70	**Benefit:** 75% = $23.05	85% = $26.10
	Thyroid function tests (comprising the service described in item 66716 and 1 or more of the following tests - estimation of free thyroxine index, free thyroxine, free T3, total T3, thyroxine binding globulin) for a patient, if at least 1 of the following conditions is satisfied: (a) the patient has an abnormal level of TSH; (b) the tests are performed: (i) for the purpose of monitoring thyroid disease in the patient; or (ii) to investigate the sick euthyroid syndrome if the patient is an admitted patient; or (iii) to investigate dementia or psychiatric illness of the patient; or (iv) to investigate amenorrhoea or infertility of the patient; (c) the medical practitioner who requested the tests suspects the patient has a pituitary dysfunction; (d) the patient is on drugs that interfere with thyroid hormone metabolism or function (Item is subject to rule 10)		
66719	**Fee:** $40.40	**Benefit:** 75% = $30.30	85% = $34.35
	TSH quantitation described in item 66716 and 1 test described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)		
66722	**Fee:** $43.40	**Benefit:** 75% = $32.55	85% = $36.90
	TSH quantitation described in item 66716 and 2 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 tests specified on the request form or performs 3 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)		
66725	**Fee:** $56.40	**Benefit:** 75% = $42.30	85% = $47.95
	TSH quantitation described in item 66716 and 3 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 tests specified on the request form or performs 4 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)		
66728	**Fee:** $69.40	**Benefit:** 75% = $52.05	85% = $59.00
	TSH quantitation described in item 66716 and 4 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 tests specified on the request form or performs 5 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)		
66731	**Fee:** $82.40	**Benefit:** 75% = $61.80	85% = $70.05
	TSH quantitation described in item 66716 and 5 tests described in item 66695 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 6 or more tests specified on the request form) (Item is subject to rule 6)		
66734	**Fee:** $95.40	**Benefit:** 75% = $71.55	85% = $81.10

66737	Tests described in items 66716 and 66695, if rendered under a request mentioned in subparagraph (2)(a)(iii) of rule 6 - each test to a maximum of 5 tests (Item is subject to rule 6) **Fee:** $13.00 **Benefit:** 75% = $9.75 85% = $11.05
66740	Quantitation, in pregnancy, of alpha-fetoprotein, human chorionic gonadotrophin, oestriol and any other substance to detect foetal abnormality, including a service described in 1 or more of items 66743, 66746, 73527 and 73529 (if performed) - 1 patient episode in a pregnancy **Fee:** $54.50 **Benefit:** 75% = $40.90 85% = $46.35
66743	Quantitation of alpha-fetoprotein in serum or other body fluids during pregnancy except if requested as part of item 66740 **Fee:** $19.90 **Benefit:** 75% = $14.95 85% = $16.95
66746	Human placental lactogen or oestriol - quantitation, except if requested as part of item 66740 - 1 test **Fee:** $31.55 **Benefit:** 75% = $23.70 85% = $26.85
66749	Amniotic fluid, spectrophotometric examination of, and quantitation of: (a) lecithin/sphingomyelin ratio; or (b) palmitic acid, phosphatidylglycerol or lamellar body phospholipid; or (c) bilirubin, including correction for haemoglobin 1 or more tests **Fee:** $32.50 **Benefit:** 75% = $24.40 85% = $27.65
66752	Quantitation of citrate, oxalate, total free fatty acids or amino acids including cysteine, homocysteine, cystine and hydroxyproline (except if performed as part of item 66773 or 66776) - 1 test **Fee:** $24.35 **Benefit:** 75% = $18.30 85% = $20.70
66755	2 or more tests described in item 66752 **Fee:** $38.30 **Benefit:** 75% = $28.75 85% = $32.60
66758	Quantitation of angiotensin converting enzyme, or cholinesterase - 1 or more tests **Fee:** $24.35 **Benefit:** 75% = $18.30 85% = $20.70
66761	Test for reducing substances in faeces by any method (except reagent strip or dipstick) **Fee:** $13.00 **Benefit:** 75% = $9.75 85% = $11.05
66764	Examination for faecal occult blood (including tests for haemoglobin and its derivatives in the faeces) by: (a) an immunological method; and (b) a chemical method (except reagent strip or dip stick); with a maximum of 3 examinations on specimens collected on separate days in a 28 day period - 1 examination by both methods *(See para PP. of explanatory notes to this Category)* **Fee:** $8.80 **Benefit:** 75% = $6.60 85% = $7.50
66767	2 examinations by both methods described in item 66764 performed on separately collected and identified specimens **Fee:** $17.60 **Benefit:** 75% = $13.20 85% = $15.00
66770	3 examinations by both methods described in item 66764 performed on separately collected and identified specimens **Fee:** $26.40 **Benefit:** 75% = $19.80 85% = $22.45
66773	Quantitation of products of collagen breakdown for the monitoring of patients with proven low bone mineral density, and if performed, a service described in item 66752 - 1 or more tests *(Low bone densitometry is defined in paragraph D1.15 of explanatory notes to Category 2 - Diagnostic Procedures and Investigations of the Medicare Benefits Schedule)* ***Fee:** $24.35 **Benefit:** 75% = $18.30 85% = $20.70*
66776	Quantitation of products of collagen breakdown for the monitoring of patients with metabolic bone disease or Paget's disease of bone, and if performed, a service described in item 66752 - 1 or more tests **Fee:** $24.35 **Benefit:** 75% = $18.30 85% = $20.70
66779	Adrenaline, noradrenaline, dopamine, histamine, hydroxyindoleacetic acid (5HIAA), hydroxymethoxymandelic acid (HMMA), homovanillic acid (HVA), metanephrines, methoxyhydroxyphenylethylene glycol (MHPG), phenylacetic acid (PAA) or serotonin - quantitation - 1 or more tests **Fee:** $39.45 **Benefit:** 75% = $29.60 85% = $33.55

66782	Porphyrins or porphyrins precursors - detection in plasma, red cells, urine or faeces - 1 or more tests **Fee:** $13.00 **Benefit:** 75% = $9.75 85% = $11.05
66785	Porphyrins or porphyrins precursors - quantitation in plasma, red cells, urine or faeces - 1 test **Fee:** $39.45 **Benefit:** 75% = $29.60 85% = $33.55
66788	Porphyrins or porphyrins precursors - quantitation in plasma, red cells, urine or faeces - 2 or more tests **Fee:** $65.00 **Benefit:** 75% = $48.75 85% = $55.25
66791	Porphyrin biosynthetic enzymes measurement of activity in blood cells or other tissues 1 or more tests **Fee:** $73.45 **Benefit:** 75% = $55.10 85% = $62.45
66794	Detection of the C282Y genetic mutation of the HFE gene and, if performed, detection of other mutations for haemochromatosis where: (a) the patient has an elevated transferrin saturation or elevated serum ferritin on testing of repeated specimens; or (b) the patient has a first degree relative with haemochromatosis; or (c) the patient has a first degree relative with homozygosity for the C282Y genetic mutation, or with compound heterozygosity for recognised genetic mutations for haemochromatosis (Item is subject to rule 21) **Fee:** $36.00 **Benefit:** 75% = $27.00 85% = $30.60
	GROUP P3 - MICROBIOLOGY
69300	Microscopy of wet film material other than blood, from 1 or more sites, obtained directly from a patient (not cultures) including: (a) differential cell count (if performed); or (b) examination for dermatophytes; or (c) dark ground illumination; or (d) stained preparation or preparations using any relevant stain or stains; 1 or more tests **Fee:** $12.20 **Benefit:** 75% = $9.15 85% = $10.40
69303	Culture and (if performed) microscopy to detect pathogenic micro-organisms (including fungi but excluding viruses) from nasal swabs, throat swabs, eye swabs and ear swabs (excluding swabs taken for epidemiological surveillance), including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) the detection of antigens not elsewhere described in this Table; or (c) a service described in item 69300; specimens from 1 or more sites **Fee:** $21.50 **Benefit:** 75% = $16.15 85% = $18.30
69306	Microscopy and culture to detect pathogenic micro-organisms (including fungi but excluding viruses) from skin or other superficial sites, including (if performed): (a) the detection of antigens not elsewhere specified in this Table; or (b) pathogen identification and antibiotic susceptibility testing; or (c) a service described in items 69300, 69303, 69312, 69318 and 73810; 1 or more tests on 1 or more specimens **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05
69309	Microscopy and culture to detect dermatophytes and other fungi causing cutaneous disease from skin scrapings, skin biopsies, hair and nails (excluding swab specimens) and including (if performed): (a) the detection of antigens not elsewhere specified in this Table; or (b) a service described in items 69300, 69303, 69306, 69312, 69318 and 73810; 1 or more tests on 1 or more specimens **Fee:** $47.00 **Benefit:** 75% = $35.25 85% = $39.95
69312	Microscopy and culture to detect pathogenic micro-organisms (including fungi but excluding viruses) from urethra, vagina, cervix or rectum (except for faecal pathogens), including (if performed): (a) the detection of antigens not elsewhere specified in this Table; or (b) pathogen identification and antibiotic susceptibility testing; or (c) a service described in items 69300, 69303, 69306 and 69318; 1 or more tests on 1 or more specimens **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05

