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)**
  - **Relative Value Guide (within Category 3) – (teal 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 AAssist.≅ 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

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

General Fee Increase
The following changes to Medicare schedule fees will apply from 1 November 2001:

- no increase in Level A items in Group A1 and equivalent attendance items;
- a 4.3% increase applies to Level B items in Group A1 and equivalent attendance items, and items 16500 – 16509, 30003 and 41704;
- a 9.6% increase for level C and D items in Group A1 and equivalent attendance items;
- a 2.5% increase to Groups A5, A14, A15 and all emergency after hours items (1, 2, 601, 602, 97, 98, 697, 698, 448 and 449)
- 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 1.6% increase will apply to all other items except for Diagnostic Imaging and Pathology items; and
- a 1.5% increase applies to items in Group I4 in the Diagnostic Imaging section of the book.

Increase in Maximum Gap Payment
The maximum patient gap between the Schedule fee and the benefits payable for out-of-hospital services increases to $55.60 as at 1 November 2001. The 85% benefit level will apply for all fees up to $370.65, after which, benefits are calculated at the Schedule fee less $55.60

REVIEW OF GENERAL MEDICAL SERVICES

The changes involve the following areas of the Schedule:-

- Incentive items (PIP) (see note below)
- Consultant Physician Attendances (new item, see note below)
- Domiciliary Medication Management Review (DMMR) (see note below)
- Fee increase for other medical practitioners (OMP) after hours emergency services (see note below)
- Enhanced Primary Care explanatory notes (see note below)
- Cardio-Thoracic (see note below)
- Relative Value Guide for Anaesthetics (see note below)
- Brachytherapy for prostate cancer (see note below)
- Sleep studies (see note below)
- Ophthalmology (see note below)
- Oral and Maxillofacial services (see note below)
- Diagnostic Imaging Services (see note below)
- Pathology (see note below)
- Hyperbaric oxygen therapy – amendment to items 13020 and 13025 to limit services to medical conditions as described within the items.
- Management of labour – item 16518 (increase in fee for medical practitioners who need to hand-over the management and delivery of labour because of complications.

NEW INCENTIVE ITEMS (PIP)

A range of new items for cervical screening, diabetes and asthma has been introduced which mirror existing consultation items and will be used to initiate Practice Incentives Program (PIP) payments for doctors who participate in the program. The following item numbers, which include both general practitioner and other non-referred attendances, relate to provision of these services:

- Items 2501, 2503, 2504, 2506, 2507, 2509, 2600, 2603, 2606, 2610, 2613 and 2616 relate to taking of a cervical smear from an unscreened or significantly underscreened woman (see explanatory note A.27 for requirements).
- Items 2517, 2518, 2521, 2522, 2525, 2526, 2620, 2622, 2624, 2631, 2633 and 2635 relate to the completion of an annual diabetes care program (see explanatory note A.28 for requirements)
- Items 2546, 2547, 2552, 2553, 2558, 2559, 2664, 2666, 2668, 2673, 2675 and 2677 relate to the completion of an Asthma 3+ Visit Plan (see explanatory note A.29 for requirements).

NEW DOMICILIARY MEDICATION MANAGEMENT REVIEW (DMMR)
A new Item (Item 900) has been introduced to the Medicare Benefits Schedule (MBS) for GP participation with pharmacists in collaborative Domiciliary Medication Management Review (DMMR) for patients living in the community setting. DMMR is also referred to as Home Medicines Review.

Under DMMR, a GP assesses a patient's medication management needs and following that assessment refers the patient to their preferred community pharmacy. With the patient's consent, the GP provides relevant clinical information that is required for the review. The community pharmacy coordinates the pharmacy component of the DMMR, including an interview with the patient in the patient's home (preferred location for the review).

Following the home interview, the GP discusses the results of the review with the reviewing pharmacist including suggested medication management strategies. The GP then develops a written medication management plan following discussion in a second consultation with the patient. The plan is used as the basis for ongoing monitoring and follow-up of the patient as required.

FEE INCREASE FOR OTHER MEDICAL PRACTITIONERS (OMP) AFTER HOURS EMERGENCY SERVICES
A 50% increase in Schedule fees will apply to Emergency Attendance - After Hours for Other Non-Referred Attendances (items 97, 98, 697 and 698). This is in response to the increase in the fees for Emergency Attendance - After Hours for General Practitioners (items 1, 2, 601, 602), implemented in the 1 May 2001 supplement to the 1 November 2000 MBS, and will to maintain the relativities between the general practitioner and other non-referred attendances as priced in the 1 November 2000 MBS.

CHANGES TO ENHANCED PRIMARY CARE EXPLANATORY NOTES
The notes for guidance have been amended to cover the involvement of a patient's informal or family carer in the EPC Items.

Other additions to the notes provide guidance on involving carers in EPC services (or components thereof) other than as a formal member of a multidisciplinary care team, and on providing reports from EPC services to carers, where appropriate and with the patient's agreement.

Records of health assessments (which must be kept by the medical practitioner) are no longer required to be signed by the patient. Where a componelt of the health assessment is conducted in the patient's home (including by a third party acting under the supervision of the practitioner) the notes make clear that the relevant item for a health assessment in the home should be claimed.

CARDIO-THORACIC
Several changes have been made to the cardio-thoracic area of the Schedule. Two new items (38220 and 38222) have been introduced to cover placement of catheters and injection of opaque material into free coronary grafts or mammary grafts. There have also been some changes to the existing coronary angiography items 38215 and 38218.

RELATIVE VALUE GUIDE FOR ANAESTHETICS
For a trial period of two years commencing 1 November 2001, the Relative Value Guide (RVG) for Anaesthesia has been introduced into the Medicare Benefits Schedule under a cost-neutral framework, as the basis for calculating Medicare benefits for anaesthesia services. These services are listed in Group T10 ***of the Medicare Benefits Schedule.***

The RVG is based on an anaesthetic unit system which reflects both the difficulty of the service and the total time taken for the service.

The RVG groups anaesthesia services within anatomical regions. These items are listed in the MBS under Group T10, Subgroups 1-16 Anaesthesia for radiological and other therapeutic and diagnostic services are grouped

separately under Subgroup 17. Also included in the RVG format are certain additional monitoring and therapeutic services, such as blood pressure monitoring (item 22012) and central vein catheterisation (item 22020) *when performed in association with the administration of anaesthesia*. These services are listed at subgroup 19. The RVG also provides for assistance at anaesthesia under certain circumstances. These items are listed at subgroup 26.

Details of the new arrangements are contained in explanatory note T.10 in Category 3 of the Schedule.

BRACHYTHERAPY FOR PROSTATE CANCER

A range of new items has been introduced for brachytherapy for prostate cancer following a Medical Services Advisory Committee (MSAC) recommendation that public funding should be made available for the procedure under specific circumstances.

Two new items (15338 and 37220) have been included to cover the procedural portion of the service for both the urologists and the radiation oncologists. Two further items (15513 and 15539) have been developed for the radiation oncologists' responsibilities for planning, dosimetry and simulation etc.

SLEEP STUDIES

A number of new and amended items for sleep studies have been introduced into the Schedule in recognition of the unique difference between paediatric and adult sleep studies, in particular, the frequency of which a wider range of underlying conditions are studied in a paediatric facility compared to an adult facility.

Four new items are proposed – two items (12210 and 12215) for children aged 0-12 years old and two items (12213 and 12217) for children aged 13 to 18. These changes also result in minor amendments to the adult sleep studies items (12203 and 12207) making it clear that they are specifically to be used for adults over the age of 18 years.

OPHTHALMOLOGY

The following changes have been made to Ophthalmology items:

- deletion of items 11206 and 11209 and introduction of new items 11204, 11205, 11210 and 11211 to cover electrodiagnostic testing; amendments to items 11222 and 11225 for computerised perimetry; and amendments to item 11240 with the introduction of 11241,11242 and 11243 for measurement of orbital contents.
- amendments to items 42614 and 46215 for clearing obstructions in the nasolacrimal passage and items 42698,42701 and 42702 for clear lens extraction for correction of anisometropia caused by the removal of a cataract in the other eye; and a new item 42771 for cyclodestructive procedures for third or subsequent treatments within a two year period.

ORAL AND MAXILLOFACIAL SERVICES

Various changes have been introduced following further review of oral and maxillofacial services by approved dental practitioners. Twenty-five items have been deleted (52031, 52136-52137, 52150-52156, 52160-52176, 52320, 52432-52434, 52448, 52454, 52470-52478, 53007, 53050, 53066), and three items have been amended in recognition of current practice (items 52035, 53054 and 53060).

CHANGES TO DIAGNOSTIC IMAGING SERVICES

Reporting requirements – a provision has been introduced which means that the report must be included as part of each diagnostic imaging service. Please refer to Section DIA.1 of the explanatory notes for the Diagnostic Imaging Services Table.

Diagnostic imaging services with an anaesthesia component – the anaesthesia formula has been removed from all relevant items. The term 'Anaes' has been inserted into these items to denote them as eligible services for the purposes of attracting an anaesthetic service. Additional items have been identified as eligible services for the purposes of attracting an anaesthesia service. Please refer to Section DIA.7 of the explanatory notes for the Diagnostic Imaging Services Table.

Ultrasound – new rules for the accreditation of medical sonographers have been introduced. Item 55112 has been replaced with three new items, these being 55113, 55114 & 55115. A fee reduction of five percent was applied to all cardiac items on 1 July 2001. Additional subgroup restrictors were applied to items 55116, 55117 and 55118 on 1 July 2001. Twelve vascular ultrasound have been deleted (55240, 55242, 55245,55247, 55250, 55254, 55258, 55260, 55263, 55265, 55268 & 55272). Three new items have been inserted (55292, 55294 & 55296). Please refer to Section DIH of the explanatory notes for the Diagnostic Imaging Services Table.

Computed tomography – a rule has been introduced which excludes the payment of Medicare benefits for computed tomography scans rendered using a hybrid positron emission tomography/computed tomography scanner. A number of items for scans of the spine have been replaced with new items (56220 to 56240) which specify the region of the spine to be scanned. The fees for computed tomography scans of facial bones, paranasal sinuses and the brain have been revised (items 56030, 56036, 56070 & 56076). The fees for the existing spiral angiography items (57350 & 57355) have been revised and

two new spiral angiography items have been inserted (57351 & 57356). Please refer to Section DII of the explanatory notes for the Diagnostic Imaging Services Table.

Diagnostic radiology – item 57936 has been replaced with four new orthopantomography items (57948 to 57957) which require the clinical indication for the referral. Existing items for diagnostic radiology scans of the spine (58112 & 58115) have been revised to refer to specific regions of the spine to be scanned. A new item has been inserted providing for scans of four regions of the spine has been inserted (58108). A restriction has been introduced between items 59903 and 59912, and a new item inserted (55925) for occasions where both these items would have otherwise been claimed. Six cardiac angiography items have been deleted (59900, 59906, 59915, 59918, 59921 & 59924) and the descriptors for items 59903 and 59912 have been adjusted. A new set of items were introduced from 1 July 2001 to cover cardiac angiography services provided on older equipment. Please refer to Section DIJ of the explanatory notes for the Diagnostic Imaging Services Table.

Nuclear medicine – a 1.5 percent fee increase has been applied to all nuclear medicine item fees.

Magnetic resonance imaging – the requirements for eligible providers have been revised and the criteria for eligible equipment have been updated in line with amendments to the eligibility requirements. The limits on the number of scans of the musculoskeletal system have been clarified (subgroups 17, 18, 19 & 21). Please refer to Section DIL of the explanatory notes for the Diagnostic Imaging Services Table.

CHANGES TO PATHOLOGY SERVICES

Three new items have been included in the Pathology Services Table covering investigation of cardiac or skeletal muscle damage (66519) and detection of Epstein Barr Virus (69472 and 69474).

A number of items have been amended as follows:

- Item 66500 (general chemistry) – addition of total cholesterol and triglycerides
- Item 66536 (HDL cholesterol) – removal of restrictions
- Item 69375 (herpes simplex virus, varicella zoster virus or cytomegalovirus) – inclusion of testing by 'nucleic acid amplification technique'
- Item 69443 (HCV genotype) – amended to allow for 1 episode in a 12 month period
- Item 72855 and 72856 (biopsy material) – addition of tissue imprint and smear
- Items 66521 – 66533 (lipids) have been deleted

A number of Rules have been amended as follows:

- Rule 4 (2) – addition of patients undergoing cyclosporin therapy
- Rule 8 – inclusion of an exception for item 66500 to allow for claiming of creatinine ratio when testing another substance in urine
- Rule 9 has been deleted

A number of abbreviations have also been amended or deleted and two new abbreviations for Hepatitis C (quantitation) – THCV and (genotype) – GHCV have been added.

Three new complexity levels for breast have been added – microdochectomy (6); large bowel (including rectum), biopsy, and confirmation or exclusion of Hirschsprung's Disease (5); lymph node – biopsy, for lymphoma or lymphoproliferative disorder (5).

One complexity level has been deleted for sinus, front nasal, ethmoidectomy (6).

SUMMARY OF CHANGES

The 1 November 2001 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following symbols appearing above the item number:-

(a) new item	†
(b) amended description	‡
(c) fee amended	+
(e) item number change	*
(f) addition (Assist.)	A
(g) items attracting an anaesthetic as at 1 November 2001	@

New Items

900 2501 2503 2504 2506 2507 2509 2517 2518 2521 2522 2525 2526 2546
2547 2552 2553 2558 2559 2600 2603 2606 2610 2613 2616 2620 2622 2624
2631 2633 2635 2664 2666 2668 2673 2675 2677 11204 11205 11210 11211 11241
11242 11243 12210 12213 12215 12217 15338 15513 15539 20100 20102 20104 20120 20124
20140 20142 20143 20144 20145 20146 20148 20160 20162 20164 20170 20172 20174 20176
20190 20192 20210 20212 20214 20216 20220 20222 20225 20300 20305 20320 20321 20330
20350 20352 20400 20401 20402 20403 20404 20405 20406 20410 20420 20450 20452 20470
20472 20474 20500 20520 20522 20524 20526 20528 20540 20542 20546 20548 20560 20600
20604 20620 20622 20630 20632 20634 20670 20680 20690 20700 20702 20705 20706 20730
20740 20745 20750 20752 20754 20756 20770 20790 20791 20792 20793 20794 20798 20800
20802 20805 20806 20810 20815 20820 20830 20832 20840 20841 20842 20844 20845 20846
20848 20850 20855 20860 20862 20864 20866 20867 20868 20880 20882 20884 20900 20902
20904 20906 20910 20912 20914 20916 20920 20924 20926 20928 20930 20932 20934 20936
20938 20940 20942 20943 20944 20946 20948 20950 20952 20954 21100 21110 21120 21130
21140 21150 21160 21170 21195 21199 21200 21202 21210 21212 21214 21220 21230 21232
21234 21260 21270 21272 21274 21280 21300 21321 21340 21360 21380 21382 21390 21392
21400 21402 21403 21404 21420 21430 21432 21440 21460 21461 21462 21464 21472 21474
21480 21482 21484 21486 21490 21500 21502 21520 21522 21530 21532 21600 21610 21620
21622 21630 21632 21634 21636 21638 21650 21652 21654 21656 21670 21680 21682 21700
21710 21712 21714 21716 21730 21732 21740 21756 21760 21770 21772 21780 21790 21800
21810 21820 21830 21832 21834 21840 21842 21850 21860 21870 21872 21878 21879 21880
21881 21882 21883 21884 21885 21886 21887 21900 21906 21908 21910 21912 21914 21915
21916 21918 21922 21925 21926 21927 21930 21935 21936 21939 21941 21943 21945 21949
21952 21955 21959 21962 21965 21969 21970 21973 21976 21980 21990 21992 21997 22001
22002 22007 22008 22012 22014 22015 22020 22025 22030 22035 22040 22045 22050 22055
22060 22065 22070 22075 22900 22905 23010 23021 23022 23023 23031 23032 23033 23041
23042 23043 23051 23052 23053 23061 23062 23063 23071 23072 23073 23081 23082 23083
23090 23100 23110 23120 23130 23140 23150 23160 23170 23180 23190 23200 23210 23220
23230 23240 23250 23260 23270 23280 23290 23300 23310 23320 23330 23340 23350 23360
23370 23380 23390 23400 23410 23420 23430 23440 23450 23460 23470 23480 23490 23500
23510 23520 23530 23540 23550 23560 23570 23580 23590 23600 23610 23620 23630 23640
23650 23660 23670 23680 23690 23700 23710 23720 23730 23740 23750 23760 23770 23780
23790 23800 23810 23820 23830 23840 23850 23860 23870 23880 23890 23900 23910 23920
23930 23940 23950 23960 23970 23980 23990 24100 24101 24102 24103 24104 24105 24106
24107 24108 24109 24110 24111 24112 24113 24114 24115 24116 24117 24118 24119 24120
24121 24122 24123 24124 24125 24126 24127 24128 24129 24130 24131 24132 24133 24134
24135 24136 25000 25005 25010 25015 25020 25025 25030 25050 25200 25205 37220 38220
38222 42771 45556 45557 45558 55292 55294 55296 56220 56221 56223 56224 56225 56226
56227 56228 56229 56230 56231 56232 56233 56234 56235 56236 56237 56238 56239 56240
57351 57356 57948 57951 57954 57957 58108 66519 69472 69474

Deleted Items

11206 11209 13600 13603 13604 13606 13609 13612 17503 17506 17701 17702 17703 17704
17705 17706 17707 17708 17709 17710 17711 17712 17713 17714 17715 17716 17717 17718
17719 17720 17721 17722 17723 17724 17725 17726 17727 17728 17729 17730 17731 17732
17733 17734 17735 17736 17737 17738 17739 17740 17741 17742 17743 17744 17745 17746
17747 17748 17749 17750 17751 17752 17753 17754 17755 17756 17757 17758 17759 17760
17761 17762 17763 17764 17765 17766 17767 17768 17769 17770 17771 17772 17773 17774
17775 17776 17777 17778 17779 17780 17781 17782 17783 17784 17785 17786 17787 17788
17789 17790 17791 17792 17793 17794 17795 17796 17797 17798 17799 17800 17805 17810
17965 17968 17970 17974 17977 17980 17983 17986 17989 17992 17995 17998 18001 18004

18007	18010	18013	18016	18019	18021	18022	18026	18027	18030	18031	18032	18033	18035
18102	18103	18105	18109	18113	18118	18119	18206	18209	18210	18211	18212	45543	45544
52031	52136	52137	52150	52152	52154	52156	52160	52166	52168	52170	52172	52174	52176
52320	52432	52434	52448	52454	52470	52476	52478						

53007	53050	53066	55240	55242	55245	55247	55250	55254	55258	55260	55263	55265	55268
55272	56210	56216	56250	56256	57936	66521	66524	66527	66530	66533			

Amended Description

11222	11225	11240	12203	12207	13020	13025	36654	36656	38215	38218	42614	42615	42698
42701	42702	51300	51303	51800	51803	52035	53054	53060	55028	55030	55032	55036	55038
55044	55048	55070	55076	55238	55244	55246	55248	55252	55256	55262	55264	55266	55270
55274	55276	55277	55278	55279	55280	55282	55284	55288	55290	55700	55704	55706	55712
55715	55718	55721	55725	55728	55729	55731	55736	55759	55764	55766	55768	55772	55774
55800	55802	55804	55806	55808	55810	55812	55814	55816	55818	55820	55822	55826	55828
55830	55832	55834	55836	55838	55840	55842	55844	55846	55850	55852	55854	56028	58706
58715	58718	58721	58909	58916	58921	58924	58927	58933	58936	59300	59303	59312	59314
59318	59700	59703	59712	59715	59718	59724	59733	59736	59739	59751	59754	60100	63450
66500	66518	66536	66548	66773	69363	69375	69443	71117	72855	72856	73912		

Fee Amended

97	98	697	698	12203	12207	16518	38215	38218	56030	56036	56070	56076	57350
57355	61302	61303	61306	61307	61310	61313	61314	61316	61317	61320	61328	61340	61348
61352	61353	61356	61360	61361	61364	61368	61369	61372	61373	61376	61381	61383	61384
61386	61387	61389	61390	61393	61397	61401	61402	61405	61409	61413	61417	61421	61425
61426	61429	61430	61433	61434	61437	61438	61441	61442	61445	61446	61449	61450	61453
61454	61457	61458	61461	61462	61465	61469	61473	61480	61484	61485	61495	61499	

Addition/Deletion (Assist.)

30439

Item Number Change

Old	New	Old	New
45543	45556	45544	45558

Items attracting an anaesthetic from 1 November 2001

56001	56007	56010	56013	56016	56022	56028	56030	56036	56041	56047	56050	56053	56056
56062	56068	56070	56076	56101	56107	56141	56147	56219	56259	56301	56307	56341	56347
56401	56407	56409	56412	56441	56447	56449	56452	56501	56507	56541	56547	56619	56625
56659	56665	56801	56807	56841	56847	57001	57007	57041	57047	57201	57247	57341	57345
57350	57355	59912	59970	59972	59974	60000	60003	60006	60009	60012	60015	60018	60021
60024	60027	60030	60033	60036	60039	60042	60045	60048	60051	60054	60057	60060	60063
60066	60069	60072	60075	60078	63000	63003	63006	63009	63012	63015	63018	63021	63024
63050	63053	63056	63059	63062	63100	63103	63106	63109	63112	63115	63118	63121	63124
63127	63130	63133	63150	63153	63156	63159	63162	63200	63203	63206	63209	63212	63215
63218	63221	63250	63253	63256	63270	63273	63276	63279	63290	63293	63300	63303	63306
63309	63312	63315	63350	63353	63356	63359	63362	63365	63400	63403	63406	63409	63412
63415	63418	63421	63424	63427	63430	63450	63453	63456	63459	63462	63465	63468	63471
63474	63477	63480	63500	63503	63506	63509	63512	63515	63518	63521	63524	63550	63553
63556	63559	63562	63565	63568	63571	63574	63580	63583	63590	63593	63600	63603	63606
63609	63612	63615	63618	63621	63624	63627	63650	63653	63656	63659	63662	63665	63668
63671	63674	63677	63680	63700	63703	63706	63709	63712	63715	63718	63721	63736	63739
63742	63745	63750	63753	63756	63800	63803	63806	63850	63853	63856	63859	63862	63865
63868	63870	63880	63883	63900	63903	63906	63909	63920	63930	63940	63943	63946	

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 2001 and continues beyond that date, the general rule is that the 1 November 2000 level of fees and benefits would apply.

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 $55.60 (indexed annually) by the patient for any one service where the Schedule fee is charged;
- for professional services rendered while hospital treatment (ie. 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' (ie. the difference between the Medicare rebate and the Schedule fee) payable by a family group or an individual in any one calendar year is $302.30 (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 moratorium; 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 moratorium 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 prescriber 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 132150 (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 PERTH WA 6000	State Headquarters Bank West Tower 108 St. George's Terrace	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 predominantly 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 RACGP College House, 1 Palmerston Crescent, South Melbourne, Victoria, 3205, 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:

Chief Executive Officer
The Royal Australian College of General Practitioners
RACGP House
1 Palmerston Crescent
SOUTH MELBOURNE VIC 3205

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 RACGP House, 1 Palmerston Crescent, South Melbourne, Victoria, 3205.

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, eg "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 ie referrals to the latter are accepted as applying to the former and benefit is not payable at the initial attendance rate for an attendance by a locum-tenens if the principal has already performed an initial attendance in respect of the particular instrument of referral.

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 (ie 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 (ie. accommodation and nursing care) is provided in a hospital or day hospital facility (other than a public 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 (ie. 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, eg. "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 (eg. 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, eg. 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 (eg 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 practitioner, 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 (ie 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 $55.60 (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" (ie. 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 $302.30 (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 (ie. 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 (ie. 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 T6 (Anaesthetics) items;
(h) All Group T7 (Regional or Field Nerve Block) items;
(i) All Group T8 (Operations) items;
(j) All Group T9 (Assistance at Operations) items.

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

Note 2: See items 2501, 2504, 2507 and 2600, 2603, and 2606 in Group A18 and A19 of Category 1 – Professional Attendances and A.27 in the explanatory notes for Category 1 – Professional Attendances.

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.

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 (eg 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).

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 (eg, 10.30 am and 3.15 pm) 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, 2501 - 2559)

A.5.1 Items 1 to 51 and 193, 195, 601, 602, 2501 - 2559 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.

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, eg 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 ie 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, 448, 449, 601, 602, 697, 698)

A.10.1 Items 1, 2, 97, 98, 448, 449, 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, 448, 449, 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, 448, 449, 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 am or after 1 pm on a Saturday, or at any time other than between 8 am and 8 pm 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, 448, 449, 601, 602, 697 or 698.

A.10.5 Items 449, 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 449, 602 and 698 are the same as those applying to Items 2, 98 and 448.

A.11 Minor Attendance by 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, eg 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; and

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

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

- be satisfied 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; and
- 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 and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment. Where the patient has an informal or family carer, a copy of the report (or relevant extracts) should be offered to the carer, with the patient's agreement.

Note: An informal or family carer is usually a family member who provides support to children or adults who have a disability, mental illness, chronic condition or who are frail aged. Carers can be parents, partners, brothers, sisters, friends or children of any age. Carers may care for a few hours a week, or all day every day. Some carers are eligible for government benefits, while others are employed or have a private income.

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 (including by a third party acting under the supervision of the practitioner) 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, the side effects and interactions of medications 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. Where problems with cognition are suspected clinically, assessment with a recognised tool such as the Folstein Mini Mental State Examination or the Hodkinson Abbreviated Mental Assessment may be appropriate.

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 may 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.

Consultation with patient's carer
Where the patient has a carer, the practitioner may find it useful to consider having the carer present for the health assessment or components thereof (subject to the patient's agreement). The patient's carer may be able to provide useful information on matters such as medication usage and compliance, continence, and physical, psychological and social function. The practitioner may also consider the degree of the patient's reliance on the carer, the capacity of the carer to provide support to the patient, and strategies to improve the patient's independence.

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) management goals with which the patient agrees; and
(c) an assessment of the kinds of treatment, health services and health care that the patient is likely to need; and
(d) 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
(e) arrangements for giving the treatment, services and care referred to in paragraph (b); 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 (and the patient's carer, where appropriate in the practitioner's view and with the patient's agreement) 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, if appropriate and with the patient's agreement, to the patient's carer).

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

The involvement of a patient's carer in a multidisciplinary care team can provide significant benefits in terms of coordination of care for the patient. Where the patient has a carer, the practitioner should consider inviting the carer to be an additional member of the multidisciplinary care plan team, with the patient's agreement and having regard to:

- the patient's circumstances;
- the degree of support provided by the carer for the patient; and
- the capacity of the carer to provide ongoing support to the patient and contribute to the work of the team.

The carer's membership of the team is in addition to the minimum three members.