‡ 69315	Microscopy and culture to detect pathogenic micro-organisms, and the detection of chlamydia from urethra, vagina, cervix or rectum and including (if performed): (a) the detection of microbial antigens; or (b) pathogen identification and antibiotic susceptibility testing; or (c) a service described in item 69300, 69303, 69306, 69312, 69318, 69363, 69369, 69370, 69372, 69375 or 73810; 1 or more tests on 1 or more specimens **Fee:** $64.00 **Benefit:** 75% = $48.00 85% = $54.40
69318	Microscopy and culture to detect pathogenic micro-organisms (including fungi but excluding viruses) from specimens of sputum (except when part of items 69324, 69327 and 69330), including (if performed): (a) the detection of antigens not elsewhere specified in this Table; or (b) pathogen identification and antibiotic susceptibility testing; or (c) a service described in items 69300, 69303, 69306 and 69312; 1 or more tests on 1 or more specimens **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05
69321	Microscopy and culture of post-operative wounds, aspirates of body cavities, synovial fluid, CSF or operative or biopsy specimens, for the presence of pathogenic micro-organisms (including fungi but excluding viruses) involving aerobic and anaerobic cultures and the use of different culture media, and including (if performed): (a) pathogen identification and antibiotic susceptibility testing; or (b) the detection of antigens not elsewhere specified in this Table; or (c) a service described in item 69300, 69303, 69306, 69312 or 69318; specimens from 1 or more sites **Fee:** $47.00 **Benefit:** 75% = $35.25 85% = $39.95
‡ 69324	Microscopy (with appropriate stains) and culture for mycobacteria - 1 specimen of sputum, urine, or other body fluid or 1 operative or biopsy specimen, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300 **Fee:** $42.00 **Benefit:** 75% = $31.50 85% = $35.70
‡ 69327	Microscopy (with appropriate stains) and culture for mycobacteria - 2 specimens of sputum, urine, or other body fluid or 2 operative or biopsy specimens, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300 **Fee:** $83.00 **Benefit:** 75% = $62.25 85% = $70.55
‡ 69330	Microscopy (with appropriate stains) and culture for mycobacteria - 3 specimens of sputum, urine or other body fluid or 3 operative or biopsy specimens, including (if performed): (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or (b) pathogen identification and antibiotic susceptibility testing; including a service mentioned in item 69300 **Fee:** $125.00 **Benefit:** 75% = $93.75 85% = $106.25
69333	Urine examination (including serial examination) by any means other than simple culture by dip slide, including: (a) cell count; and (b) culture; and (c) colony count; and (d) (if performed) stained preparations; and (e) (if performed) identification of cultured pathogens; and (f) (if performed) antibiotic suseptibility testing; and (g) (if performed) examination for pH, specific gravity, blood, albumin, urobilinogen, sugar, acetone or bile salts **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10
‡ 69336	Microscopy of faeces for ova, cysts and parasites using concentration techniques (including the use of appropriate stains) with no more than 3 examinations on specimens collected on separate days in any 7 day period, including (if performed) a service mentioned in item 69300 - 1 examination **Fee:** $18.65 **Benefit:** 75% = $14.00 85% = $15.90
69339	2 examinations described in item 69336 performed on separately collected and identified specimens **Fee:** $37.25 **Benefit:** 75% = $27.95 85% = $31.70
69342	3 examinations described in item 69336 performed on separately collected and identified specimens **Fee:** $55.90 **Benefit:** 75% = $41.95 85% = $47.55

‡ 69345	Culture and (if performed) microscopy without concentration techniques of faeces for faecal pathogens, using at least 2 selective or enrichment media and culture in at least 2 different atmospheres including (if performed): (a) pathogen identification and antibiotic susceptibility testing; and (b) the detection of clostridial toxins or antigens not elsewhere specified in this Table; and (c) a service described in item 69300; with no more than 3 examinations performed on separately collected and identified specimens in any 7 day period - 1 examination **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95
69348	2 examinations described in item 69345 performed on separately collected and identified specimens **Fee:** $103.30 **Benefit:** 75% = $77.50 85% = $87.85
69351	3 examinations described in item 69345 performed on separately collected and identified specimens **Fee:** $154.95 **Benefit:** 75% = $116.25 85% = $131.75
69354	Blood culture for pathogenic micro-organisms (other than viruses), including sub-cultures and (if performed): (a) identification of any cultured pathogen; and (b) necessary antibiotic susceptibility testing; to a maximum of 3 sets of cultures - 1 set of cultures **Fee:** $30.00 **Benefit:** 75% = $22.50 85% = $25.50
69357	2 sets of cultures described in item 69354 **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00
69360	3 sets of cultures described in item 69354 **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50
69363	Detection of clostridium difficile or clostridium difficile toxin (except if a service described in item 69345, 69348, 69351, 69369 or 69372 has been performed) - 1 or more tests **Fee:** $25.00 **Benefit:** 75% = $18.75 85% = $21.25
69366	Test for *Helicobacter pylori* in faeces, for either: (a) the confirmation of *Helicobacter pylori* colonisation; where (i) suitable biopsy material for diagnosis cannot be obtained at endoscopy in patients with peptic ulcer disease, or where the diagnosis of peptic ulcer has been made on barium meal; or (ii) in patients with a history of peptic ulcer disease or gastric neoplasia, where endoscopy is not indicated; or (b) the monitoring of the success of eradication therapy for *Helicobacter pylori* in patients with peptic ulcer disease; where any request for the test by a medical practitioner specifically identifies in writing one or more of the clinical indications for the test **Fee:** $34.10 **Benefit:** 75% = $25.60 85% = $29.00
69369	Detection of chlamydia by any method in specimens from 1 or more sites **Fee:** $27.80 **Benefit:** 75% = $20.85 85% = $23.65
69370	Detection of chlamydia by any method and *Neisseria gonorrhoeae* by nucleic acid amplification techniques in specimens from 1 or more sites **Fee:** $32.80 **Benefit:** 75% = $24.60 85% = $27.90
‡ 69372	Detection of microbial antigens (except if the service described in item 69369 or 69370 has been performed) - 1 or more tests **Fee:** $25.00 **Benefit:** 75% = $18.75 85% = $21.25
69375	Examination for Herpes simplex virus, 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 not on antiretroviral therapy - 1 or more assays on 1 or more specimens in any 1 episode **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 **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 **Fee:** $176.00 **Benefit:** 75% = $132.00 85% = $149.60

69384	Quantitation of 1 antibody to microbial or exogenous antigens not elsewhere described in the Schedule - 1 test (This fee applies where a laboratory performs the only antibody test specified on the request form or performs 1 test and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $15.30 **Benefit:** 75% = $11.50 85% = $13.05
69387	2 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 estimations specified on the request form or performs 2 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $28.00 **Benefit:** 75% = $21.00 85% = $23.80
69390	3 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 estimations specified on the request form or performs 3 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $42.00 **Benefit:** 75% = $31.50 85% = $35.70
69393	4 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 estimations specified on the request form or performs 4 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $56.00 **Benefit:** 75% = $42.00 85% = $47.60
69396	5 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 estimations specified on the request form or performs 5 of the antibody tests specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6) **Fee:** $70.00 **Benefit:** 75% = $52.50 85% = $59.50
69399	6 or more tests described in item 69384 **Fee:** $84.00 **Benefit:** 75% = $63.00 85% = $71.40
69402	Tests described in item 69384, if rendered under a request referred to in subparagraph (2) (a) (iii) of rule 6 - each test to a maximum of 5 tests (Item is subject to rule 6) **Fee:** $14.00 **Benefit:** 75% = $10.50 85% = $11.90
69405	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness during that pregnancy) including: (a) the determination of 1 of the following - rubella immune status, specific syphilis serology, hepatitis B surface antigen; and (b) (if performed) a service described in 1 or more of items 69384, 69414 to 69435, 69447 to 69456, 69462 and 69465 **Fee:** $15.30 **Benefit:** 75% = $11.50 85% = $13.05
69408	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness during that pregnancy) including: (a) the determination of 2 of the following - rubella immune status, specific syphilis serology or, hepatitis B surface antigen; and (b) (if performed) a service described in 1 or more of items 69384, 69414 to 69435, 69447 to 69456, 69462 and 69465 **Fee:** $27.15 **Benefit:** 75% = $20.40 85% = $23.10
69411	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness during that pregnancy) including: (a) the determination of all 3 of the following - rubella immune status, specific syphilis serology and, hepatitis B surface antigen; and (b) (if performed) a service described in 1 or more of items 69384, 69414 to 69435, 69447 to 69456, 69462 and 69465 **Fee:** $38.15 **Benefit:** 75% = $28.65 85% = $32.45

69414	Investigation for acute Hepatitis A using: Hepatitis A IgM antibody test (Item is subject to rule 12) **Fee:** $15.30	**Benefit:** 75% = $11.50	85% = $13.05
69417	Determination of immune status to Hepatitis A using: Hepatitis A IgG antibody test (Item is subject to rule 12) **Fee:** $15.30	**Benefit:** 75% = $11.50	85% = $13.05
69420	Investigation for acute or resolving Hepatitis B, or testing of close, recent contacts of proven Hepatitis B infection, including: (a) Hepatitis B surface antigen test; and (b) Hepatitis B core antibody test; and (c) (if performed) Hepatitis B e antibody test (where the Hepatitis B surface antigen test is negative and Hepatitis B core antibody test is positive) (Item is subject to rule 12) **Fee:** $27.15	**Benefit:** 75% = $20.40	85% = $23.10
69423	Investigation for resolution of Hepatitis B if the Hepatitis B core antibody test is positive and the Hepatitis B surface antigen test is negative, including: (a) Hepatitis B core antibody test; and (b) Hepatitis B surface antigen test; and (c) Hepatitis B surface antibody test (Item is subject to rule 12) **Fee:** $38.15	**Benefit:** 75% = $28.65	85% = $32.45
69426	Determination of immune status to Hepatitis B (post exposure) using: Hepatitis B core antibody test (Item is subject to rule 12) **Fee:** $15.30	**Benefit:** 75% = $11.50	85% = $13.05
69429	Determination of immune status to Hepatitis B (post vaccination) using: Hepatitis B surface antibody test (Item is subject to rule 12) **Fee:** $15.30	**Benefit:** 75% = $11.50	85% = $13.05
69432	Investigation for chronic Hepatitis B or determination of carriage of Hepatitis B antigen using: Hepatitis B surface antigen test (Item is subject to rule 12) **Fee:** $15.30	**Benefit:** 75% = $11.50	85% = $13.05
69435	Investigation for chronic Hepatitis B or carriage of Hepatitis B antigen if the Hepatitis B surface antigen test is positive, including: (a) Hepatitis B surface antigen test; and (b) Hepatitis B e antigen test (Item is subject to rule 12) **Fee:** $27.15	**Benefit:** 75% = $20.40	85% = $23.10
69438	Testing for Hepatitis C using: Hepatitis C antibody test (Item is subject to rule 12) **Fee:** $16.70	**Benefit:** 75% = $12.55	85% = $14.20
69441	Supplementary testing for Hepatitis C antibodies using a different Hepatitis C antibody assay on the specimen which has a reactive result on the initial Hepatitis C antibody test. (Item is not subject to rule 12) **Fee:** $16.70	**Benefit:** 75% = $12.55	85% = $14.20
† 69442	Quantitation of HCV RNA load in plasma or serum in the pretreatment evaluation for antiviral therapy of a patient with chronic HCV hepatitis - where any request for the test is made by or on the advice of the specialist or consultant physician who manages the treatment of the patient with chronic HCV hepatitis (including a service in item 69444 or 69445) - not exceeding 1 episode in a 12 month period (Item is subject to rule 20) **Fee:** $176.00	**Benefit:** 75% = $132.00	85% = $149.60