Where the patient's carer is not a member of the multidisciplinary team, the practitioner should involve the patient's carer and provide information to the carer where appropriate and with the patient's agreement.

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; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dieticians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

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

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

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, taking into account any care and support provided by the patient's carer and the carer's capacity to provide ongoing support. Additional responsibilities should not be assigned to the patient's carer without the carer's agreement. 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) or Divisions of General Practice.
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 in the judgement of the patient's usual medical practitioner there have been significant changes in the patient's clinical condition or in the patient's care support arrangements which have significantly affected their clinical condition 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.
(e) A.21.17 The review of the plan must also include:
(f) discussing the review of the plan with the patient (and the patient's carer, where appropriate); and
(g) recording the patient's agreement to reviewing the plan; and

(h) offering a copy of relevant parts of the revised multidisciplinary care plan (if any) to the patient (and, if appropriate and with the patient's agreement, to the patient's carer), and giving copies to persons who, under the revised plan, will give the patient the treatment, service and care mentioned in the plan.

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 multidisciplinary 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.

Where the patient has a carer, the practitioner should take account of the impact of the tasks identified in the case conference on the capacity of the carer to provide support to the patient. Additional responsibilities should not be assigned to the patient's carer without the carer's agreement.

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 two other members, who participate in the case conference, each of whom provides a different kind of care or service to the patient, and one of whom may be another medical practitioner (normally a specialist or consultant physician).

The involvement of a patient's carer in a multidisciplinary case conference team can provide significant benefits in terms of coordination of care for the patient. Where the patient has a carer, the practitioner should consider inviting the carer to be an

additional member of the multidisciplinary case conference team, with the patient's agreement and where the carer's input is likely to be relevant to the subject matter of the case conference. The carer's membership of the team is in addition to the minimum three members.

Where the patient's carer is not a member of the multidisciplinary team, the practitioner should involve the carer and provide information to the carer where appropriate and with the patient's agreement.

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; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dieticians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

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

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

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 the patient's carer, if appropriate and with the patient's agreement), and giving each other member of the team a summary of the conference; and
(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 ensuring that the following activities are completed and documented in the patient's medical records:
(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 (and the patient's carer, if appropriate and with the patient's agreement) 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 and to the patient's carer, if appropriate and with the patient's agreement.

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 A.24.5 "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 A.24.4 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 A.24.4 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.

A.25 Attendances by Medical Practitioners who are Sports Physicians

A.25.1 Items 444 to 447 relate specifically to attendances rendered by medical practitioners who are holders of the Fellowship of the Australian College of Sport Physicians (FACSP) and who participate in, and meet the requirements for, quality assurance and continuing medical education as required by the ACSP.

A.25.2 Items 444 to 447 cover four categories of 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.25.3 The attendances are divided into four categories relating to the level of complexity, namely:

(i) Level 1
(ii) Level 2
(iii) Level 3
(iv) Level 4

A.25.4 To assist medical practitioners who are sports physicians in selecting the appropriate item number for Medicare benefit purposes the following notes in respect of the various levels are given.

LEVEL 1
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.

LEVEL 2
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 1 and 2 relate not to time but to complexity.

LEVEL 3
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 3 attendance. The words following 'OR' in the items for Levels 2 and 3 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, eg - 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 2 attendance.

LEVEL 4
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 4 attendance.

Recording Clinical Notes
A.25.5 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.25.6 Where, during the course of a single attendance by medical practitioners who are sports physicians, 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).

A.26 Domiciliary Medication Management Reviews

A.26.1 This item is available to people living in the community setting who meet the criteria for DMMR. The item is not available for in-patients of a hospital, day hospital facility, or care recipients in residential aged care facilities. Patients may also refer to DMMR as *Home Medicines Review*.
A.26.2 This item should generally be undertaken by the medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.
A.26.3 DMMR's are targeted at patients who are likely to benefit from such a review, and for whom quality use of medicines may be an issue or who are at risk of medication misadventure because of their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or because of a lack of knowledge and skills to use medicines to their best effect.
A.26.4 A medical practitioner must assess that a DMMR is clinically necessary to ensure quality use of medicines or address patient's needs. Examples of risk factors known to predispose people to medication related adverse events are:

- currently taking 5 or more regular medications;
- taking more than 12 doses of medication per day;
- significant changes made to medication treatment regimen in the last 3 months;
- medication with a narrow therapeutic index or medications requiring therapeutic monitoring;
- symptoms suggestive of an adverse drug reaction;
- sub-optimal response to treatment with medicines;
- suspected non-compliance or inability to manage medication related therapeutic devices;
- patients having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties;
- patients attending a number of different doctors, both general practitioners and specialists; and
- recent discharge from a facility / hospital (in the last 4 weeks).

A.26.5 For item 900 a DMMR includes all DMMR-related services provided by the medical practitioner from the time the patient is identified as potentially needing a medication management review to the preparation of a draft medication management plan, and discussion and agreement with the patient.

- The potential need for a DMMR may be identified either by the medical practitioner in the process of a consultation or by receipt of advice from the patient, a carer or another health professional including a pharmacist.
- The medical practitioner must assess the clinical need for a DMMR from a quality use of medicines perspective with the patient as the focus, and formally initiate a DMMR if appropriate.
- If the DMMR is initiated during the course of a consultation undertaken for another purpose, this consultation may also be claimed separately.
- If the consultation at which the medication management review is initiated is only for the purposes of initiating the review only item 900 should be claimed.
- If the medical practitioner determines that a DMMR is not necessary, item 900 does not apply. In this case, normal consultation items should be used.
- The item covers the consultation at which the results of the medication management review are discussed and the medication management plan agreed with the patient. Any immediate action required to be done at the time of completing the DMMR (eg writing prescriptions or making referrals) should be treated as part of the DMMR item. Any subsequent follow up should be treated as a normal consultation item.
- Practitioners should not conduct a separate consultation in conjunction with completing the DMMR unless it is clinically indicated that a problem must be treated immediately.
- The benefit is not claimable and an account should not be rendered until all components of this item have been rendered (See General Notes 7, Billing Procedures).
- Where a DMMR cannot be completed due to circumstances beyond the control of the medical practitioner (for example, because the patient decides to not proceed further with the DMMR, or because of a change in the circumstances of the patient), the relevant MBS attendance items should be used.

A.26.6 The process of ***referral to a community pharmacy*** includes:

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

A.26.7 The ***discussion of the review findings and report including suggested medication management strategies with the reviewing pharmacist*** includes:

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

A.26.8 Development of ***a written medication management plan following discussion with the patient*** includes:

- Developing a draft medication management plan and discussing this with the patient; and
- Once agreed, offering a copy of the written medication management plan to the patient and providing a copy to the community pharmacist.

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

A.26.9 Benefits for a DMMR service under this item are payable not more than once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (for example, diagnosis of a new condition or recent discharge from hospital involving significant changes in medication). In such cases the patient's invoice or Medicare voucher should be annotated to indicate that the DMMR service was required to be provided within 12 months of another DMMR service.

A.27 Taking a cervical smear from a woman who is unscreened or significantly under-screened (Items 2501 – 2509, 2600 – 2616)

A.27.1 The item numbers 2501, 2503, 2504, 2506, 2507, 2509, 2600, 2603, 2606, 2610, 2613 and 2616 should be used in place of the usual attendance item where as part of a consultation, a medical practitioner takes a cervical smear from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years.

A.27.2 The items apply only to women between the ages of 20 and 69 inclusive who have a cervix, have had intercourse and have not had a cervical smear in the last four years.

A.27.3 When providing this service, the doctor must satisfy themselves that the woman has not had a cervical smear in the last four years by:

- asking the woman if she can remember having a cervical screen in the last four years; and
- checking their own practice's medical records.

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

A.27.4 Women from the following groups are more likely than the general population to be unscreened or significantly under-screened - low socioeconomic status, culturally and linguistically diverse backgrounds, Indigenous communities, rural and remote areas and older women.

A.27.5 Vault smears are not eligible for items 2501 – 2509 and 2600 – 2616.

A.27.6 In addition to attracting a Medicare rebate, the use of these items will initiate a cervical screening incentive payment through the Practice Incentives Program (PIP).

A.27.7 From 1 November 2001, a PIP incentive for taking a cervical screen from women who have not been screened for four years will be paid. This incentive will be paid to the bank account nominated by the medical practitioner who provided the service, in accordance with individual practice arrangements, if the service was provided in a general practice participating in the PIP. The Health Insurance Commission will contact PIP practices to provide information about the incentive and arrange payment details.

A.28 Completion of an annual cycle of care for patients with Diabetes Mellitus (Items 2517 – 2525, 2620 – 2635)

A.28.1 The item numbers 2517, 2518, 2521, 2522, 2525, 2526, and 2620, 2622, 2624, 2631, 2633, 2635, should be used in place of the usual attendance item when a consultation completes the minimum annual requirements of care for a patient with established diabetes mellitus.

A.28.2 The minimum requirements of care are:

Assess diabetes control by measuring HbA_{1c}	• At least once per year
Ensure that a comprehensive eye examination is carried out	• At least once every two years
Measure weight and height and calculate BMI	• At least once every six months
Measure blood pressure	• At least once every six months
Examine feet	• At least once every six months
Measure total cholesterol, triglycerides and HDL cholesterol	• At least once every year
Test for microalbuminuria	• At least once per year
Provide self-care education	• Patient education regarding diabetes management
Review diet	• Reinforce information about appropriate dietary choices
Review levels of physical activity	• Reinforce information about appropriate levels of physical activity
Check smoking status	• Encourage cessation of smoking (if relevant)
Review of Medication	• Medication review

A.28.3 These requirements are based on the general practice guidelines produced by the Royal Australian College of General Practitioners and Diabetes Australia (DA/RACGP, *Diabetes Management in General Practice,* 6th ed., 2000). Doctors using these items should familiarise themselves with these guidelines and with subsequent editions of these guidelines as they become available.

A.28.4 Use of these items certifies that the minimum annual cycle of care has been completed for a patient with established diabetes mellitus in accordance with the guidelines above.

A.28.5 The requirements for claiming this item are the minimum needed to provide good care to a patient with diabetes. Additional levels of care will be needed by insulin-dependent patients and those with abnormal review findings, complications and/or co-morbidities.

A.28.6 In addition to attracting a Medicare rebate, recording an annual completion of care cycle through the use of these items will initiate a diabetes incentive payment through the Practice Incentives Program (PIP).
A.28.7 From November 2001, PIP diabetes incentive payments will be available for completion of an annual cycle of individual patient care. This incentive will only be paid once per year, per patient. The incentive will be paid to the bank account nominated by the medical practitioner who provided the service, in accordance with individual practice arrangements, if the service was provided in a general practice participating in the PIP. A further payment through the PIP for practices reaching target levels of care for their patients with diabetes will be introduced in 2002. More detailed information on these incentives will be provided separately to practices participating in the PIP and will be available from the HIC. The HIC will contact PIP practices to provide information about the incentive and arrange payment details.

A.29 Completion of the Asthma '3+ Visit Plan' (Items 2546 – 2559, 2664 - 2677)

Minimum Requirements

A.29.1 The item numbers 2546, 2547, 2552, 2553, 2558, 2559 and 2664, 2666, 2668, 2673, 2675 and 2677 should be used in place of the usual attendance item when a consultation completes the requirements of the Asthma '3+Visit Plan' for management. At a minimum this must include:

- At least 3 asthma related consultations in the previous 4 weeks (minimum) to 4 months (maximum)for a patient with moderate to severe asthma,
- At least two of these consultations to have been planned recalls,
- Diagnosis and assessment of severity,
- Review of asthma related medication, and
- Provision of written asthma action plan and education of the patient. (If the patient is unable to use a written action plan, alternative patient education may be provided and documented in the medical record.)

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

Assessment of Severity

A.29.2 As a rule of thumb, patients who meet the following criteria can be assumed to have been assessed as having moderate to severe asthma:

- Symptoms on most days, OR
- Use of preventer medication, OR
- Bronchodilator use at least 3 times per week, OR
- Hospital attendance or admission following an acute exacerbation of asthma.

A.29.3 If the rule of thumb does not apply to a particular patient, the classification of severity described by the current edition of the National Asthma Council's *Asthma Management Handbook* can be used. The website address is:

www.NationalAsthma.org.au

Asthma '3+visit plan'

A.29.4 The National Asthma Council recommendations for the '3+visit plan are as follows:

(NOTE: This is provided as a guide only and each case should be addressed on its individual merits)

Visit 1
This will often be a visit at which your patient presents with an unrelated problem and doesn't mention asthma until the end of the consultation.

- Manage the issue that caused asthma to be discussed, eg worsening asthma symptoms, request for a script
- Introduce the concept of a 'contract' for care: the '3+ Visit Plan' and the reasons for review
- If the patient presents solely for an asthma-related problem, or it is clinically appropriate and possible, include the items in Visit 2.
- Give **3+ Visit Plan** handout to patient.

Visit 1 should be billed under the normal attendance items.

Visit 2

- New patient: ascertain status, including history, medication and management.
- Existing patient: assess present situation, including review of medical records and consolidation/collection of information on history, medication and management.
- What do they know and what do they need to know? (knowledge)
- How do they feel about their asthma? (perception)
- What do they want from you, the GP?
- Review medication devices technique.
- Perform physical examination (including spirometry).
- Grade asthma severity and level of control.
- Consider 2 weeks of peak expiratory flow rate (PEFR) recording and charting.
- Is a change in medication required?

Visit 2 should be billed under the normal attendance items.

Visit 3 (approximately 2 weeks later)

- Review patient and his/her PEFR record.
- Perform spirometry (if not already done, or consider redoing).
- Complete written Asthma Action Plan. (Advice on content is available in the current edition of the National Asthma Council's *Asthma Management Handbook*.)
- Further identify trigger factors: consider RAST, skin-prick tests (if not already done).
- Is a change in medication required?
- Check on, reinforce and expand education.

Visit 3 should be billed under the appropriate item listed in Group A18 and Group A19 under Category 1 – Professional Attendances which will initiate the payment of an incentive through the Practice Incentive Program (PIP) in addition to attracting a Medicare rebate.

Visit 4 (approximately 4 weeks later)

- Assess progress.
- Review Asthma Action Plan.
- Discuss results of trigger factor tests (if applicable).
- Check on, reinforce and expand education.

Visit 4 should be billed under the normal attendance items.

Source - National Asthma Council <www.NationalAsthma.org.au>

A.29.5 In addition to attracting a Medicare rebate, recording the completion of the minimum requirements for an Asthma '3+ Visit Plan' through the use of these items will initiate an asthma incentive payment through the Practice Incentive Program (PIP).

A.29.6 From 1 November 2001, PIP Asthma '3+ Visit Plan' incentive payments will be available for providing the minimum requirements of the 3+ Visit Plan as specified in clause A.29.1 above. This incentive will be paid to the bank account nominated by the medical practitioner who provided the service, in accordance with individual practice arrangements, if the service was provided in a general practice participating in the PIP. The Health Insurance Commission will contact PIP practices to provide information about the incentive and arrange payment details.

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 Electroretinography (Items 11204, 11205, 11210, 11211)

D1.3.1 Current professional guidelines and standards for electroretinography, electroculography and pattern retinography are produced by the International Society for Clinical Electrophysiology of Vision (ISCEV).

D1.4 Computerised Perimetry (Items 11222 and 11225)

D1.4.1 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.

D1.4.2 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.)

D1.5 Orbital Contents (Items 11240, 11241, 11242, 11243)

D1.5.1 Where an additional service is necessary items 11242 and 11243 should be utilised.

D1.6 Electrocochleography (Item 11304)

D1.6.1 This item refers to electrochleography with insertion of electrodes through the tympanic membrane.

D1.7 Non-determinate Audiometry (Item 11306)

D1.7.1 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 D1.7.1.

D1.8 Audiology Services (Items 11309 - 11321)

D1.8.1 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 1269.3.1998 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.

D.1.9 Oto-acoustic Emission Audiometry (Item 11332)

D1.9.1 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.

D1.10 Respiratory Function Tests (Item 11503)

D1.10.1 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.

D1.11 Investigations of Vascular Disease (Items 11603-11624)

D1.11.1 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.

D1.12 Twelve-lead Electrocardiography (Item 11700)

D1.12.1 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.

D1.13 Twelve-lead Electrocardiography, Report Only (Item 11701)

D1.13.1 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.

D1.14 Electrocardiographic (ECG) Recording of Ambulatory Patient (Items 11708, 11709)

D1.14.1 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.

D1.14.2 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.

D1.14.3 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.

D1.15 Signal Averaged ECG Recording (Item 11713)

D1.15.1 Benefits are only payable under this item if the ECG data is analysed and reported on by a specialist physician or a consultant physician.

D1.16 Epicutaneous Patch Testing (Items 12012, 12015 & 12018)

D1.16.1 A standard epicutaneous patch test battery refers to the European Standard Series or the International Contact Research Group Standard Series.

D1.17 Investigations for Sleep Apnoea (Items 12203, 12207, 12210, 12213, 12215 and 12217)

D1.17.1 A "qualified adult sleep medicine practitioner" as described in Items 12203 and 12207, a "qualified paediatric sleep medicine practitioner" as described in Items 12210 and 12213 and a "qualified sleep medicine practitioner" as described in Items 12215 and 12217 means:

For practitioners who commence 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 either adult or paediatric 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 either adult or paediatric 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 either Adult or Paediatric 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.

D1.17.2 In relation to paragraph (d) of these items, generally, the patient should be seen in consultation by a qualified sleep medicine practitioner to determine the necessity for the investigation unless the necessity has been clearly established by other means.

D1.17.3 Item 12207 relates to overnight investigation of sleep aponea 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-respiratory failure; and
- previous studies have demonstrated failure of continuous 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)

D1.17.4 – Items 12215 and 12217 relate to overnight investigation for sleep apnoea where a fourth or subsequent investigation becomes necessary in a twelve month period when therapy with Continuous Positive Airway Pressure (CPAP), bilevel pressure support and/or ventilation is instigated or in the presence of recurring hypoxia and supplemental oxygen is required.

D1.17.5 Claims for benefits in respect of items 12207, 12215 and 12217 should be accompanied by clinical details confirming the presence of the conditions set out in D1.17.3 and D1.17.4. 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.)

D1.18 Bone Densitometry (Items 12306 to 12321)

D1.18.1 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.

D1.18.2 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

D1.18.3 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.

D1.18.4 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.

D1.18.5 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.

D1.18.6 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.

D1.18.7 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

D1.18.8 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.

D1.18.9 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.

D1.18.10 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.

D1.18.11 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.

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 monoplace or multiplace chamber for the duration of the hyperbaric treatment.

(b) is supported by:
- at least one specialist with training in Diving and Hyperbaric Medicine, 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 facility during normal working hours;

(c) and is staffed by:
- a registered medical practitioner with training in Diving and Hyperbaric Medicine who is present in the hyperbaric facility and immediately available at all times when patients are undergoing treatment; and
- a registered nurse with specific training in hyperbaric patient care to the published standards of the Hyperbaric Oxygen Facility Industry Guidelines (Draft Australian Standard SF346) who is present during hyperbaric oxygen therapy.

(d) 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 Administration of Blood or Bone Marrow already Collected (Item 13706)

T1.4.1 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.

T1.5 Collection of Blood (Item 13709)

T1.5.1 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.

T1.5.2 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.

T1.6 Intensive Care Units (ICU)

T1.6.1 '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.

T1.6.2 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.

T1.6.3 In respect to T1.6.1(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.

T1.6.4 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.

T1.6.5 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.

T1.6.6 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.

T1.6.7 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.

T1.6.8 Benefits are payable for admissions to an Intensive Care Unit following surgery only where clear clinical justification for post-operative intensive care exists.

T1.7 Procedures Associated with Intensive care (Items 13818, 13842, 13857)

T1.7.1 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.

T1.7.2 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.
T1.7.3 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.
T1.7.4 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.
T1.7.5 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.

T1.8 Management and Procedures in Intensive Care Unit (Items 13870, 13873, 13876)
Items 13870 and 13873
T1.8.1 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.
T1.8.2 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
T1.8.3 Item 13876 covers the monitoring of pressures in an ICU.
T1.8.4 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.
T1.8.5 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.

T1.9 Implanted Pump or Reservoir/Drug Delivery Device (Items 13939 and 13942)
T1.9.1 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.

T1.10 PUVA or UVB Therapy (Items 14050, 14053)
T1.10.1 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.

T1.11 Laser Photocoagulation (Items 14106 - 14132)
T1.11.1 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

T1.11.2 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 (ie 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.

T2.3 Brachytherapy of the Prostate (Item 15338)

T2.3.1 Brachytherapy treatment is only recommended for patients with a gland volume of less than or equal to 40cc and who have a life expectancy of at least 10 years.

T2.3.2 An approved site is one that has been licensed by the relevant Radiation Advisory Body.

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 (ie 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, eg. blood transfusion;
(ii) where the condition of the mother and/or baby is such as to require the services of another practitioner (eg. 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 (ie 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.

ANAESTHETICS (Group T6)

T6.1 Pre-anaesthetic Consultations

T6.1.1 Before a procedure is decided upon, a practitioner may refer a patient to a specialist anaesthetist for a pre-anaesthesia consultation. Such an attendance will attract benefit as follows:-

(i) if, as a result of the consultation, anaesthesia and surgery proceeded in the ordinary way, then Item 17603 applies;
(ii) if, as a result of the consultation, the procedure 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.

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 anaesthesia combines a regional nerve block with general anaesthesia for an operative procedure, benefit will be paid only under the relevant anaesthesia item as set out in Group T10.
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 T10 anaesthesia 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 Maintenance of Regional or Field Nerve Block (Items 18222, 18225)

T7.2.1 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.
T7.2.2 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.

T7.3 Intrathecal or Epidural Injection (Item 18232)

T7.3.1 This items covers caudal infusion/injection.

T7.4 Destruction of Nerve Branch by Neurolytic Agent (18292)

T7.4.1 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, eg. 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, eg. 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, eg. 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, eg. 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, listed in Group T8 (other than Subgroup 12 of that Group), performed on a patient on the one occasion (except as provided in paragraph T8.5.3) 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.

(d) For these purposes the term "operation" only refers to 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 T8.7. 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

Treatment of fracture of (cont.)	After-care Period
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 (eg. 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, eg. both buttocks and both thighs attract benefits under Item 30171 once only, ie 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 and other premalignant skin lesions 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.

8.24 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) - eg. supraomohyoid neck dissection (levels I-III) or lateral neck dissection (levels II-IV).

Item 31429 (removal of 4 lymph node levels) - eg. 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 (eg. 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 Selective Coronary Angiography with placement of catheters, with or without injection into coronary and/or mammary artery grafts (items 38215, 38218, 38220 and 38222)

T8.35.1 Medicare benefits are payable for items 38220 and 38222 where the services are performed as stand alone services or when one or both services are performed in conjunction with either 38215 or 38218.

T8.36 Ureteroscopy (Item 36803)

T8.36.1 Item 36803 refers to ureteroscopy of one ureter when performed for the purpose of inspection alone. It may not be used when one of the other ureteroscopy numbers (Items 36806 or 36809) or pyeloscopy numbers (Items 36652, 36654 or 36656) is used for a ureteroscopic procedure performed in the same ureter or collecting system. It may be used when inspection alone is carried out in one ureter independently from a ureteroscopic or pyeloscopic procedure in another ureter or collecting system. If Item number 36803 is used with one of the other above 5 numbers, it must be specified that item number 36803 refers to ureteroscopy performed in another ureter eg. 36654 (Right side) and 36803 (Left side). 36803 may also be used in this way if there is a partial or complete duplex collecting system eg. 36809 (Lower pole moiety ureter, Left

side) and 36803 (Upper pole moiety ureter, Left side).

T8.36.2 Item numbers 36806 and 36809 may only be used together when 2 independent ureteroscopic procedures are performed in separate ureters. These separate ureters may be components of a complete or partial duplex system. If both these numbers are used together, the Regulations require qualification of these item numbers by the site, as is necessary with 36803 eg. 36806 (Right side) and 36809 (Left side).

T8.37 Brachytherapy of the Prostate (Item 37220)

T8.37.1 Brachytherapy treatment is only recommended for patients with a gland volume of less than or equal to 40cc and who have a life expectancy of at least 10 years.

T8.37.2 An approved site is one that has been licensed by the relevant Radiation Advisory Body.

T8.38 Radical or Debulking Operation for Ovarian Tumour including Omentectomy (Item 35720)

T8.38.1 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.

T8.39 Cardiac Pacemaker Insertion (Items 38209, 38212, 38281, 38284)

T8.39.1 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).

T8.40 Coronary Artery Bypass (Items 38497 - 38503)

T8.40.1 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.

T8.41 Re-operation via Median Sternotomy (Item 38640)

T8.41.1 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.

T8.42 Skull Base Surgery (Items 39640 - 39662)

T8.42.1 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.

T8.42.2 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.

T8.43 Intradiscal Injection of Chymopapain (Item 40336)

T8.43.1 The fee for this item includes routine post-operative care. Associated radiological services attract benefits under the appropriate item in Group I3.

T8.44 Removal of Ventilating Tube from Ear (Item 41500)

T8.44.1 Benefits are not payable under Item 41500 for removal of ventilating tube. This service attracts benefits on an attendance basis.

T8.45 Meatoplasty (Item 41515)

T8.45.1 When this procedure is associated with Item 41530, 41548, 41557, 41560 or 41563 the multiple operation rule applies.

T8.46 Reconstruction of Auditory Canal (Item 41524)

T8.46.1 When associated with Item 41557, 41560 or 41563 the multiple operation rule applies.

T8.47 Removal of Nasal Polyp or Polypi (Items 41662, 41665, 41668)

T8.47.1 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.

T8.48 Larynx, Direct Examination (Item 41846)

T8.48.1 Benefit is not attracted under this item when an anaesthetist examines the larynx during the course of administration of a general anaesthetic.

T8.49 Microlaryngoscopy (Item 41858)

T8.49.1 This item covers the removal of "juvenile papillomata" by mechanical means, eg. cup forceps. Item 41861 refers to the removal by laser surgery.

T8.50 Refractive Keratoplasty (Item 42671)

T8.50.1 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.

T8.51 Capsulectomy or Lensectomy (Items 42731)

T8.51.1 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			

T8.51.2 This list of exclusions was developed following consultation with the Royal Australian College of Ophthalmologists.

T8.52 Cyclodestructive Procedures (Items 42770 and 42771)

T8.52.1 Item 42770 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period item 42771 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 Laser Trabeculoplasty (Items 42782, 42783)

T8.53.1 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.)

T8.54 Laser Iridotomy (Items 42785, 42786)

T8.54 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.)

T8.55 Laser Capsulotomy (Items 42788, 42789)

T8.55 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.)

T8.56 Laser Vitreolysis or Corticolysis of lens material or Fibrinolysis (Items 42791, 42792)

T8.56 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.)