† 69443	Nucleic acid amplification and determination of hepatitis C virus (HCV) genotype provided: (a) the patient is HCV RNA positive; and (b) the patient is being evaluated for antiviral therapy of chronic HCV hepatitis; where any request for the test is made by or on the advice of the specialist or consultant physician who manages the treatment of the patient with chronic HCV hepatitis - not exceeding 1 episode **Fee:** $200.00 **Benefit:** 75% = $150.00 85% = $170.00
69444	Detection of Hepatitis C viral RNA if at least 1 of the following criteria is satisfied: (a) the patient is Hepatitis C seropositive and has normal liver function tests on 2 occasions at least 6 months apart; (b) the patient's serological status is uncertain after testing; (c) the test is performed for the purpose of: (i) determining the Hepatitis C status of an immunosuppressed or immunocompromised patient; or (ii) the detection of acute Hepatitis C prior to seroconversion where considered necessary for the clinical management of the patient; not exceeding 1 episode in a 12 month period (Item is subject to rule 20) **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50
† 69445	Detection of Hepatitis C viral RNA in a patient undertaking antiviral therapy for chronic HCV hepatitis (including a service described in item 69444) - not exceeding 4 episodes in a 12 month period (Item is subject to rule 20) **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50
69447	Investigation for acute or chronic Hepatitis D in a patient with a positive Hepatitis B surface antigen test using: Hepatitis D antibody test (Item is subject to rule 12) **Fee:** $15.30 **Benefit:** 75% = $11.50 85% = $13.05
69450	Determination of immune status to Hepatitis A and Hepatitis B, including: (a) Hepatitis A IgG antibody test; and (b) Hepatitis B core antibody test or Hepatitis B surface antibody test (Item is subject to rule 12) **Fee:** $27.15 **Benefit:** 75% = $20.40 85% = $23.10
69453	Investigation for chronic viral hepatitis, or Hepatitis B or Hepatitis C carriage, including: (a) Hepatitis B surface antigen test; and (b) Hepatitis C antibody test (Item is subject to rule 12) **Fee:** $28.55 **Benefit:** 75% = $21.45 85% = $24.30
69456	Investigation for chronic viral hepatitis, or Hepatitis B or Hepatitis C carriage, if Hepatitis B surface antigen test is positive, including: (a) Hepatitis C antibody test; and (b) Hepatitis B surface antigen test; and (c) Hepatitis B e antigen test (Item is subject to rule 12) **Fee:** $39.55 **Benefit:** 75% = $29.70 85% = $33.65
69459	Investigation for acute Hepatitis A, Hepatitis B, Hepatitis C and Hepatitis D in a patient with a currently elevated transaminase level, including: (a) Hepatitis A IgM antibody test; and (b) Hepatitis C antibody test; and (c) Hepatitis B surface antigen test; and (d) Hepatitis B core antibody test; and (e) (if performed) Hepatitis B e antibody test (if Hepatitis B surface antigen test is negative and Hepatitis B core antibody test is positive); and (f) (if performed) Hepatitis D antibody test (if Hepatitis B surface antigen test is positive) (Item is subject to rule 12) **Fee:** $50.55 **Benefit:** 75% = $37.95 85% = $43.00
‡ 69462	Determination of Hepatitis B status and testing for Hepatitis C, including: (a) Hepatitis C antibody test; and (b) Hepatitis B core antibody test and if this is positive; (c) Hepatitis B surface antigen test (Item is subject to rule 12) **Fee:** $39.55 **Benefit:** 75% = $29.70 85% = $33.65

69465	Syphilis serology and any 1 of items 69435, 69438 or 69453 (Item is subject to rule 12) **Fee:** $38.15	**Benefit:** 75% = $28.65	85% = $32.45
69468	Investigation for acute Hepatitis A and Hepatitis C in a patient with a currently elevated transaminase level, including: (a) Hepatitis A IgM antibody test; and (b) Hepatitis C antibody test (Item subject to rule 12) **Fee:** $30.20	**Benefit:** 75% = $22.65	85% = $25.70
69471	Test of cell mediated immunity in blood for the detection of active tuberculosis or atypical mycobacterial infection in an immunosuppressed or immunocompromised patient - 1 test **Fee:** $34.10	**Benefit:** 75% = $25.60	85% = $29.00
	GROUP P4 - IMMUNOLOGY		
71057	Electrophoresis, quantitative and qualitative, of serum, urine or other body fluid all collected within a 28 day period, to demonstrate: (a) protein classes; or (b) presence and amount of paraprotein; including the preliminary quantitation of total protein, albumin and globulin - 1 specimen type **Fee:** $35.20	**Benefit:** 75% = $26.40	85% = $29.95
71058	Examination as described in item 71057 of 2 or more specimen types **Fee:** $49.85	**Benefit:** 75% = $37.40	85% = $42.40
‡ 71059	Electrophoresis and immunofixation or immunoelectrophoresis or isoelectric focussing of: (a) urine for detection of Bence Jones proteins; or (b) serum, plasma or other body fluid; and characterisation, if detected, of a paraprotein or cryoglobulin not previously characterised - examination of 1 specimen type (eg. serum, urine or CSF) **Fee:** $28.80	**Benefit:** 75% = $21.60	85% = $24.50
71060	Examination as described in item 71059 of 2 or more specimen types **Fee:** $43.45	**Benefit:** 75% = $32.60	85% = $36.95
71062	Electrophoresis and immunofixation or immuno electrophoresis or isoelectric focussing of CSF for the detection of oligoclonal bands and including if required electrophoresis of the patient's serum for comparison purposes - 1 or more tests **Fee:** $43.45	**Benefit:** 75% = $32.60	85% = $36.95
71064	Detection and quantitation of cryoglobulins or cryofibrinogen - 1 or more tests **Fee:** $20.45	**Benefit:** 75% = $15.35	85% = $17.40
71067	Quantitation of total immunoglobulins A, G, M or D by any method in serum, urine or other body fluid - 1 test **Fee:** $14.85	**Benefit:** 75% = $11.15	85% = $12.65
71069	2 tests described in item 71067 **Fee:** $23.45	**Benefit:** 75% = $17.60	85% = $19.95
71071	3 or more tests described in item 71067 **Fee:** $32.05	**Benefit:** 75% = $24.05	85% = $27.25
71073	Quantitation of all 4 immunoglobulin G subclasses - each patient episode **Fee:** $104.75	**Benefit:** 75% = $78.60	85% = $89.05
71075	Quantitation of immunoglobulin E (total), with a maximum of 2 patient episodes in any 12 month period - each patient episode **Fee:** $26.70	**Benefit:** 75% = $20.05	85% = $22.70
71077	Quantitation of immunoglobulin E (total) in the follow up of a patient with proven immunoglobulin-E-secreting myeloma, proven congenital immunodeficiency or proven allergic bronchopulmonary aspergillosis, with a maximum of 6 patient episodes in a 12 month period - each patient episode **Fee:** $26.70	**Benefit:** 75% = $20.05	85% = $22.70
71079	Detection of specific immunoglobulin G or E antibodies to single or multiple potential allergens, with a maximum of 4 patient episodes in a 12 month period - each patient episode **Fee:** $26.50	**Benefit:** 75% = $19.90	85% = $22.55
71081	Quantitation of total haemolytic complement **Fee:** $40.00	**Benefit:** 75% = $30.00	85% = $34.00

71083	Quantitation of complement components C3 and C4 or properdin factor B - 1 test **Fee:** $19.90 **Benefit:** 75% = $14.95 85% = $16.95
71085	2 tests described in item 71083 **Fee:** $28.55 **Benefit:** 75% = $21.45 85% = $24.30
71087	3 or more tests described in item 71083 **Fee:** $37.20 **Benefit:** 75% = $27.90 85% = $31.65
71089	Quantitation of complement components or breakdown products of complement proteins not elsewhere described in an item in this Schedule - 1 test **Fee:** $28.75 **Benefit:** 75% = $21.60 85% = $24.45
71091	2 tests described in item 71089 **Fee:** $52.10 **Benefit:** 75% = $39.10 85% = $44.30
71093	3 or more tests described in item 71089 **Fee:** $75.45 **Benefit:** 75% = $56.60 85% = $64.15
71095	Quantitation of serum or plasma eosinophil cationic protein, or both, to a maximum of 3 assays in 1 year, for monitoring the response to therapy in corticosteroid treated asthma, in a child aged less than 12 years **Fee:** $40.00 **Benefit:** 75% = $30.00 85% = $34.00
71097	Antinuclear antibodies - detection in serum or other body fluids, including quantitation if required **Fee:** $25.10 **Benefit:** 75% = $18.85 85% = $21.35
71099	Double-stranded DNA antibodies - quantitation by 1 or more methods other than the Crithidia method **Fee:** $26.20 **Benefit:** 75% = $19.65 85% = $22.30
71101	Antibodies to 1 or more extractable nuclear antigens - detection in serum or other body fluids **Fee:** $17.15 **Benefit:** 75% = $12.90 85% = $14.60
71103	Characterisation of an antibody detected in a service described in item 71101 (including that service) **Fee:** $51.35 **Benefit:** 75% = $38.55 85% = $43.65
71106	Rheumatoid factor - detection by any technique in serum or other body fluids, including quantitation if required **Fee:** $11.15 **Benefit:** 75% = $8.40 85% = $9.50
71109	Antibodies to tissue antigens (acetylcholine receptor, adrenal cortex, cardiolipin, glomerular basement membrane, heart, histone, insulin, insulin receptor, intrinsic factor, islet cell, lymphocyte, neuron, neutrophil cytoplasm, ovary, parathyroid, platelet, salivary gland, skeletal muscle, skin basement membrane and intercellular substance, thyroglobulin, thyroid microsome or thyroid stimulating hormone receptor) - detection, including quantitation if required, of 1 antibody **Fee:** $34.10 **Benefit:** 75% = $25.60 85% = $29.00
71113	Detection of 2 antibodies described in item 71109 **Fee:** $46.80 **Benefit:** 75% = $35.10 85% = $39.80
71115	Detection of 3 antibodies described in item 71109 **Fee:** $59.50 **Benefit:** 75% = $44.65 85% = $50.60
71117	Detection of 4 antibodies described in item 71109 **Fee:** $72.20 **Benefit:** 75% = $54.15 85% = $61.40
71119	Antibodies to tissue antigens not elsewhere specified in this Table - detection, including quantitation if required, of 1 antibody **Fee:** $17.10 **Benefit:** 75% = $12.85 85% = $14.55
71121	Detection of 2 antibodies specified in item 71119 **Fee:** $20.50 **Benefit:** 75% = $15.40 85% = $17.45
71123	Detection of 3 antibodies specified in item 71119 **Fee:** $23.90 **Benefit:** 75% = $17.95 85% = $20.35
71125	Detection of 4 or more antibodies specified in item 71119 **Fee:** $27.30 **Benefit:** 75% = $20.50 85% = $23.25

71127	Functional tests for lymphocytes - quantitation other than by microscopy of: (a) proliferation induced by 1 or more mitogens; or (b) proliferation induced by 1 or more antigens; or (c) estimation of 1 or more mixed lymphocyte reactions; including a test described in item 65066 or 65070 (if performed), with a maximum of 2 patient episodes in a 12 month period - each patient episode **Fee:** $174.05 **Benefit:** 75% = $130.55 85% = $147.95
71129	2 tests described in item 71127 **Fee:** $215.00 **Benefit:** 75% = $161.25 85% = $182.75
71131	3 or more tests described in item 71127 **Fee:** $255.95 **Benefit:** 75% = $192.00 85% = $217.60
71135	Quantitation of neutrophil function, comprising at least 2 of the following: (a) chemotaxis; (b) phagocytosis; (c) oxidative metabolism; (d) bactericidal activity; including any test described in item 65066 or 65070 (other than nitroblue tetrazolium reduction slide test), with a maximum of 2 patient episodes in a 12 month period - each patient episode **Fee:** $205.25 **Benefit:** 75% = $153.95 85% = $174.50
71137	Quantitation of cell-mediated immunity by multiple antigen delayed type hypersensitivity intradermal skin testing using a minimum of 7 antigens, with a maximum of 2 patient episodes in a 12 month period - each patient episode **Fee:** $29.85 **Benefit:** 75% = $22.40 85% = $25.40
71139	Characterisation of 3 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations, including a total lymphocyte count by any method, on 1 or more specimens of blood, CSF or serous fluid **Fee:** $102.65 **Benefit:** 75% = $77.00 85% = $87.30
71141	Characterisation of 3 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations on 1 or more disaggregated tissue specimens **Fee:** $194.80 **Benefit:** 75% = $146.10 85% = $165.60
71143	Characterisation of 6 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations for the diagnosis (but not monitoring) of an immunological or haematological malignancy, including a service described in 1 or both of items 71139 and 71141 (if performed), on a specimen of blood, CSF, serous fluid or disaggregated tissue **Fee:** $256.60 **Benefit:** 75% = $192.45 85% = $218.15
71145	Characterisation of 6 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations for the diagnosis (but not monitoring) of an immunological or haematological malignancy, including a service described in 1 or more of items 71139, 71141 and 71143 (if performed), on 2 or more specimens of disaggregated tissues or 1 specimen of disaggregated tissue and 1 or more specimens of blood, CSF or serous fluid **Fee:** $418.95 **Benefit:** 75% = $314.25 85% = $368.05
71147	HLA-B27 typing **Fee:** $40.00 **Benefit:** 75% = $30.00 85% = $34.00
71149	Complete tissue typing for 4 HLA-A and HLA-B Class I antigens (including any separation of leucocytes), including (if performed) a service described in item 71147 **Fee:** $106.85 **Benefit:** 75% = $80.15 85% = $90.85
71151	Tissue typing for HLA-DR, HLA-DP and HLA-DQ Class II antigens (including any separation of leucocytes) - phenotyping or genotyping of 2 or more antigens **Fee:** $117.30 **Benefit:** 75% = $88.00 85% = $99.75
	GROUP P5 - TISSUE PATHOLOGY
72813	Examination of complexity level 2 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 14) **Fee:** $79.00 **Benefit:** 75% = $59.25 85% = $67.15

72816	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen (Item is subject to rule 14) **Fee:** $84.50	**Benefit:** 75% = $63.40	85% = $71.85
72817	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 or more separately identified specimens (Item is subject to rule 14) **Fee:** $94.50	**Benefit:** 75% = $70.90	85% = $80.35
72823	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen (Item is subject to rule 14) **Fee:** $95.00	**Benefit:** 75% = $71.25	85% = $80.75
72824	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 to 4 separately identified specimens (Item is subject to rule 14) **Fee:** $138.00	**Benefit:** 75% = $103.50	85% = $117.30
72825	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 5 or more separately identified specimens (Item is subject to rule 14) **Fee:** $176.00	**Benefit:** 75% = $132.00	85% = $149.60
72830	Examination of complexity level 5 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 14) **Fee:** $160.00	**Benefit:** 75% = $120.00	85% = $136.00
72836	Examination of complexity level 6 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 14) **Fee:** $190.00	**Benefit:** 75% = $142.50	85% = $161.50
72844	Enzyme histochemistry of skeletal muscle for investigation of primary degenerative or metabolic muscle diseases or of muscle abnormalities secondary to disease of the central or peripheral nervous system - 1 or more tests **Fee:** $30.00	**Benefit:** 75% = $22.50	85% = $25.50
72846	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 antibodies (Item is subject to rule 14) **Fee:** $42.00	**Benefit:** 75% = $31.50	85% = $35.70
72847	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4 or more antibodies (Item is subject to rule 14) **Fee:** $56.00	**Benefit:** 75% = $42.00	85% = $47.60
72851	Electron microscopic examination of biopsy material - 1 separately identified specimen (Item is subject to rule 14) **Fee:** $180.00	**Benefit:** 75% = $135.00	85% = $153.00
72852	Electron microscopic examination of biopsy material - 2 or more separately identified specimens (Item is subject to rule 14) **Fee:** $240.00	**Benefit:** 75% = $180.00	85% = $204.00

72855	Intraoperative frozen section diagnosis of biopsy material - 1 separately identified specimen (Item is subject to rule 14) **Fee:** $180.00 **Benefit:** 75% = $135.00 85% = $153.00
72856	Intraoperative frozen section diagnosis of biopsy material - 2 or more separately identified specimens (Item is subject to rule 14) **Fee:** $240.00 **Benefit:** 75% = $180.00 85% = $204.00
	GROUP P6 - CYTOLOGY
73043	Cytology (including serial examinations) of nipple discharge or smears from skin, lip, mouth, nose or anus for detection of precancerous or cancerous changes 1 or more tests **Fee:** $19.80 **Benefit:** 75% = $14.85 85% = $16.85
73045	Cytology (including serial examinations) for malignancy (other than an examination mentioned in item 73053); and including any Group P5 service, if performed on: (a) specimens resulting from washings or brushings from sites not specified in item 73043; or (b) a single specimen of sputum or urine; or (c) 1 or more specimens of other body fluids; 1 or more tests **Fee:** $45.00 **Benefit:** 75% = $33.75 85% = $38.25
73047	Cytology of a series of 3 sputum or urine specimens for malignant cells **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50
73049	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues **Fee:** $65.00 **Benefit:** 75% = $48.75 85% = $55.25
73051	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues if: (a) the aspiration is performed by a recognised pathologist; or (b) a recognised pathologist attends the aspiration and performs cytological examination during the attendance **Fee:** $163.85 **Benefit:** 75% = $122.90 85% = $139.30
73053	Cytology of smears from cervix: (a) for detection of precancerous or cancerous changes in women with no symptoms, signs or recent history suggestive of cervical neoplasia; or (b) due to an unsatisfactory smear taken in the circumstances defined in para (a) above; or (c) if there is inadequate information provided to use item 73055; each examination *(See para PP. of explanatory notes to this Category)* **Fee:** $18.50 **Benefit:** 75% = $13.90 85% = $15.75
73055	Cytology not associated with item 73053, of smears from cervix in association with: (a) the management of previously detected abnormalities including precancerous or cancerous conditions; or (b) the investigation of women with symptoms, signs or recent history suggestive of cervical neoplasia; each test *(See para PP. of explanatory notes to this Category)* **Fee:** $18.50 **Benefit:** 75% = $13.90 85% = $15.75
73057	Cytology of smears from vagina, not associated with item 73053 or 73055 nor to monitor hormone replacement therapy - each test *(See para PP. of explanatory notes to this Category)* **Fee:** $18.50 **Benefit:** 75% = $13.90 85% = $15.75
73059	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049 and 73051 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 antibodies **Fee:** $42.00 **Benefit:** 75% = $31.50 85% = $35.70
73060	Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049 and 73051 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4 or more antibodies **Fee:** $56.00 **Benefit:** 75% = $42.00 85% = $47.60