T8.57 Division of Suture by Laser (Item 42794)
T8.57.1 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.

T8.58 Laser Coagulation of Corneal or Scleral Blood Vessels (Item 42797)
T8.58.1 Benefits under this item are restricted to 4 treatments in a 2 year period. There is no provision for additional treatments in that period.
T8.58.2 Benefits are not payable under Item 42797 for procedures undertaken for cosmetic purposes (see paragraph 13.1.2 of the General Explanatory Notes).

T8.59 Readjustment of Adjustable Sutures (Item 42845)
T8.59.1 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.

T8.60 Full Face Chemical Peel (Items 45019, 45020)
T8.60.1 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 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.)

T8.61 Abrasive therapy/Resurfacing (Items 45021 - 45026)
T8.61.1 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.
T8.61.2 Items 45021 and 45024 cover abrasive therapy only. Services performed using a laser are not eligible for benefits under these items.

T8.62 Foreign Implant (Item 45051)
T8.62.1 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.

T8.63 Escharotomy (Item 45054)
T8.63.1 Benefits are payable once only under Item 45054 for each limb (or chest) regardless of the number of incisions to each of these areas.

T8.64 Local Skin Flap - Definition
T8.64.1 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.
T8.64.2 By definition, direct wound closure (eg. 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.
T8.64.3 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.
T8.64.4 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.

T8.64.5 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, 45520, 45522, 45524, 45563, 45587, 45632-45644, 45659, 45662, 45677-45713.

T8.65 Free grafting to burns (Items 45406 - 45418)
T8.65.1 Items 45406 to 45418 cover split skin grafting using autografts, homografts or xenografts.

T8.66 Augmentation Mammaplasty (Items 45524, 45527, 45528)

T8.66.1 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).

T8.66.2 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.)

T8.67 Breast Reconstruction, Myocutaneous Flap (Item 45530)

T8.67.1 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.

T8.67.2 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.

T8.68 Breast Ptosis (Items 45556, 45557 and 45558)

T8.68.1 For the purposes of Item 45556, Medicare benefit is only payable for the correction of breast ptosis when performed unilaterally, to match the position of the contralateral breast. Additional benefit is not payable if this procedure is also performed on the contralateral breast.

T8.68.2 Items 45557 and 45558 apply where correction of breast ptosis is indicated because the nipple is inferior to the infra-mammary groove. Claims for benefits 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.)

T8.69 Nipple and/or Areola Reconstruction (Item 45545, 45546)

T8.69.1 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.

T8.69.2 Item 45546 covers the non-surgical creation of nipple or areola by intradermal colouration.

T8.70 Liposuction (Items 45584, 45585)

T8.70.1 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.

T8.70.2 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.)

T8.71 Meloplasty for Correction of Facial Asymmetry (Items 45587, 45588)

T8.71.1 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.

T8.71.2 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.)

T8.72 Reduction of Eyelids (Items 45617, 45620)

T8.72.1 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.

T8.73 Rhinoplasty (45638, 45639)

T8.73.1 Benefits are payable for septoplasty (Item 41671) where performed in conjunction with rhinoplasty.

T8.73.2 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 (ie 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.)

T8.74 Vermilionectomy (Item 45669)

T8.74.1 Item 45669 covers treatment of the entire lip.

T8.75 Osteotomy of Jaw (Items 45720 - 45752)

T8.75.1 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, eg. iliac crest, would attract additional benefit under Item 47726 or 47729 for the harvesting, plus Item 48239 or 48242 for the grafting.

T8.75.2 For the purposes of these items, a reference to maxilla includes the zygoma.

T8.76 Genioplasty (Items 45761)

T8.76.1 Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

T8.77 Reduction of Dislocation or Fracture

T8.77.1 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.

T8.77.2 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.

T8.77.3 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.

T8.77.4 The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts benefits on an attendance basis.

T8.78 Internal Fixation (Items 48678-48690)

T8.78.1 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.

T8.79 Wrist Surgery (Items 49200-49227)

T8.79.1 For the purposes of these items, the wrist includes both the radiocarpal joint and the midcarpal joint.

T8.80 Joint or other Synovial Cavity, Aspiration of, or Injection into (Items 50124, 50125)

T8.80.1 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.

RELATIVE VALUE GUIDE FOR ANAESTHESIA (Group T10)

For a trial period of two years commencing 1 November 2001, the Relative Value Guide (RVG) for Anaesthesia has been introduced into the Medicare Benefits Schedule under a cost neutral framework, as the basis for calculating Medicare benefits for anaesthesia services. This follows a feasibility study commissioned by the Commonwealth and guided jointly with the profession and extensive consultation with representatives of the Australian Society of Anaesthetists, the Australian Medical Association and the Rural Doctors Association of Australia.

Prior to the introduction of the RVG on 1 November 2001, the Schedule fee for anaesthesia was established by reference to the anaesthesia base ("B") and average time ("T") units allocated to the associated procedure. For example:

30409	LIVER BIOPSY, percutaneous (**Anaes: 17706 = 4B + 2T**)

These anaesthesia unit values listed against medical/surgical/diagnostic and Oral & Maxillofacial services in the 1 November 2000 Medicare Benefits Schedule, no longer apply. From 1 November 2001, the Schedule fee for anaesthesia is established using the RVG Schedule.

T10.1 Overview of the RVG

T10.1.1 The RVG groups anaesthesia services within anatomical regions. These items are listed in the MBS under Group T10, Subgroups 1-16 Anaesthesia for radiological and other therapeutic and diagnostic services are grouped separately under Subgroup 17. Also included in the RVG format are certain additional monitoring and therapeutic services, such as blood pressure monitoring (item 22012) and central vein catheterisation (item 22020) *when performed in association with the administration of anaesthesia* (see Note T10.7). These services are listed at subgroup 19.

T10.1.2 As well, the RVG provides for assistance at anaesthesia under certain circumstances (see point T10.8). These items are listed at subgroup 26.

T10.1.3 The RVG is based on an anaesthesia unit system reflecting the difficulty of the service and the total time taken for the service. Each unit has been assigned a dollar value.

T10.1.4 Under the RVG, the Medicare benefit for anaesthesia in connection with a procedure is comprised of up to three components:

(a) the **basic** units allocated to each anaesthetic procedure, reflecting the degree of difficulty of the procedure (an item in the range 20100-21997), for example:

20702	**INITIATION AND MANAGEMENT OF ANAESTHESIA** for percutaneous liver biospy (4 basic units) Fee: $68.60 Benefit: 75% $51.45 85% $58.35

(b) the **time** unit allocation reflecting the **total time** of the anaesthesia (an item in the range 23010-24136), for example;

23033	- 41 MINUTES to 45 MINUTES (3 units) Fee: $51.45 Benefit: 75%= $38.60 85% = $43.75

plus, where appropriate

(c) **modifying** units recognising certain added complexities in anaesthesia (an item/s in the range 25000-25020), for example

25015	**ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA** where the patients age is 1 year or less or 70 years or greater (1 unit) Fee: $17.15 Benefit: 75% $12.90 85% $14.60

T10.1.5 Each assistant at anaesthesia service in subgroup 26 has also been allocated a number of base units. The total time that the assistant anaesthetist was in active attendance on the patient is then added, along with modifiers, as appropriate, to establish the fee for the assistant service. For example:

25200	**ASSISTANCE IN THE ADMINISTRATION OF ANAESTHESIA** on a patient in imminent danger of death requiring continuous life saving emergency treatment , to the exclusion of all other patients **Derived Fee** An amount of $85.75 (5 basic units) plus an item in the range 23010-24136) plus, where applicable, an item/s in the range 25000 – 25020

T10.1.6 In addition to assistant fees being derived in this way, where whole body perfusion, item 22060, is performed, the Schedule fee is determined on base units, the total time for the perfusion, and modifying units, as appropriate i.e

22060	**WHOLE BODY PERFUSION, CARDIAC BYPASS**, using heartlung machine or equivalent **Derived Fee** An amount of $343.00 (20 Basic Units) plus the fee for the perfusion time (an item in the range 23010-24136) plus, where applicable, the fee for patient modifiers (an item/s in the range 25000 – 25020)

T10.2 Eligible Services

T10.2.1 With some exceptions (see note T10.13), a Medicare benefit is only payable for anaesthesia which is performed in connection with an "eligible" service. Under the Health Insurance Regulations, an "eligible" service is defined as a clinically relevant professional service (as outlined in paragraph 1.1.4 of the General Explanatory Notes of the Medicare Benefits Schedule) which is listed in the Schedule and which has been identified as attracting an anaesthetic fee.

T10.3 RVG Unit Values

Basic Units

T10.3.1 The RVG basic unit allocation represents the degree of difficulty of the anaesthetic procedure relative to the anatomical site and physiological impact of the surgery.

Time Units

T10.3.2 The number of time units is calculated from the total time of the anaesthesia service, the assistant at anaesthesia service or the whole body perfusion service:

- ***for anaesthesia***, time is considered to begin when the anaesthetist commences exclusive and continuous care of the patient for anaesthesia. Time ends when the anaesthetist is no longer in professional attendance, that is, when the patient is safely placed under the supervision of other personnel;
- ***for assistance at anaesthesia***, time is taken to be the period that the assistant anaesthetist is in active attendance on the patient during anaesthesia; and
- ***for perfusion***, perfusion time begins with the commencement of anaesthesia and finishes with the closure of the chest.

T10.3.3 For up to and including the first 4 hours of time, each 15 minutes (or part thereof) constitutes 1 time unit. For time beyond 4 hours, each time unit equates to 10 minutes (or part thereof).

T10.3.4 For statistical purposes, the first 2 hours of time after the first 15 minutes is represented in the Medicare Benefits Schedule by item numbers in 5 minute increments.

For example:

	ANAESTHESIA, ASSISTANCE AT ANAESTHESIA OR PERFUSION TIME - for anaesthesia in connection with an eligible medical service or a dental service or assistance at anaesthesia in connection with an eligible medical service or for perfusion in connection with an eligible medical service		
23010	- 15 MINUTES OR LESS (1 unit) Fee: $17.15	Benefit: 75%= $12.90	Benefit: 85% = $14.60
23021	- 16 MINUTES TO 20 MINUTES (2 units) Fee: $34.30	Benefit: 75%= $25.75	Benefit: 85% = $29.20
23022	- 21MINUTES to 25 MINUTES (2 units) Fee: $34.30	Benefit: 75%= $25.75	Benefit: 85% = $29.20
23023	- 26 MINUTES to 30 MINUTES (2 units) Fee: $34.30	Benefit: 75%= $25.75	Benefit: 85% = $29.20
23031	- 31 MINUTES to 35 MINUTES (3 units) Fee: $51.45	Benefit: 75%= $38.60	Benefit: 85% = $43.75
23032	- 36 MINUTES to 40 MINUTES (3 units) Fee: $51.45	Benefit: 75%= $38.60	Benefit: 85% = $43.75
23033	- 41 MINUTES to 45 MINUTES (3 units) Fee: $51.45	Benefit: 75%= $38.60	Benefit: 85% = $43.75

T10.3.5 For services lasting between 15 minutes and two hours, the appropriate 5 minute item number should be included on accounts.

Modifying Units (25000 – 25050)

T10.3.6 Modifying units have been included in the RVG to recognise added complexities in anaesthesia or perfusion, associated with the patient's age, physical status or the requirement for emergency surgery. These cover the following clinical situations:

- ***A patient with severe systemic disease that significantly limits activity (item 25000)***. Examples of this would include: severely limiting heart disease; severe diabetes with vascular complications or moderate to severe degrees of pulmonary insufficiency. This modifier is equivalent to ASA physical status indicator 3.
- ***A patient with severe systemic disease which is a constant threat to life (item 25005)***. This covers patients with severe systemic disorders that are already life-threatening, not always correctable by an operation.

Examples would include: patients with heart disease showing marked signs of cardiac failure; persistent angina or advanced degrees of pulmonary, hepatic, renal or endocrine insufficiency. This modifier is equivalent to ASA physical status indicator 4.

- ***A moribund patient who is not expected to survive for 24 hours with or without the operation (item*** 25010***)***. Examples would include: a burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure or massive pulmonary embolus. This is equivalent to ASA physical status indicator 5.
- ***Where the patient's age is less than 1 year or greater than 70 years (item*** 25015***).***
- ***For anaesthesia, assistance at anaesthesia or a perfusion service in association with an *emergency procedure (item*** 25020***).***
- ***For anaesthesia or assistance at anaesthesia in association with an *after hours emergency procedure (items*** 25025 ***and*** 25030***).***
- ***For a perfusion service in association with *after hours emergency surgery (item*** 25050***).***

* Note: The emergency modifier and the after hours emergency modifiers cannot both be claimed in the one anaesthesia assistance at anaesthesia or perfusion episode.

T10.3.7 It should also be noted that modifiers are not stand alone services and can only be claimed in association with anaesthesia, assistance at anaesthesia or with a perfusion service covered by item 22060.

Definition of Emergency

T10.3.8 For the purposes of both the emergency modifier and the after hours emergency modifiers, emergency is defined as being where the patient requires immediate treatment without which there would be significant threat to life or body part.

Definition of After Hours

T10.3.9 For the purposes of the after hours emergency modifier items, the after hours period is defined as being the period from 8pm to 8am on any weekday or at any time on a Saturday, a Sunday or a public holiday. Benefit for the After Hours Emergency Modifiers is only payable where more than 50% of the time for the emergency anaesthesia, the assistance at emergency anaesthesia or the perfusion service is provided in the after hours period. In situations where less than the 50% of the time for the service falls in the after hours period, the emergency modifier rather than the after hours emergency modifier applies. For information about deriving the fee for the service where the after hours emergency modifier applies see point T10.4.2.