	GROUP P7 - CYTOGENETICS
73287	Chromosome studies, including preparation, count, karyotyping and identification by banding techniques or fragile X-site determination of 1 or more of any tissue or fluid except blood - 1 or more tests **Fee:** $354.00 **Benefit:** 75% = $265.50 85% = $303.10
73289	Chromosome studies, including preparation, count, karyotyping and identification by banding techniques or fragile X-site determination of blood - 1 or more tests **Fee:** $322.00 **Benefit:** 75% = $241.50 85% = $273.70
	GROUP P8 - INFERTILITY AND PREGNANCY TESTS
73521	Semen examination for presence of spermatozoa or examination of cervical mucus for spermatozoa (Huhner's test) **Fee:** $9.50 **Benefit:** 75% = $7.15 85% = $8.10
73523	Semen examination (other than post-vasectomy semen examination), including: (a) measurement of volume, sperm count and motility; and (b) examination of stained preparations; and (c) morphology; and (if performed) (d) differential count and 1 or more chemical tests; with a maximum of 4 episodes in a 12 month period - each episode **Fee:** $41.20 **Benefit:** 75% = $30.90 85% = $35.05
73525	Sperm antibodies - sperm-penetrating ability 1 or more tests **Fee:** $28.00 **Benefit:** 75% = $21.00 85% = $23.80
73527	Human chorionic gonadotrophin (HCG) - detection in serum or urine by 1 or more methods, including serial dilution (if performed) for diagnosis of pregnancy 1 or more tests **Fee:** $9.90 **Benefit:** 75% = $7.45 85% = $8.45
73529	Human chorionic gonadotrophin (HCG), quantitation in serum by 1 or more methods (except by latex, membrane, strip or other pregnancy test kit) for diagnosis of threatened abortion, or followup of abortion or diagnosis of ectopic pregnancy, including any services performed in item 73527 - 1 test **Fee:** $28.25 **Benefit:** 75% = $21.20 85% = $24.05
	GROUP P9 - SIMPLE BASIC PATHOLOGY TESTS
73801	Semen examination for presence of spermatozoa **Fee:** $6.75 **Benefit:** 75% = $5.10 85% = $5.75
73802	Leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin, haematocrit or erythrocyte count 1 test **Fee:** $4.45 **Benefit:** 75% = $3.35 85% = $3.80
73803	2 tests described in item 73802 **Fee:** $6.20 **Benefit:** 75% = $4.65 85% = $5.30
73804	3 or more tests described in item 73802 **Fee:** $7.95 **Benefit:** 75% = $6.00 85% = $6.80
73805	Microscopy of urine, whether stained or not, or catalase test **Fee:** $4.45 **Benefit:** 75% = $3.35 85% = $3.80
73806	Pregnancy test by 1 or more immunochemical methods **Fee:** $9.90 **Benefit:** 75% = $7.45 85% = $8.45
73807	Microscopy for wet film other than urine, including any relevant stain **Fee:** $6.75 **Benefit:** 75% = $5.10 85% = $5.75
73808	Microscopy of Gram-stained film, including (if performed) a service described in item 73805 or 73807 **Fee:** $8.45 **Benefit:** 75% = $6.35 85% = $7.20
73809	Chemical tests for occult blood in faeces by reagent stick, strip, tablet or similar method **Fee:** $2.30 **Benefit:** 75% = $1.75 85% = $2.00

73810	Microscopy for fungi in skin, hair or nails - 1 or more sites **Fee:** $6.75	**Benefit:** 75% = $5.10	85% = $5.75
73811	Mantoux test **Fee:** $10.95	**Benefit:** 75% = $8.25	85% = $9.35
	GROUP P10 - PATIENT EPISODE INITIATION		
73901	Initiation of a patient episode that consists only of a service described in item 73053, 73055 or 73057 from a person who is not in a recognised hospital or a prescribed laboratory **Fee:** $8.00	**Benefit:** 75% = $6.00	85% = $6.80
73903	Initiation of a patient episode that consists only of 1 or more services described in items 72813, 72816, 72817, 72823, 72824, 72825, 72830 and 72836 from a person who is an in-patient of a hospital other than a recognised hospital **Fee:** $14.30	**Benefit:** 75% = $10.75	85% = $12.20
73905	Initiation of a patient episode that consists only of 1 or more services described in items 72813, 72816, 72817, 72823, 72824, 72825, 72830 and 72836 from a person who is not an in-patient of a private hospital and not a patient of a recognised hospital **Fee:** $8.00	**Benefit:** 75% = $6.00	85% = $6.80
73907	Initiation of a patient episode by collection of a specimen for a service (other than a service described in item 73901, 73903, 73905 or in Group P9) if the specimen is collected in a licensed collection centre **Fee:** $17.15	**Benefit:** 75% = $12.90	85% = $14.60
73909	Initiation of a patient episode by collection of a specimen for a service (other than a service described in item 73901, 73903, 73905 or in Group P9) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person who is an in-patient of a hospital other than a recognised hospital **Fee:** $17.15	**Benefit:** 75% = $12.90	85% = $14.60
73910	Initiation of a patient episode by collection of a specimen for a service (other than a service described in item 73901, 73903 or 73905 or in Group P9) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person in the place where the person was residing **Fee:** $10.50	**Benefit:** 75% = $7.90	85% = $8.95
‡ 73912	Initiation of a patient episode by collection of a specimen for a service (other than a service described in item 73901, 73903 or 73905 or in Group P9) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person in a nursing home or institution **Fee:** $17.15	**Benefit:** 75% = $12.90	85% = $14.60
73913	Initiation of a patient episode by collection of a specimen for a service (other than a service described in item 73901, 73903, 73905 or 73907 or items in Group P9) if the specimen is collected from the person by the person **Fee:** $10.10	**Benefit:** 75% = $7.60	85% = $8.60
73915	Initiation of a patient episode by collection of a specimen for a service (other than a service described in items 73901, 73903 or 73905 or items in Group P9) if the specimen is collected by or on behalf of the treating practitioner **Fee:** $10.10	**Benefit:** 75% = $7.60	85% = $8.60
	GROUP P11 - SPECIMEN REFERRED		
73921	Receipt of a specimen by an approved pathology practitioner of an approved pathology authority from another approved pathology practitioner of a different approved pathology authority or another approved pathology authority (Item is subject to subrule 15(9) and 17(3)) **Fee:** $10.50	**Benefit:** 75% = $7.90	85% = $8.95

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PATHOLOGY SERVICES

(ABBREVIATIONS)

Abnormal haemoglobins	AH	65117
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Hormones - oestradiol	E2	66695
Hormones - oestriol	E3	66740, 66746
Hormones - oestrone	E1	66695
Hormones - parathyroid hormone	PTH	66695
Hormones - pentagastrin	PSTR	66689
Hormones - progesterone	PROG	66695
Hormones - prolactin	PROL	66695
Hormones - renin	REN	66695
Hormones - sex hormone binding globulin	SHBG	66695

Hormones - somatomedin	SOMA	66695
Hormones - suppression by dexamethasone or glucose	GHSG	66686
Hormones - testosterone	TES	66695
Hormones - urine steroid fraction or fractions	USF	66695
Hormones - vasoactive intestinal peptide	VIP	66695
Hormones - vasopressin	ADH	66695
Hormones & hormone binding proteins (see individual hormones and proteins)		66695
Huhner's test	HT	73521
Human chorionic gonadotrophin - quantitation	HCG	66650-53, 66740, 73529
Human chorionic gonadotrophin – detection for pregnancy diagnosis	HCGP	73527, 73529
Human placental lactogen	HPL	66746
HVA (homovanillic acid)	HVA	66779
Hydatid - microbial antibody testing	HYD	69384
Hydroxy methoxy phenylethylene glycol	HMPG	66779
Hydroxy-3-methoxymandelic acid, previously known as VMA)	HMMA	66779
Hydroxychloroquine	HOCQ	66611
Hydroxyindoleacetic acid	HIAA	66779
Hydroxyprogesterone	OHP	66695
Hydroxyproline	HYDP	66752
Imipramine	IMIP	66611
Immediate frozen section diagnosis of biopsy material	FS	72855-56
Immunocyto. 1-3 antibodies	ICC	73059
Immunocyto. 4+ antibodies	ICC1	73060
Immunoelectrophoresis and electrophoresis – characterisation of cryoglobulins	RYO	71059
Immunoelectrophoresis and electrophoresis – characterisation of paraprotein	PPRO	71059
Immunoglobulins - A	IGA	71067
Immunoglobulins - D	IGD	71067
Immunoglobulins - E (total)	IGE	71075-79
Immunoglobulins - G	IGG	71067
Immunoglobulins - G, 4 subclasses	SIGG	71073
Immunoglobulins - M	IGM	71067
Immunohistochemical investigation of biopsy material	HIS	72846-47
Infectious mononucleosis	IM	69384
Influenza A - microbial antibody testing	FLA	69384
Influenza B - microbial antibody testing	FLB	69384
Insulin	INS	66695
Insulin - hypoglycaemia test	INHY	66689
Insulin - tissue antigens - antibodies	AINS	71109
Insulin receptor antibodies - tissue antigens – antibodies	INSA	71109
Intercellular cement substance of skin - tissue antigens - antibodies	ICCS	71109
Intestinal disaccharidases	INTD	66680
Intrinsic factor - tissue antigens - antibodies	AIF	71109
Invest. HepA/HepC	HAC	69468
Iron studies (iron, transferrin & ferritin)	IS	66596
Islet cell - tissue antigens - antibodies	AIC	71109
Isoelectric focussing and electrophoresis – characterisation of cryoglobulins	RYO	71059
Isoelectric focussing and electrophoresis – characterisation of paraprotein	PPRO	71059
Jo-1 - tissue antigens - antibodies	JO1	71119
Keratin - tissue antigens - antibodies	KERA	71119
Kleihauer test	KLEI	65162
Lactate	LACT	66500
Lactate - dehydrogenase	LDH	66500
Lactate - dehydrogenase isoenzymes	LDI	66641
Lamellar body phospholipid	LBPH	66749
Lead	PB	66665
Lecithin/sphingomyelin ratio (amniotic fluid)	LS	66749
Legionella pneumophila - serogroup 1 - microbial antibody testing	LP1	69384
Legionella pneumophila - serogroup 2 - microbial antibody testing	LP2	69384
Leishmaniasis - microbial antibody testing	LEI	69384

Leptospira - microbial antibody testing	LEP	69384
Leucocyte count	WCC	65070
Leucocyte count - 3 surface markers - blood, CSF, serous fluid	LMH3	71139
Leucocyte count - 3 surface markers - tissue	LMT3	71141
Leucocyte count - 6 surface markers - blood, CSF, serous fluid & tissue(s)	LMHT	71145
Leucocyte count - 6 surface markers - blood, CSF, serous fluid or tissue	LM6	71143
Lignocaine	LIGN	66611
Lip - cytology on specimens from	SMCY	73043
Lipase	LIP	66500
Lipid studies (see test groups at para PQ.4)	FATS	66521
Lipoprotein subclasses - electrophoresis	LEPG	66539
Listeria - microbial antibody testing	LIS	69384
Lithium	LI	66611
Liver function tests (see test groups at para PQ.4)	LFT	66515
Liver/kidney microsomes - tissue antigens - antibodies	LKA	71119
Lupus anticoagulant	LUPA	65132-37, 65142
Luteinizing hormone	LH	66695
Lymphocyte - tissue antigens - antibodies	ALY	71109
Lymphocytes - functional tests - 1 test	LF1	71127
Lymphocytes - functional tests - 2 tests	LF2	71129
Lymphocytes - functional tests - 3 tests	LF3	71131
Magnesium	MG	66500
Mammary serum antigen	MSA	66650
Manganese	MN	66669-70
Mantoux test	MANT	73811
Measles - microbial antibody testing	MEA	69384
Mercury	HG	66672-73
Metabolic bone disease	CBMB	66776
Metalbumin detection (Schumm's test)	SCHM	65117
Metanephrines	MNEP	66779
Methadone	MTDN	66611
Methotrexate	MTTA	66611
Methsuximide	MSUX	66611
Metronidazole	MRDZ	66611
Mexiletine (Mexitil)	MEX	66611
Mianserin	MIAS	66611
Microalbumin	MALB	66560
Microbial antibody testing - actinomycetes	ACT	69384
Microbial antibody testing - adenovirus	ADE	69384
Microbial antibody testing - aspergillus	ASP	69384
Microbial antibody testing - avian precipitins (bird fancier's disease)	APP	69384
Microbial antibody testing - Blastomyces	BLM	69384
Microbial antibody testing - Bordetella pertussis	BOR	69384
Microbial antibody testing - Borrelia burgdorferi	BOB	69384
Microbial antibody testing - Brucella	BRU	69384
Microbial antibody testing - Campylobacter jejuni	CAM	69384
Microbial antibody testing - Candida	CAN	69384
Microbial antibody testing - Chlamydia	CHL	69384
Microbial antibody testing - Coccidioides	CCC	69384
Microbial antibody testing - Coxsackie B1-6	COX	69384
Microbial antibody testing - cryptococus	CRY	69384
Microbial antibody testing - cytomegalovirus	CMV	69384
Microbial antibody testing - cytomegalovirus serology in pregnancy	CMVP	69384
Microbial antibody testing - dengue	DEN	69384
Microbial antibody testing - diphtheria	DIP	69384
Microbial antibody testing - echinococcus	ECC	69384
Microbial antibody testing - echo-coxsackie group	ECH	69384
Microbial antibody testing - Entamoeba histolytica	AMO	69384
Microbial antibody testing - Epstein Barr virus	EBV	69384
Microbial antibody testing - fluorescent treponemal antibody - absorption test	FTA	69384

(FTA-ABS)		
Microbial antibody testing - Haemophilus influenzae	HUS	69384
Microbial antibody testing - hepatitis C	HCV	69438
Microbial antibody testing - herpes simplex virus	HPA	69384
Microbial antibody testing - Histoplasma	HIP	69384
Microbial antibody testing - hydatid	HYD	69384
Microbial antibody testing - infectious mononucleosis	IM	69384
Microbial antibody testing - influenza A	FLA	69384
Microbial antibody testing - influenza B	FLB	69384
Microbial antibody testing - Legionella pneumophila - serogroup 1	LP1	69384
Microbial antibody testing - Legionella pneumophila - serogroup 2	LP2	69384
Microbial antibody testing - leishmaniasis	LEI	69384
Microbial antibody testing - Leptospira	LEP	69384
Microbial antibody testing - Listeria	LIS	69384
Microbial antibody testing - measles	MEA	69384
Microbial antibody testing - Micropolyspora faeni	MIC	69384
Microbial antibody testing - mumps	MUM	69384
Microbial antibody testing - Murray Valley encephalitis	MVE	69384
Microbial antibody testing - Mycoplasma pneumoniae	MYC	69384
Microbial antibody testing - Neisseria menigitidis	MEN	69384
Microbial antibody testing - Newcastle disease	NCD	69384
Microbial antibody testing - parainfluenza 1	PF1	69384
Microbial antibody testing - parainfluenza 2	PF2	69384
Microbial antibody testing - parainfluenza 3	PF3	69384
Microbial antibody testing - paratyphi	PTY	69384
Microbial antibody testing - pertussis	PER	69384
Microbial antibody testing - poliomyelitis	PLO	69384
Microbial antibody testing - Proteus OX 19	POX	69384
Microbial antibody testing - Proteus OXK	POK	69384
Microbial antibody testing - Q fever	QFF	69384
Microbial antibody testing - rapid plasma reagin test	RPR	69384
Microbial antibody testing - respiratory syncytial virus	RSV	69384
Microbial antibody testing - Ross River virus	RRV	69384
Microbial antibody testing - rubella	RUB	69384
Microbial antibody testing - Salmonella typhi (H)	SAH	69384
Microbial antibody testing - Salmonella typhi (O)	SAO	69384
Microbial antibody testing - Schistosoma	STO	69384
Microbial antibody testing - streptococcal serology - anti-DNASE B titre	ADNB	69384
Microbial antibody testing - streptococcal serology - anti-streptolysin O titre	ASOT	69384
Microbial antibody testing - Streptococcus pneumoniae	PCC	69384
Microbial antibody testing - tetanus	TET	69384
Microbial antibody testing - Thermoactinomyces vulgaris	THE	69384
Microbial antibody testing - thermopolyspora	TPS	69384
Microbial antibody testing - Toxocara	TOC	69384
Microbial antibody testing - toxoplasma	TOX	69384
Microbial antibody testing - TPHA (Treponema pallidum haemagglutination test)	TPHA	69384
Microbial antibody testing - Treponema pallidum haemagglutination test	TPHA	69384
Microbial antibody testing - trichinosis	TOS	69384
Microbial antibody testing - typhus, Weil-Felix	TYP	69384
Microbial antibody testing - Varicella zoster	VCZ	69384
Microbial antibody testing - VDRL (Venereal Disease Research Laboratory)	VDRL	69384
Microbial antibody testing - Yersinia enterocolitica	YER	69384
Microbial antigen testing - Chlamydia	MCCH	69315, 69369
Microbial antigen testing - Clostridium difficile	CLDT	69363
Microbial antigen testing - group B streptococcus	STB	69372
Microbial antigen testing - Haemophilus influenzae	HI	69372
Microbial antigen testing - herpes simplex virus	HSV	69375
Microbial antigen testing - Neisseria gonorrhoeae	GON	69372
Microbial antigen testing - Neisseria meningitidis	NMG	69372
Microbial antigen testing - respiratory syncytial virus	RSVN	69372

Microbial antigen testing - Streptococcus pneumoniae	SPN	69372
Microbial antigen testing - Varicella zoster	VCZN	69375
Micropolyspora faeni	MIC	69384
Microscopic examination of - faeces for parasites	OCP	69336-42
Microscopy of wet film material other than blood	MWFM	69300
Microscopy & culture of - material from nose, throat, eye or ear	MCSW	69303
Microscopy & culture of - material from skin	MCSK	69309
Microscopy and culture of - postoperative wounds, aspirates of body cavities	MCPO	69321
Microscopy & culture of - superficial sites	MCSS	69306
Microscopy & culture of - urethra, vagina, cervix or rectum	MCGR	69312
Microscopy & culture of - specimens of sputum	MCSP	69318
Microscopy & culture of - specimens of sputum, urine or other body fluids for mycobacteria 1 specimen	AFB1	69324
Microscopy & culture of - specimens of sputum, urine or other body fluids for mycobacteria 2 specimens	AFB2	69327
Microscopy & culture of - specimens of sputum, urine or other body fluids for mycobacteria 3 specimens	AFB3	69330
Microscopy & culture to detect pathogenic micro-organisms including chlamydia	MCCH	69315
Microscopy, culture, identification & sensitivity of urine	UMCS	69333
Mitochondria - tissue antigens - antibodies	MA	71119
Mouth - cytology on specimens from	SMCY	73043
Mumps - microbial antibody testing	MUM	69384
Murray Valley encephalitis - microbial antibody testing	MVE	69384
Mycobacteria microscopy & culture of sputum - 1 specimen	AFB1	69324
Mycobacteria microscopy & culture of sputum - 2 specimens	AFB2	69327
Mycobacteria microscopy & culture of sputum - 3 specimens	AFB3	69330
Mycoplasma pneumoniae - microbial antibody testing	MYC	69384
Myoglobin	MYOG	66518
N-acetyl procainamide	NAPC	66611
Neisseria gonorrhoeae by NAA techniques and chlamydia by any method	CHGO	69370
Neisseria gonorrhoeae - microbial antigen testing	GON	69372
Neisseria menigitidis - antigens	NMG	69372
Neisseria menigitidis - microbial antibody testing	MEN	69384
Neisseria menigitidis - microbial antigen testing	NMG	69372
Neural tube defects and Down's syndrome (see test groups at para PQ.4)	NTDD	66740
Neuron - tissue antigens - antibodies	ANE	71109
Neutrophil cytoplasm - tissue antigens - antibodies	ANCA	71109
Neutrophil functions	NFT	71135
Newcastle disease - microbial antibody testing	NCD	69384
Nickel	NI	66672-73
Nipple discharge - cytology on specimens from	SMCY	73043
Nitrazepam	NITR	66611
Nordothiepin	NDIP	66611
Norfluoxetine	NFLE	66611
Nortriptyline	NORT	66611
Nose - cytology on specimens from	SMCY	73043
Nose - microscopy & culture of material from	MCSW	69303
Nuclear antigens - detection of antibodies to	ANA	71097
Oestradiol	E2	66695
Oestriol	E3	66740, 66746
Oestrone	E1	66695
Oligoclonal proteins	OGP	71062
Op/biopsy specimens - microscopy & culture of material from	MCPO	69321
Oral glucose challenge test - gestational diabetes	OGCT	66545
Oral glucose tolerance test - gestational diabetes	GTTP	66542
Osmolality, serum or urine	OSML	66563
Ovary - tissue antigens - antibodies	AOV	71109
Oxalate	OXAL	66752
Oxazepam	OXAZ	66611
PAA (phenyl acetic acid)	PAA	66779