T10.4 Deriving the Schedule Fee Under the RVG

T10.4.1 The Schedule fee for each component of anaesthesia (base items, time items and modifier items) in the RVG Schedule was derived by applying the unit value to the total number of anaesthesia units for each component . For example:

ITEM	**DESCRIPTION**	**SCHEDULE FEE**
17603	Pre-anaesthesia Consultation	$33.40

Item	**Description**	***Units***	**SCHEDULE FEE (Units x $17.15)**
20840	Anaesthesia for resection of perforated bowel	6	$102.90
23190	Time – 4 hours 30minutes	19	$325.85
25000	Modifier - Physical status	1	$ 17.15
25020	Modifier - Emergency Surgery	2	$ 34.30
22012	Central Venous Pressure Monitoring	3	$ 51.45

10.4.2 After Hours Emergency Services

T10.4.2.1 When deriving the fee for the after hours emergency modifier for anaesthesia or assistance at anaesthesia, the 50% loading applies to the anaesthesia or assistance service from Group T10 and to any additional clinically relevant therapeutic or diagnostic service from Group T10, Subgroup 18, provided during the anaesthesia episode. For example:

Item	**Description**	***Units***	**SCHEDULE FEE (Units x $17.15)**
20840	Anaesthesia for resection of perforated bowel	6	$102.90
23190	Time – 4 hours 30minutes	19	$325.85
25000	Modifier - Physical status	1	$ 17.15
25020	Modifier - Emergency Surgery	2	$ 34.30
22012	Central Venous Pressure Monitoring	3	$ 51.45
	TOTAL UNITS	29	$497.35

25025	Anaesthesia After Hours Emergency Modifier (Schedule fee $497.35 x 50%)	$248.70

T10.4.3 Multiple Anaesthesia Services

T10.4.3.1Where anaesthesia is provided for services covered by multiple items in the RVG, Medicare benefit is only payable for the RVG item with the highest basic unit value. However, the time component should include the total anaesthesia time taken for all services. For example:

Item	**Description**	***Units***	**SCHEDULE FEE (Units x $17.15)**
20790	Anaesthesia for Cholecystectomy	7	$137.20
20752	Incisional Hernia	0	$ 0.00
23100	Time – 2hrs 30mins	10	$171.50
25015	Physical Status – Over 70	1	$ 17.15

T10.4.4 Prolonged Anaesthesia

T10.4.4.1 Under the RVG, the previous rules that related to prolonged anaesthesia no longer apply. Where anaesthesia is prolonged beyond that which an anaesthetist would normally encounter for a particular service, the RVG provides for the anaesthetist to claim the total anaesthesia time for the procedure/s.

T10.5 Account Requirements

T10.5.1 Before benefit will be paid for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of details additional to those set out at paragraph 7.1 of the General Explanatory Notes of the 1 November 2000 Medicare Benefits Schedule are required on the anaesthetist's account:

- the anaesthetist's account must show the name/s of the medical practitioner/s who performed the associated operation/s. As well, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and total time of the anaesthetic.
- the assistant anaesthetist's account must show the names/s of the medical practitioners who performed the associated operation/s, as well as the name of the principal anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthetic.
- The perfusionist's account must record the start time, end time and total time of the perfusion service where the after hours emergency modifier is claimed.

T10.6 General Information

T10.6.1 The Health Insurance Act provides that where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of anaesthesia. The administration of anaesthesia also includes the pre-anaesthesia consultation with the patient in preparation for that administration, except where such consultation entails a separate attendance carried out at a place other than an operating theatre or an anaesthesia induction room. The pre-anaesthesia consultation for a patient should be performed in association with a clinically relevant service.

T10.6.2 Except in special circumstances, benefit is not payable for the administration of anaesthesia listed in Subgroups 1-18, unless the anaesthesia is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which anaesthesia is administered.

T10.6.3 Fees and benefits for anaesthesia services under the RVG cover all essential components in the administration of the anaesthesia service. Separate benefit may be attracted, however, for complementary services such as central venous pressure and direct arterial pressure monitoring (see note T10.7).

It should be noted that additional benefit is not payable for intravenous infusion or electrocardiographic monitoring, provision for which has been made in the value determined for the anaesthetic units.

T10.6.4 The Medicare benefit derived under the RVG for the administration of anaesthesia is the benefit payable for that service irrespective of whether one or more than one medical practitioner administers it. However, benefit is provided under Subgroup 24 for the services of one assistant anaesthetist (who must not be either the surgeon or assistant surgeon (see Note 10.8)

T10.6.5 Where a regional nerve block or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block is assessed as an anaesthesia item according to the advice in paragraph T10.4. When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

T10.6.6 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.

T10.6.7 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.

T10.6.8 It may happen that the professional service for which the anaesthesia is administered does not itself attract a benefit because it is part of the after-care of an operation. This does not, however, affect the benefit payable for the anaesthesia

service. Benefit is payable for anaesthesia administered in connection with such a professional service (or combination of services) even though no benefit is payable for the associated professional service.
T10.6.9 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.

T10.7 Additional Services Performed in Connection with Anaesthesia – Subgroup 19
T10.7.1 Included in the RVG format are a number of additional or complimentary services which may be provided in connection with anaesthesia such as pulmonary artery pressure monitoring (item 22012) and intra-arterial cannulation (item 22025).
T10.7.2 These items (with the exception of peri-operative nerve blocks (22030-22050)) and perfusion services (22055–22075) have also been retained in the MBS in the non-RVG format, for use by practitioners who provide these services other than in association with anaesthesia.
T10.7.3 Where an anaesthetist provides an additional (clinically relevant) service during anaesthesia that is not one listed in Subgroup 19 (excluding intravenous infusion or electrocardiographic monitoring) the relevant non-RVG item should be claimed.

T10.8 Assistance in the Administration of Anaesthesia (Items 25200 and 25205)
T10.8.1 The RVG provides for a separate benefit to be paid for the services of an assistant anaesthetist in connection with an operation or series of operations in specified circumstances, as outlined below. This benefit is payable only in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.
Assistance at anaesthesia in connection with emergency treatment (Item 25200)
T10.8.2 Item 25200 provides for assistance at anaesthesia where the patient is in imminent danger of death.
Situations where imminent danger of death requiring an assistant anaesthetist might arise include: complex airway problems, anaphylaxis or allergic reactions, malignant hyperpyrexia, neonatal and complicated paediatric anaesthesia, massive blood loss and subsequent resuscitation, intra-operative cardiac arrest, critically ill patients from intensive care units or inability to wean critically ill patients from pulmonary bypass.
Assistance in the administration of elective anaesthesia (Item 25205)
T10.8.3 A separate benefit is payable under Item 25205 for the services of an assistant anaesthetist in connection with elective anaesthesia in the circumstances outlined in the item descriptor. This benefit is only payable in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.
T10.8.4 For the purposes of Item 25205, a "complex paediatric case" involves one or more of the following:-
(i) the need for invasive monitoring (intravascular or transoesophageal); or
(ii) organ transplantation; or
(iii) craniofacial surgery; or
(iv) major tumour resection; or
(iv) separation of conjoint twins.

T10.9 Perfusion Services (Items 22055-22075)
T10.9.1 Perfusion services covered by items 22055-22075 have been included in the RVG format.
T10.9.2 The "Time" component for item 22060 is defined as beginning with the commencement of anaesthesia and finishing with the closure of the chest.
T10.9.3 Medicare benefits are not payable for perfusion unless the perfusion is performed by a medical practitioner other than the medical practitioner who renders the associated medical service in Group T8 or the medical practitioner who administers the anaesthesia listed in the RVG in Group T10. The service must be performed by a medical practitioner in order to attract Medicare benefits. The "on behalf of" provisions do not apply.
T10.9.4 Medicare benefit is payable where the perfusionist provides a clinically necessary service/s from Group T10, Subgroup 19 in addition to the perfusion service.

T10.10 Anaesthesia as a therapeutic procedure (Item 21965)
T10.10.1 Claims under this item should be submitted to Medicare for approval of benefits and should contain full clinical details of 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 Notes of the 1 November 2000 Medicare Benefits Schedule.)

T10.11 Discontinued Surgery (Item 21990)
T10.11.1 Claims for benefits under Item 21990 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.

T10.12 Anaesthesia in connection with a procedure not identified as attracting a Medicare benefit for anaesthesia (Item 21997)
T10.12.1 Payment of benefit for Item 21997 is not restricted to the service being performed in connection with a surgical service in Group T8. Item 21997 may be performed with any item in the Medicare Benefits Schedule that has not been

identified as attracting a Medicare benefit for anaesthesia (including attendances) in circumstances where anaesthesia is considered clinically necessary. 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 of the 1 November 2000 Medicare Benefits Schedule.)

T10.13 Anaesthesia in connection with a dental service (Items 22900 and 22905)

T10.13.1 Items 22900 and 22905 cover the administration of anaesthesia in connection with a dental service that is not a service covered by an item in the Medicare Benefits Schedule i.e removal of teeth and restorative dental work. Therefore, the requirement that anaesthesia be performed in association with an "eligible" service (as defined in point T10.2) does not apply to dental anaesthesia items 22900 and 22905.

T10.14 Anaesthesia in connection with cleft lip and cleft palate repair (Items 20102 and 20172)

T10.14.1 Anaesthesia associated with cleft lip and cleft palate repair is covered in Subgroup 1 of the RVG Schedule, under items 20102 and 20172.

T10.15 Anaesthesia in connection with an Oral and MaxillofaciaI service (Category 4 of the Medicare Benefits Schedule)

T10.15.1 Benefit for anaesthesia provided by a medical practitioner in association with an Oral and Maxillofacial service (Category 4 of the Medicare Benefits Schedule) is derived using the RVG (see point OC.4 in Category 4 of the Medicare Benefits Schedule). Benefit for anaesthesia for oral and maxillofacial services should be claimed under the appropriate RVG item from Subgroup 1 or 2.

T10.16 Peri-operative blocks for post operative pain (Items 22030 to 22050)

T10.16.1 Benefits are only payable for peri-operative nerve blocks performed for the management of post-operative pain that are specifically catered for under items 22030 to 22050.

T10.17 Introduction of a Narcotic (Item 22030)

T10.17.1 Benefits are attracted for this procedure irrespective of the stage of the operation at which the narcotic is introduced.

T10.18 Epidural Injection for Control of Post-operative Pain (Item 22035)

T10.18.1 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.

T10.19 Regional or Field Nerve Blocks for Post-operative Pain (Items 22040 - 22050)

T10.19.1 Benefits are payable under Items 22040 to 22050 in addition to the general anaesthesia for the related procedure.

T10.20 Anaesthesia for radical procedures on the chest wall (Item 20474)

T10.20.1 Radical procedures on the chest wall referred to in item 20474 would include procedures such as pectus excavatum.

T10.21 Anaesthesia for extensive spine or spinal cord procedures (Item 20670)

T10.21.1 This item covers major spinal surgery involving multiple levels of the spinal cord and spinal fusion where performed. Procedures covered under this item would include the Harrington Rod technique. Surgery on individual spinal levels would be covered under items 20600, 20620 and 20630.

T10.22 Anaesthesia for femoral artery embolectomy (Item 21274)

T10.22.1 Item 21274 covers anaesthesia for femoral artery embolectomy. Grafts involving intra-abdominal vessels would be covered under item 20880.

T10.23 Anaesthesia for cardiac catheterisation (Item 21941)

T10.23.1 Item 21941 does not include either central vein catheterisation or insertion of right heart balloon catheter. Anaesthesia for these procedures is covered under item 21943.

T10.24 Anaesthesia for 2 dimensional real time transoesophageal echocardiography (Item 21936)

T10.24.1 Benefits are payable for anaesthesia in connection with 2 dimensional real time transoesophageal echocardiography, (including intra-operative echocardiography) which includes doppler techniques, real time colour flow mapping and recording onto video tape or digital medium.

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.

For a trial period of two years commencing 1 November 2001, the Relative Value Guide (RVG) for Anaesthesia has been introduced into the Medicare Benefits Schedule under a cost neutral framework, as the basis for calculating the Medicare benefits for anaesthesia services.

Prior to the introduction of the RVG on 1 November 2001, the Schedule fee for anaesthesia was established by reference to the anaesthesia base ("B") and average time ("T") units allocated to the associated procedure. For example:

51904	LIPECTOMY – wedge excision of skin or fat – 1 excision (Anaes. 17710 = 4B + 6T)

These anaesthesia unit values listed against medical/surgical/diagnostic and Oral & Maxillofacial services in the 1 November 2000 Medicare Benefits Schedule, no longer apply. From 1 November 2001 the Schedule fee for anaesthesia is established using the RVG schedule at Category 3 - Group T10.

Before the payment of benefits for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of details additional to those set out in paragraph 7.1 of the General Explanatory Notes of the 1 November 2000 Medicare Benefits Schedule are required on the anaesthetist's account:

- The anaesthetist's account must show the name/s of the medical practitioner/s who performed the associated operation/s. Also, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and the total time of the anaesthesia;
- The assistant anaesthetist's account must show the name/s of the medical practitioners who performed the associated operation/s, as well as the name of the principle anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthesia.