Palmitic acid in amniotic fluid	PALM	66749
Pap smear	CCR	73053
Papanicolaou test	CCR	73053
Paracetamol	PARA	66611
Parainfluenza 1 - microbial antibody testing	PF1	69384
Parainfluenza 2 - microbial antibody testing	PF2	69384
Parainfluenza 3 - microbial antibody testing	PF3	69384
Paraprotein characterisation - by electrophoresis, and immunoelectrophoresis or immunofixation or isoelectric focussing	PPRO	71059
Paraprotein quantitation - by electrophoresis	EPPI	71057
Paraprotein characterisation - on concurrently collected serum or urine	PPSU	71060
Paraquat	PARQ	66611
Parasites - microscopic examination of faeces	OCP	69336-42
Parathyroid - tissue antigens - antibodies	PTHA	71109
Parathyroid hormone (PTH)	PTH	66695
Paratyphi - microbial antibody testing	PTY	69384
Partial thromboplastin time	PTT	65120
Patient episode initiation fees	PEI	73901-15
Pentagastrin	PSTR	66689
Pentobarbitone	PENT	66611
Perhexiline	PHEX	66611
Pertussis - microbial antibody testing	PER	69384
Phenobarbitone	PHBA	66611
Phensuximide	PHEN	66611
Phenylacetic acid	PAA	66779
Phenytoin	PHEY	66611
Phosphate	PHOS	66500
Phosphatidylglycerol	PTGL	66749
Plasminogen	PLAS	65139
Platelet - tissue antigens - antibodies	APA	71109
Platelet - aggregation	PLTG	65144
Platelet - count	PLTC	65070
PM-Sc1 - tissue antigens - antibodies	PM1	71119
Poliomyelitis - microbial antibody testing	PLO	69384
Porphobilinogen in urine	UPG	66782
Porphyrins - quantitative test, 1 or more fractions	PR	66785
Porphyrins in urine - qualitative test	UPR	66782
Potassium	K	66500
Prealbumin	PALB	66632
Prednisolone	PRED	66611
Pregnancy serology - 1 test	MSP1	69405
Pregnancy serology - 2 tests	MSP2	69408
Pregnancy serology - 3 tests	MSP3	69411
Pregnancy testing		73806
Pregnancy testing – HCG detection	HCGP	73527,73529
Pregnancy testing - diagnosis of Down's syndrome and neural tube defect (see tests groups at para PQ.4)	NTDD	66740
Pregnancy testing – HCG quantitation	HCG	73529
Primidone	PRIM	66611
Procainamide	PCAM	66611
Progesterone	PROG	66695
Prolactin	PROL	66695
Prominal	PROM	66611
Propranolol	PPNO	66611
Prostate specific antigen	PSA	66656
Prostatic acid phosphatase	ACP	66656
Protein C	PROC	65132-36, 65142, 65171
Protein S	PROS	65132-36,

		65142, 65171
Protein, quantitation of - alpha fetoprotein	AFP	66650-53, 66740, 66743
Protein, quantitation of - alpha-1-antitrypsin	AAT	66635
Protein, quantitation of - beta-2-microglobulin	BMIC	66629
Protein, quantitation of - caeruloplasmin	CPLS	66632
Protein, quantitation of - C-1 esterase inhibitor	CEI	66644
Protein, quantitation of - classes or presence and amount of paraprotein by electrophoresis	EPPI	71057
Protein, quantitation of - ferritin (see also Iron studies)	FERR	66593
Protein, quantitation of - for Down's syndrome/neural tube defect testing	NTDD	66740
Protein, quantitation of - haptoglobins	HGLB	66632
Protein, quantitation of - microalbumin	MALB	66560
Protein, total - quantitation of	PROT	66500
Proteus OX 19 - microbial antibody testing	POX	69384
Proteus OXK - microbial antibody testing	POK	69384
Prothrombin gene mutation	PGM	65168, 65174
Prothrombin time	PT	65120
Pyruvate	PVTE	66500
Q fever - microbial antibody testing	QFF	69384
Quinalbarb	QUIB	66611
Quinidine	QUIN	66611
Quinine	QNN	66611
Rapid plasma reagin test - microbial antibody testing	RPR	69384
RAST	RAST	71079
Rectum - microscopy & culture of material from	MCGR	69312
Rectum - microscopy & culture of material from	MCCH	69315
Red blood cells - Kleihauer	KLEI	65162
Red cell folate & serum B12	B12F	66602
Red cell folate & serum B12 & serum folate if required	B12F	66602
Red cell folate and serum folate	RCF	66599
Red cell porphyrins - qualitative test	RCP	66782
Referred specimen fee		73921
Renin	REN	66695
Reptilase test	REPT	65120
Respiratory syncytial virus - microbial antibody testing	RSV	69384
Respiratory syncytial virus - microbial antigen testing	RSVN	69372
Reticulin – tissue antigens - antibodies	RCA	71119
Reticulocyte count	RETC	65072
Rheumatoid factor	RF	71106
Rheumatoid factor - quantitation	RFQ	71106
Ross River virus - microbial antibody testing	RRV	69384
RSV (respiratory syncytial virus) - microbial antibody testing	RSV	69384
RSV (respiratory syncytial virus) - microbial antigen testing	RSVN	69372
Rubella – serology	RUB	69384
Salicylate (aspirin)	SALI	66611
Salivary gland - tissue antigens - antibodies	ASG	71109
Salmonella typhi (H) - microbial antibody testing	SAH	69384
Salmonella typhi (O) - microbial antibody testing	SAO	69384
Schistosoma - microbial antibody testing	STO	69384
Scl-70 – tissue antigens - antibodies	SCL	71119
Secretin	SSGR	66689
Selenium	SE	66669-70
Semen examination	SEE	73523
Semen examination - for spermatozoa (post vasectomy)	SES	73521
Serology - in pregnancy (see Pregnancy serology)		
Serotonin	5HT	66779
Serum - Bl2	B12	66599
Serum - folate (with Bl2 red cell folate)	B12F	66602
Serum - folate (with Bl2)	B12	66599

Sex hormone binding globulin	SHBG	66695
Skeletal muscle - tissue antigens - antibodies	SLA	71109
Skin - cytology	SMCY	73043
Skin - microscopy & culture of material from	MCSS	69306
Skin - microscopy & culture of material from	MCSK	69309
Skin basement membrane - tissue antigens - antibodies	SKA	71109
Smooth muscle - tissue antigens - antibodies	SMA	71119
Snake venom	HISS	66623
Sodium	NA	66500
Solid tissue or tissues - chemical assays	ENZS	66683
Solid tissue or tissues - cytology of fine needle aspiration	FNCY	73049
Solid tissue or tissues - cytology of fine needle aspiration by, or in presence of pathologist	FNCP	73051
Somatomedin	SOMA	66695
Sotalol	SALL	66611
Specific IgG or IgE antibodies	RAST	71079
Specimen referred fee	73921	
Sperm antibodies	SAB	73525
Sperm antibodies - penetrating ability	SPA	73525
Sputum - cytology (1 specimen)	BFCY	73045
Sputum - cytology (3 specimens)	SPCY	73047
Sputum - for mycobacteria - 1 specimen	AFB1	69324
Sputum - for mycobacteria - 2 specimens	AFB2	69327
Sputum - for mycobacteria - 3 specimens	AFB3	69330
Sputum - microscopy & culture of specimens	MCSP	69318
Stelazine	STEL	66611
Steroid fraction or fractions in urine	USF	66695
Streptococcal serology - anti-DNASE B titre - microbial antibody testing	ADNB	69384
Streptococcal serology - anti-streptolysin O titre - microbial antibody testing	ASOT	69384
Streptococcus - Group B	STB	69372
Streptococcus pneumoniae - CSF antigens	SPN	69372
Streptococcus pneumoniae - microbial antibody testing	PCC	69384
Streptococcus pneumoniae - microbial antigen testing	SPN	69372
Strontium	SR	66672-73
Stypven test	STYP	65120
Sugar water test	SWT	65075
Sulthiame (Ospolot)	SUL	66611
Supplementary testing for Hepatitis C antibodies	HCST	69441
Synacthen stimulation test	SYNS	66689
Syphilis serology (see test groups at para PQ.4)	STS	69387
Syphilis serology with 1 of 69435, 69438 or 69453	SHV	69465
Testosterone	TES	66695
Tetanus - microbial antibody testing	TET	69384
Thalassaemia studies	TS	65078
Theophylline	THEO	66611
Thermoactinomyces vulgaris - microbial antibody testing	THE	69384
Thermopolyspora - microbial antibody testing	TPS	69384
Thiopentone	TOPO	66611
Thioridazine	THIO	66611
Throat - microscopy & culture of material from	MCSW	69303
Thrombin time	TT	65120
Thrombophilia testing – see individual thrombophilia tests		
Thyroglobulin	TGL	66650
Thyroglobulin - tissue antigens - antibodies	ATG	71109
Thyroid function tests (including TSH)	TFT	66719
Thyroid microsome - tissue antigens - antibodies	TMA	71109
Thyroid stimulating hormone (if requested on its own, or as a preliminary test to thyroid function testing)	TSH	66716
Thyroid stimulating hormone (if requested with other hormones referred to in item 66695)	TSH	66722-34

Thyrotrophin releasing hormone test	TRH	66689
Total protein	PROT	66500
Toxocara - microbial antibody testing	TOC	69384
Toxoplasma - microbial antibody testing	TOX	69384
TPHA (Treponema pallidum haemagglutination test) - microbial antibody testing	TPHA	69384
Treponema pallidum haemagglutination test - microbial antibody testing	TPHA	69384
Trichinosis - microbial antibody testing	TOS	69384
Triglycerides	TRIG	66521
Trimipramine	TRIM	66611
Troponin	TROP	66518
Tryptic activity in faeces	TAF	66677
TSH receptor antibody test - tissue antigens - antibodies	TSHA	71109
Tuberculosis	MANT	73811
Tumour markers - CA-125 antigen	C125	66650
Tumour markers - CA-15.3 antigen	CA15	66650
Tumour markers - CA-19.9 antigen	CA19	66650
Tumour markers - carcinoembryonic antigen	CEA	66650
Tumour markers - mammary serum antigen	MSA	66650
Tumour markers - prostate specific antigen	PSA	66656
Tumour markers - prostatic acid phosphatase - 1 or more fractions	ACP	66656
Tumour markers - thyroglobulin	TGL	66650
Typhus, Weil-Felix - microbial antibody testing	TYP	69384
Urate	URAT	66500
Urea	U	66500
Urea, electrolytes, creatinine (see test groups at para PQ.4)	U&E	66515
Urethra - microscopy & culture of material from	MCGR	69312
Urethra - microscopy & culture of material from	MCCH	69315
Urine - acidification test	UAT	66587
Urine - catalase test	UCAT	73805
Urine - cystine (cysteine)	UCYS	66782
Urine - cytology - on 1 specimen	BFCY	73045
Urine - cytology - on 3 specimens	SPCY	73047
Urine - haemoglobin	UHB	66782
Urine - microscopy, culture, identification & sensitivity	UMCS	69333
Urine - porphobilinogen	UPG	66782
Urine - porphyrins - qualitative test	UPR	66782
Urine - steroid fraction or fractions	USF	66695
Urine - urobilinogen	UUB	66782
Vagina - microscopy & culture of material from	MCGR	69312
Vagina - microscopy & culture of material from	MCCH	69315
Vagina - cytology on specimens from	CVO	73057
Valproate (Epilim)	VALP	66611
Vancomycin	VAN	66611
Varicella zoster - microbial antibody testing	VCZ	69384
Varicella zoster - microbial antigen testing	VCZN	69372
Vasoactive intestinal peptide	VIP	66695
Vasopressin	ADH	66695
VDRL (Venereal Disease Research Laboratory) - microbial antibody testing	VDRL	69384
Viscosity of blood or plasma	VISC	65060
Vitamins - B12	B12	66599
Vitamins - D	VITD	66608
Vitamins - folate	RCF	66599
Vitamins - quantitation of A, B1, B2, B3, B6, C or E	VIT	66605
VMA (see HMMA)		
Von Willebrand's factor	VWF	65150
Von Willebrand's factor antigen	VWA	65150
Warfarin	WFR	66611
Yersinia enterocolitica - microbial antibody testing	YER	69384
Zinc	ZN	66667-70

COMPLEXITY LEVELS FOR HISTOPATHOLOGY ITEMS

Specimen Type	Complexity Level
Adrenal resection, neoplasm	5
Adrenal resection, not neoplasm	4
Anus, all specimens not otherwise specified	3
Anus, neoplasm, biopsy	4
Anus, neoplasm, radical resection	6
Appendix	3
Artery, all specimens not otherwise specified	3
Artery, biopsy	4
Bartholin's gland - cyst	3
Bile duct, resection - all specimens	6
Bone, biopsy, currettings or fragments - lesion	5
Bone, biopsy or currettings quantitation - metabolic disease	6
Bone, femoral head	4
Bone, resection, neoplasm - all sites and types	6
Bone marrow, biopsy	4
Bone - all specimens not otherwise specified	4
Brain neoplasm, resection - cerebello-pontine angle	4
Brain or meninges, biopsy - all lesions	5
Brain or meninges, not neoplasm - temporal lobe	6
Brain or meninges, resection - neoplasm (intracranial)	5
Brain or meninges, resection - not neoplasm	4
Branchial cleft, cyst	4
Breast, excision biopsy, guidewire localisation - non-palpable lesion	6
Breast, excision biopsy, or radical resection, malignant neoplasm - all specimen types	6
Breast, incision biopsy or needle biopsy, malignant neoplasm - all specimen types	4
Breast tissue - all specimens not otherwise specified	4
Bronchus, biopsy	4
Carotid body - neoplasm	5
Cholesteatoma	3
Digits, amputation - not traumatic	4
Digits, amputation - traumatic	2
Ear, middle and inner - not cholesteatoma	4
Endocrine neoplasm - not otherwise specified	5
Extremity, amputation or disarticulation - neoplasm	6
Extremity, amputation - not otherwise specified	4
Eye, conjunctiva - biopsy or pterygium	3
Eye, cornea	4
Eye, enucleation or exenteration - all lesions	5
Eye - not otherwise specified	4
Fallopian tube, biopsy	4
Fallopian tube, ectopic pregnancy	4
Fallopian tube, sterilization	2
Fetus with dissection	6
Foreskin - new born	2
Foreskin - not new born	3
Gallbladder	3
Gallbladder and porta hepatis-radical resection	6
Ganglion cyst, all sites	3
Gum or oral mucosa, biopsy	4
Heart valve	4
Heart - not otherwise specified	5

Hernia sac	2
Hydrocele sac	2
Jaw, upper or lower, including bone, radical resection for neoplasm	6
Joint and periarticular tissue, without bone - all specimens	3
Joint tissue, including bone - all specimens	4
Kidney, biopsy including transplant	5
Kidney, nephrectomy transplant	5
Kidney, partial or total nephrectomy or nephroureterectomy - neoplasm	6
Kidney, partial or total nephrectomy - not neoplasm	4
Large bowel (including rectum), biopsy - all sites	4
Large bowel, colostomy - stoma	3
Large bowel (including rectum), polyp	4
Large bowel, segmental resection - colon, not neoplasm	5
Large bowel (including rectum), segmental resection, neoplasm	6
Larynx, biopsy	4
Larynx, partial or total resection	5
Larynx, resection with nodes or pharynx or both	6
Lip, biopsy or wedge resection	4
Liver, hydatid cyst - resection for trauma	4
Liver, total or subtotal hepatectomy	6
Liver - all specimens not otherwise specified	5
Lung, needle or transbronchial biopsy	4
Lung, resection - neoplasm	6
Lung, wedge biopsy	5
Lung segment, lobe or total - not neoplasm	5
Lymph node, biopsy - all sites	4
Lymph nodes, regional resection - all sites	5
Mediastinum mass	5
Muscle, biopsy	5
Nasopharynx or oropharynx, biopsy	4
Nerve, biopsy neuropathy	5
Nerve, neurectomy or removal of neoplasm	4
Nerve - not otherwise specified	3
Nose, mucosal biopsy	4
Nose or sinuses, polyps	3
Odontogenic neoplasm	5
Odontogenic or dental cyst	4
Oesophagus, biopsy	4
Oesophagus, diverticulum	3
Oesophagus, partial or total resection	6
Omentum, biopsy	4
Ovary with or without tube - neoplasm	5
Ovary with or without tube - not neoplasm	4
Pancreas, biopsy	5
Pancreas, cyst	4
Pancreas, subtotal or total with or without splenectomy	6
Parathyroid gland(s)	4
Penisectomy with node dissection	5
Penisectomy - simple	4
Peritoneum, biopsy	4
Pituitary neoplasm	4
Placenta - not third trimester	4
Placenta - third trimester, abnormal pregnancy or delivery	4
Pleura or pericardium, biopsy or tissue	4
Products of conception, spontaneous or missed abortion	4
Products of conception, termination of pregnancy	3

Prostate, radical resection	6
Prostate - all types of specimen not otherwise specified	4
Retroperitoneum, neoplasm	5
Salivary gland, Mucocele	3
Salivary gland, neoplasm - all sites	5
Salivary gland - all specimens not otherwise specified	4
Sinus, front nasal, ethmoidectomy	6
Sinus, paranasal, biopsy	4
Sinus, paranasal, resection - neoplasm	5
Skin, biopsy - blistering skin diseases	5
Skin, biopsy - inflammatory dermatosis	5
Skin,eyelid, wedge resection	4
Skin, local resection - orientation or margins, at least 5cm long	4
Skin, resection of malignant melanoma with full evaluation including measurement of Breslow thickness and Clark level	5
Skin - all specimens not otherwise specified including all neoplasms and cysts	3
Small bowel, diverticulum	3
Small bowel, resection - neoplasm	6
Small bowel - all specimens not otherwise specified	4
Soft tissue, extensive resection at least 5cm long - neoplasm	6
Soft tissue, lipoma and variants	3
Soft tissue, neoplasm, not lipoma - all specimens	5
Soft tissue - not otherwise specified	4
Spleen	5
Stomach, endoscopic biopsy or endoscopic polypectomy	4
Stomach, resection, neoplasm - all specimens	6
Stomach - all specimens not otherwise specified	4
Tendon or tendon sheath, giant cell neoplasm	4
Tendon or tendon sheath - not otherwise specified	3
Testis, biopsy	5
Testis and adjacent structures, castration	2
Testis and adjacent structures, neoplasm with or without nodes	5
Testis and adjacent structures, vas deferens sterilization	2
Testis and adjacent structures - not otherwise specified	3
Thymus - not otherwise specified	5
Thyroglossal duct - all lesions	4
Thyroid - all specimens	5
Tissue or organ not otherwise specified, abscess	3
Tissue or organ not otherwise specified, haematoma	3
Tissue or organ not otherwise specified, malignant neoplasm with regional nodes	6
Tissue or organ not otherwise specified, neoplasm local	4
Tissue or organ not otherwise specified, pilonidal cyst or sinus	3
Tissue or organ not otherwise specified, thrombus or embolus	3
Tissue or organ not otherwise specified, veins varicosity	3
Tissue or organ - all specimens not otherwise specified	3
Tongue, biopsy	4
Tongue or tonsil, neoplasm local	5
Tongue or tonsil, neoplasm with nodes	6
Tonsil, biopsy - excluding resection of whole organ	4
Tonsil or adenoids or both	2
Trachea, biopsy	4
Ureter, biopsy	4
Ureter, resection	5
Urethra, biopsy	4
Urethra, resection	5
Urinary bladder, partial or total with or without prostatectomy	6

Urinary bladder, transurethral resection of neoplasm	5
Urinary bladder - all specimens not otherwise specified	4
Uterus, cervix, curettings or biopsy	4
Uterus, cervix cone, biopsy (including LLETZ or LEEP biopsy)	5
Uterus, endocervix, polyp	3
Uterus, endometrium, polyp	3
Uterus with or without adnexa, malignant neoplasm - all specimen types not otherwise specified	5
Uterus with or without adnexa, neoplasm, Wertheim's or pelvic clearance	6
Uterus and/or cervix - all specimens not otherwise specified	4
Vagina, biopsy	4
Vagina, radical resection	6
Vaginal mucosa, incidental	3
Vulva or labia, biopsy	4
Vulval, subtotal or total with or without nodes	6