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, 52138, 52141, 52144, 52147, 52182, 52300, 52303, 52312, 52315, 52321, 52324, 52336, 52339, 52424, 52440, 52452, 52480, 52482, 52600, 52603, 52609, 52612, 52615, 52624, 52626, 52627, 52800, 52803, 52806, 52809, 52818, 52824, 52828, 52830, 53006, 53009, 53016, 53215, 53220, 53225, 53226, 53236, 53239, 53242, 53406, 53409, 53412, 53413, 53415, 53416, 53453, 53460.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under item 51300.

Benefits payable under Item 51803

51906, 52054, 52094, 52114, 52117, 52120, 52122, 52123, 52126, 52129, 52131, 52148, 52158, 52184, 52186, 52306, 52330, 52333, 52337, 52342, 52345, 52348, 52351, 52354, 52357, 52360, 52363, 52366, 52369, 52372, 52375, 52378, 52379, 52380, 52382, 52430, 52442, 52444, 52446, 52456, 52484, 52618, 52621, 52812, 52815, 52821, 52832, 53015, 53017, 53019, 53209, 53212, 53218, 53221, 53224, 53227, 53230, 53233, 53414, 53418, 53419, 53422, 53423, 53424, 53425, 53427, 53429, 53455.

or at a combination of procedures (including those identified as payable under item 51800 above) for which the aggregate fee exceeds the amount specified in the item.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under Item 51303.

Assistance at multiple operations

Where assistance is provided at two or more operations performed on a patient on the one occasion the multi operation formula is applied to all the operations to determine the surgical fee payable to each approved dental practitioner. The multi-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Items 51800/51300 or 51803/51303).

The derived fee applicable to Item 51803/51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery.

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.

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)
T7.7.1 This item includes the use of botulinus toxin as a neurolytic agent.

CATEGORY 5 - DIAGNOSTIC IMAGING 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).

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, 55037, 55039, 55045, 55047, 55049, 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, 55854. 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.

The service for which Medicare benefits are payable includes the rendering of a report to the requesting practitioner. Exceptions to this are as follows:

(a) Where the service is rendered in conjunction with a surgical procedure, the findings may be noted on the operation record (item 55054, 55130, 55848, 55850, 57341, 57345, 59312, 59314, 60506 and 60509)
(b) A report is not required for services rendered in preparation for a radiological procedure (items 60903, 60915, 60918 and 60927)

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 Specialists

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, 58108, 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, 57939, 57942, 57945, 57948, 57951, 57954, 57957, 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, 56001, 56007, 56010, 56013, 56016, 56022, 56028, 56041, 56047 56050, 56053, 56056, 56062, 56068, 56101, 56107, 56141, 56147, 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, 58108, 58109, 58112, 58115, 58306 58506, 58521, 58524, 58527, 58909, 59103, 59703, 60000, 60003, 60006, 60009, 60506, 60509, 61109, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63621, 63671, 63712.

Oral medicine and oral pathology surgeons may also request the following items:

55030, 55032, 56001, 56007, 56010, 56013, 56016, 56022, 56028, 56041, 56047, 56050, 56053, 56056, 56062, 56068, 56101, 56107, 56141, 56147, 56301, 56307, 56341, 56347, 56401, 56407, 56441, 56447, 57341, 57345, 58306, 58506, 58909, 59103, 59703, 60000, 60003, 60006, 60009, 60506, 60509, 61109, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63003, 63103, 63273, 63621, 63671, 63712.

Prosthodontists may also request the following items:

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, 58108, 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 Benefits 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.

DIA.7 DIAGNOSTIC IMAGING SERVICES WITH AN ANAESTHESIA COMPONENT

New arrangements for the payment of Medicare benefits for anaesthetic services have been introduced with effect from November 2001. These effectively remove the anaesthetic formula. In addition, a new schedule of anaesthetic items has been introduced onto the General Medical Services Table.

These new arrangements have impacted on the Diagnostic Imaging Services Table as follows:

- Payment of Medicare benefits for anaesthesia are restricted to instances where the anaesthetic has been performed in association with an 'eligible service'; ie, a service which is identified in the item description by the term 'Anaes.';
- Where a service has previously been identified as attracting an anaesthetic, the anaesthesia formula has been removed from item descriptions and the term 'Anaes.' has been retained or inserted into the item description;
- Additional items have been identified as being eligible for an anaesthesia service, and have had the term 'Anaes.' inserted into the item description. These include all other CT, MRI, digital subtraction angiography and selective coronary arteriography items not previously identified.

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 follows:

- 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 ultrasound services, where the service is performed on behalf of a medical practitioner the report must record the name of the sonographer.
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) 3352 8600

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 that:

(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 two 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 NOTICE OF POSSIBLE BREACHES

DIF.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.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.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 55600 and 55603. 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 55600 and 55603 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, 55036, 55038, 55044, 55048, 55070, 55076), 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

Item 55112 was deleted on 1 July 2001. The deleted item has been replaced with three new items, being 55113, 55114 and 55115. These changes have been made in consultation with representatives of the Cardiac Society of Australia and New Zealand, the Australian Diagnostic Imaging Association, and the Royal Australian and New Zealand College of Radiologists, and are designed to provide more information on the use of echocardiography.
A fee reduction of five (5) percent was applied to all cardiac ultrasound items on 1 July 2001. Additional subgroup restrictors were applied to items 55116, 55117 and 55118 on 1 July 2001.

DIH.2 Ultrasonic Cross-sectional Echography (Items 55028 to 55054, 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 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.

New rules for musculoskeletal ultrasound

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 55238-55296)
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 55296 (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, 55256.

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 55256 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.

Changes have been made to items from 1 November 2001. These are detailed below. These changes were initiated and agreed to by representatives from the following groups: the Royal Australasian College of Surgeons; the Royal Australian and New Zealand College of Radiologists; Australian Sonographers Association; the Royal Australian College of General Practitioners; the Royal Australasian College of Physicians and the Australian and New Zealand Association of Physicians in Nuclear Medicine.

DIH.5.1 Deleted Items
The following twelve vascular ultrasound items have been deleted: 55240, 55242, 55245, 55247, 55250, 55254, 55258, 55260, 55263, 55265, 55268 and 55272.

In previous cases where these items would have been used, the services should now be billed under the equivalent existing item (ie, 55238, 55244, 55246, 55248, 55252, 55256, 55262, 55264, 55266 or 55270) and the relevant item in the General Medical Services Table (ie, items 11603, 11606, 11609 or 11612).

DIH.5.2 New Items
Three new items have been added to the vascular ultrasound subgroup, these being items 55292, 55294 and 55296. These items are for the imaging of surgically created arteriovenous fistulas, conduit mapping prior to vascular surgery and skin marking of perforating veins respectively. The phrases 'prior to vascular surgery' in item 55294 and 'prior to varicose vein surgery' in item 55296 mean that surgery was expected to follow within a period of time during which the mapping or marking would be useful for the surgery.

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 or 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

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 Sonographer Accreditation

From 1 November 2001, sonographers performing medical ultrasound examinations (either R or NR type items) on behalf of a medical practitioner must be suitably qualified and involved in a relevant and appropriate Continuing Professional Development program. For further information, please contact the Department on (02) 6289 7727, or the Australasian Sonographer Accreditation Registry on (02) 8850 1144 or through their website at http://www.asar.com.au.

DIH.8 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 55600 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.9 Obstetric and Gynaecological Ultrasound Item Restructure

The obstetric and gynaecological ultrasound items were restructured and placed in a separate ultrasound subgroup with effect from 1 November 2000.

The revised structure was 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 structure contains items which are clinically based and which will assist the more appropriate utilisation of these items. The fees for the items are structured to reflect the varying levels of complexity in obstetric ultrasound.

DIH.10 Rules for Obstetric Ultrasound

DIH.10.1 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.

DIH.10.2 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.

DIH.10.3 Obstetric Ultrasound Items for Multiple Pregnancies
As of 1 November 2000, obstetric ultrasound items 55759 to 55774 were 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 items incorporate a fee adjustment in recognition of the added complexity and costs associated with scanning multiple pregnancies. Based on the recommendations of the profession, the items apply only to patients where a multiple pregnancy has been confirmed by ultrasound.

The items include identical restrictions and provisions as the 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.11 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.12 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.13 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

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 CT service where PET scan is performed
A new rule with effect from 1 November 2001 means that Medicare benefits are not payable for any CT scans rendered using a Hybrid PET/CT scanner. This change was made on advice of the Royal Australian and New Zealand College of Radiologists and the Australian Diagnostic Imaging Association.

DII.3 New CT Spine Items
Effective from 1 November 2001 items 56210, 56216, 56250 and 56256 have been deleted and replaced by new CT items which separate the examination of the spine into the cervical, thoracic and lumbosacral regions. This change was agreed with by the Royal Australian and New Zealand College of Radiologists and the Australian Diagnostic Imaging Association. The new items are 56220 to 56240 inclusive. They include items for CT scans of two region of the spine (56233, 56234, 56235 and 56236) and for all three regions of the spine (56237, 56238, 56239 and 56240)

Restrictions apply to the following items:

a) Item 56233 is used where two examinations from items 56220, 56221 and 56223 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed
b) Item 56234 is used where two examinations from items 56224, 56225 and 56226 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed
c) Item 56235 is used where two examinations from items 56227, 56228 and 56229 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed
d) Item 56236 is used where two examinations from items 56230, 56231 and 56232 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed

Example: for a CT examination of the spine where the cervical and thoracic regions are to be studied (item 56233), item number 56200 and 56221 must be specified.

DII.4 Revised fees for CT scans of the facial bones, paranasal sinuses and the brain

Effective from 1 November 2001, the schedule fee for CT scans of the facial bones, the paranasal sinuses and the brain (56030, 56036, 56070 and 56076) have been reduced to the schedule fee applicable to the equivalent CT scans of the facial bone, paranasal sinuses or both. The change was made on the advice of the Royal Australian and New Zealand College of Radiologists and the Australian Diagnostic Imaging Association.

DII.5 New Spinal Angiography (Items 57351 and 57356)

Effective from 1 November 2001, there are two new CT spiral angiography items (57351 and 57356) which apply under certain circumstances specified in the items, where items 57350 or 57355 have been performed within the previous 12 months.

DII.6 Scan of more than one area

Items have been provided to cover the common combinations of regions - see DII.9. 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.7 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 56220, 56221 and 56223).

DII.8 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.9 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.10 Professional Supervision of 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.11 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 items cover services provided on older equipment. These items are:

56041, 56047, 56050, 56053, 56056, 56062, 56068, 56070, 56076, 56141, 56147, 56259, 56341, 56347, 56441, 56447, 56449, 56452, 56541, 56547, 56659, 56665, 56841, 56847, 57041, 57047, 57247, 57345, 57355.

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.12 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.13 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 New Orthopantomography items
Effective 1 November 2001, the general orthopantomography item 57936 has been deleted and replaced by four new items (57948, 57951, 57954 and 57957) which cover specific clinical indications. The benefits have not been changed. The new

items are designed to provide more information on the use of orthomantomography and were introduced in consultation with the Royal Australian and New Zealand College of Radiology and the Australian Diagnostic Imaging Association.

DIJ.5 New Spine Items
Effective 1 November 2001, items 58112 and 58115 have been revised. The multiple region items require that the regions of the spine to be studied must be specified on any account issued or patient assignment forms completed.

Where item 58112 is rendered (spine, two regions), the item numbers for the regions of the spine being studied must be specified (ie from items 58100, 58103, 58106 and 58109).

Example: for a radiographic examination of the spine where the cervical and thoracic regions are to be studied, item numbers 58100 and 58103 must be specified on any account issued or patient assignment forms completed.

Where item 58115 is rendered (spine, three regions), the item numbers for the regions of the spine being studied must be specified (items 58100, 58103, 58106 and 58109).

Example: for a radiographic examination of the spine where the cervical, the thoracic and the lumbosacral regions are to be studied, item numbers 58100, 58103 and 58106 must be specified on any accounts issued or patient assignment forms completed.

DIJ.6 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.7 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.8 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.9 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 Items 56220, 56221 and 56223 would apply.

DIJ.10 Cardiac Angiography
A restriction has been introduced between item 59903 and item 59912 so that they can no longer be claimed for the same occasion of service. A new item, 59925, is available for occasions of service where both items 59903 and 59912 would have otherwise been claimed.

Items 59900, 59906, 59915, 59918, 59921 and 59924 have been deleted in order to bring the Schedule in line with current clinical practice. The descriptors for items 59903 and 59912 have been adjusted to reflect changes made elsewhere in the Schedule. These changes have been made in consultation with representatives of the Cardiac Society of Australia and New Zealand, the Australian Diagnostic Imaging Association, and the Royal Australian and New Zealand College of Radiologists.

DIJ.10.1 Capital Sensitivity
From 1 July 2001, a new set of items with reduced Schedule Fees will apply to cardiac angiography services provided on equipment that is ten years old or more. 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. These new items are 59971, 59972, 59973 and 59974. These items are identified by the addition of the letters '(NK)' at the end of the item, and should be used where services are performed on equipment ten years old or older.

Items 59903, 59912, 59925 and 59970 have the letter '(K)' included at the end of the item. These items should be used where services are performed on equipment first installed in Australia less than ten years ago. In the case of imported pre-used equipment, the services must have been performed on a date which is less than ten years from the first date of manufacture of the equipment. Description updates have been applied to existing items to reflect these changes.

It should be noted that the letter 'K' denotes capital sensitivity rather than the letter 'C' as this letter is already in use elsewhere in the Medicare Benefits Schedule.

DIJ.11 Digital Subtraction Angiography (DSA) (Items 60000-60084)
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.12 Preparation Items (Items 60918 and 60927)
Benefits are not payable for preparation items when rendered with any service other than that specified in each item.

Items 60903 and 60915 were deleted on 1 July 2001 in order to reflect current clinical practice. Items 60918 and 60927 were updated to reflect the changes to the angiography and report items.

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 on 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 61361 applies specifically to a standard hepatobiliary study to which has been added an infusion of sinaclide (CCK-8) following which acquisition is continued and quantification of gallbladder ejection fraction and/or common bile duct activity time curves are performed.

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.

Effective from 1 November 2001, the limits on the number of services which can be claimed in a 12 month period for items in subgroups 17, 18, 19 and 21 will apply to the specific anatomical site being scanned. However, Medicare benefits for these subgroups will be payable for a maximum of one service per item per episode of care.

Example: for item 63609, MRI scan to exclude derangement of the hip or its supporting structure, benefits would be payable for one scan performed on the right hip, within a 12 month period.

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
The requirements for eligible providers have been revised with effect from 1 November 2001 on the advice of the Royal Australian and New Zealand College of Radiologists and the Australian Diagnostic Imaging Association. From this date, in Group I5, an eligible provider is a specialist in diagnostic radiology who satisfies the Health Insurance Commission (HIC) that:
(a) the MRI facility at which he or she provides MRI services has achieved, or is in the process of achieving, registration in the Royal Australian and New Zealand 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 in the diagnostic services table (the proposed equipment) is eligible equipment (refer to DIL.8)

In order to become an eligible provider or to seek clarification regarding these requirements providers should contact the HIC.

DIL.8 Eligible equipment
The rules for eligible equipment have changed, for 'existing units' with effect from July 2001 and for 'additional units' with effect from May 2001. These rules are contained in the Health Insurance (Diagnostic Imaging Services Table) Regulations 2001 (the Regulations).

For equipment to be 'eligible equipment' it must be:
(A) Eligible equipment under Rule 31 of the Regulations
i must be listed and described in Schedule 2 of the Regulations; or
ii be replacement equipment for equipment listed in Schedule 2, of the same or greater magnet strength as the original equipment; or

iii equipment that is a temporary replacement for equipment to which subparagraph (i) or (ii) applies; and

- Be located in:
  i a medical practice, or the radiology department of a hospital, specified in column 2 of the relevant item in Schedule 2 (the original place); or
  ii another medical practice or radiology department of a hospital, that offers a comprehensive range of diagnostic imaging procedures, and that has the same postcode as the original place.

- If all or a part of the equipment is permanently replaced, the HIC must have been given, before the replacement took place, a written notice:
  (a) giving details of the proposed replacement; and
  (b) if any of the information in Schedule 2 in relation to the equipment has changed because of the replacement – stating the correct information.

- If the equipment is replaced by temporary replacement equipment, the HIC must have been given, before the date when the temporary replacement equipment is to begin operating, a written notice stating:
  (a) the name and address of the place where the temporary replacement equipment is to be installed; and
  (b) the manufacturer, scanner model, magnet strength, and magnet serial number of the temporary replacement equipment; and
  (c) the date when the temporary replacement equipment is to begin operating; and
  (d) the date when the temporary replacement equipment is to cease operating.

- If the equipment is moved to another place the Commission must have been given, before the equipment is moved, a written notice stating:
  (a) The name and address of the place to which the equipment is to be moved; and
  (b) The date when the equipment is to be moved.

(B) Additional eligible equipment under Rule 31A of the Regulations

- Eligible equipment is equipment other than equipment to which Rule 31 applies
  i that is registered under the 'MRI Additional Units Eligibility Scheme', and
  ii in relation to which the registration has not been cancelled or otherwise ceased to have effect.

For these rules;

- **Comprehensive**, in relation to a range of diagnostic imaging procedures, means that the range includes x-ray, ultrasound and computed tomography (CT) procedures.
- **Medical practice** means a medical practice conducted by:

A sole practitioner; or
  (a) A group of practitioners within the meaning of subsection 16A(9) or (10) of the Act; or
  (b) A medical entrepreneur.

- **Temporary replacement equipment**, for equipment, means equipment that:
  (a) Is able to be used to perform the same kind of diagnostic imaging procedures as the permanent equipment; and
  (b) Is used for no longer than 2 months in a medical practice, or radiology department of a hospital, that offers a comprehensive range of diagnostic imaging procedures, and that has the same postcode as the place where the permanent equipment was being used, while the permanent equipment is being serviced or repaired.

DIL.9 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

CATEGORY 6 - PATHOLOGY 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 and when the specimen is obtained:

(a) a private patient in a private hospital, or approved day hospital facility;

(b) a private patient in a recognised hospital;

(c) a Medicare (public) 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. MULTIPLE SERVICES RULE

PD.1 Description of Rule

The term "Multiple Services Rule" (Rule 3 of the Pathology Services Table) describes an arrangement which places limits on the benefits payable for items in the Pathology Services Table depending on the range of services performed during a single patient episode. A patient episode is defined in PO.4 of these notes.

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 18

The term "Episode Cone" describes an arrangement under which Medicare benefits payable in a patient episode for a set of pathology services, containing more than three items, ordered by a general practitioner for a non-hospitalised patient, will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. Further information on the episode coning arrangements is provided in PO.5 of these notes.

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 8123 or email npacc@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 principles also require pathology laboratories to address National Pathology Accreditation Advisory Council standards. Copies of the principles and standards are available from the Secretariat, National Pathology Accreditation Advisory Council (see PH.6) on (02) 6289 8123 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 develop policy for accreditation of pathology laboratories, introduce and maintain uniform standards of practice in pathology services throughout Australia and initiate and coordinate educational programs in relation to pathology practice. The agencies used to inspect laboratories on the 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 8123 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 **will commence on 1 December 2001** replacing the LCC Scheme.

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 8073 or e-mail pstc@health.gov.au and/or write to: Secretary, PSTC, MDP 107, 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 Medical Services Advisory Committee (MSAC). MSAC has been established to advise the Minister on the strength of evidence pertaining to new and emerging medical technologies and procedures in relation to their safety, effectiveness and cost effectiveness, and under what circumstances public funding should be supported.

Any person or organisation seeking to make a submission to MSAC can contact the MSAC Secretariat on (02) 6289 6811 or email msac.secretariat@health.gov.au and/or write to: 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 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.2 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.3 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. Item 73055 should be used for repeated smears due to an unsatisfactory routine smear, or if there is inadequate information provided.

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.4 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.5 Lithium

A test for the quantitation of lithium is claimable under item 66611 - ‘quantitation of a drug being used therapeutically’.

PP.6 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’.

PP.7 Items referring to the ‘detection of’

Items that contain the term ‘detection of’ should be taken to mean ‘testing for the presence of’.

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 or cardiac markers	Creatine kinase isoemzymes, myoglobin, troponin	CE / CM	66518, 66519
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	FATS	66500

	triglycerides (TRIG)		
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

Only one of these histopathology examination items (72813, 72816, 72817, 72823, 72824, 72825, 72830 and 72836) 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.

Immunohistochemistry items 72846 and 72847 and immunocytochemistry items 73059 and 73060 are 'Pathologist-determinable services' for tissue examination items 72813 to 72836 and cytology items 73045 to 73051 respectively.

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, 66503, 66506, 66509, 66512 and 66515 or 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, sulphasalazine or penicillamine therapy of a patient;

(e) a service described in item 66500 - 66515 in relation to methotrexate therapy of a patient;

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

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

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

(g) quantitative estimation of albumin and calcium in relation to therapy of a patient with vitamin D, its metabolites or analogues;

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. Creatinine ratios - Group P2 (chemical):

A pathology service mentioned in an item (except item 66500) in Group P2 (chemical) that:
(a) involves the measurement of a substance in urine; and
(b) requires calculation of a substance/creatinine ratio;
is taken to include the measurement of creatinine necessary for the calculation.

Thyroid function testing

9. (1) For item 66719:

abnormal level of TSH means a level of TSH that is outside the normal reference range in respect of the particular method of assay used to determine the level.

9. (2) Except where paragraph (a) of item 66719 is satisfied, the amount specified in the item is not payable in respect of a pathology service described in the item unless the pathologist who renders the service has a written statement from the medical practitioner who requested the service that satisfies subrule (3).

9. (3) The written statement from the medical practitioner must indicate:

(a) that the tests are required for a particular purpose, being a purpose specified in paragraph (b) of item 66719; or
(b) that the medical practitioner who requested the tests suspects the patient has pituitary dysfunction; or
(c) that the patient is on drugs that interfere with thyroid hormone metabolism or function.

Meaning of "serial examinations or cultures"

10. For an item in Group P3 (Microbiology):

(a) ***serial examinations or cultures*** means a series of examinations or cultures requested on 1 occasion whether or not:
  (i) the materials are received on different days by the approved pathology practitioner; or
  (ii) the examinations or cultures were requested on 1 or more request forms by the treating practitioner; and
(b) if:
  (i) tests are carried out in relation to a patient episode; and
  (ii) specimen material from the patient episode is stored; and
  (iii) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;
the later tests and the earlier tests are taken to be part of one patient episode.

Investigation for hepatitis and syphilis serology

11. (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.

11.(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

12. For items in Group P4 (Immunology), in items 71119, 71121, 71123 and 71125, if:

(a) tests are carried out in relation to a patient episode; and
(b) specimen material from the patient episode is stored; and
(c) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;
the later tests and the earlier tests are taken to be part of one patient episode.

Tests on biopsy material - Group P5 (Tissue pathology) and Group P6 (Cytology)

13. (1) For items in Group P5 (Tissue pathology):

(a) ***biopsy material*** means all tissue (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.

13. (2) For Groups P5 and P6 of the pathology services table, services in Group P6 include any services described in Group P5 on the material submitted for a test in Group P6.

13. (3) For subrule (2), any sample submitted for cytology from which a cell block is prepared does not qualify for a Group P5 item.

13.(4) If more than 1 of the services mentioned in items 72813, 72816, 72817, 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.

13.(5) If more than 1 histopathological examinations are performed on separate specimens, of different complexity levels, from a single patient episode, a medicare benefit is payable only for the examination that has the highest schedule fee.

13.(6) In items 72813, 72816, 72817, 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

14. (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 residential aged care home; or
(l) accommodation for aged persons that is attached to a residential aged care home or situated within a residential aged care home.

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.

14. (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.

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

14. (4) An item in Group P10 or P11 does not apply to a pathology service unless at least 1 item in Groups P1 to P8 also applies to the service.

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

14. (6) An item in Group P11 applies only to the approved pathology practitioner or approved pathology authority to whom the specimen mentioned in the item was referred.

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

(a) services referred to in 1 or more items in Group P5 and 1 or more of Groups P1, P2, P3, P4, P6, P7 and P8 are rendered by an approved pathology practitioner in the laboratory of another approved pathology authority; or
(b) services referred to in 1 or more items in Group P6 and 1 or more of Groups P1, P2, P3, P4, P5, P7 and P8 are rendered by another approved pathology practitioner in another approved pathology authority;
the fee specified in the applicable item in Group P10 is payable to both approved pathology practitioners.

14. (8) If more than one specimen is collected from a person on the same day for the provision of pathology services:

(a) in accordance with more than 1 request; and
(b) in or by a single approved pathology authority;
only a single amount specified in the applicable item in Group P10 is payable for the services.

14. (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

15. 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

16. (1) An item in Group P11 does not apply to a referral if:

(a) a service in respect of the same patient episode has been carried out by the referring approved pathology authority; and
(b) the approved pathology authority to which the referral is made is related to the referring approved pathology authority.

16. (2) An approved pathology Authority is ***related to*** another approved pathology authority for subrule (1) if:

(a) both approved pathology authorities are employed (including employed under contract) by the same person, whether or not the person is also an approved pathology authority; or
(b) either of the approved pathology authorities is employed (including employed under contract) by the other; or
(c) both approved pathology authorities are corporations and are related corporations within the meaning of the Corporations 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).

16. (3) An item in Group P11 does not apply to a referral if the following common tests are referred either singly or in combination (except if the following items are referred in combination with other items not similarly specified): 65060, 65070, 65120, 66500, 66503, 66506, 66509, 66512, 66515, 66521, 66524, 66527, 66530, 66533, 66536, 66596, 69300, 69303, 69333 or 73527.

Abbreviations

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

17. (2) The names of services or drugs not listed in Part 3 of this table must be written in full.

Certain pathology services to be treated as 1 service

18. (1) In this rule:

general practitioner means a medical practitioner who:
(a) is not a consultant physician in any specialty; and
(b) is not a specialist in any specialty;

set of pathology services means a group of pathology services:
(a) that consists of services that are described in at least 4 different items; and
(b) all of which are requested in a single patient episode; and
(c) each of which relates to a patient who is not an admitted patient of a hospital; and

(d) 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).

18. (2) If a general practitioner requests a set of pathology services, the pathology services in the set are to be treated as individual pathology services in accordance with this rule.

18. (3) If the fee specified in 1 item that describes any of the services in the set of pathology services is higher than the fees specified in the other items that describe the services in the set:
(a) the pathology service described in the first-mentioned item is to be treated as 1 pathology service; and
(b) either:
(i) the pathology service in the set that is described in the item that specifies the second-highest fee is to be treated as 1 pathology service; or
(ii) if 2 or more items that describe any of those services specify the second-highest fee - the pathology service described in the item that specifies the second-highest fee, and has the lowest item number, is to be treated as 1 pathology service; and
(c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.

18. (4) If the fees specified in 2 or more items that describe any of the services in the set of pathology services are the same, and higher than the fees specified in the other items that describe the services in the set:
(a) the pathology service in the set that is described in the item that specifies the highest fee, and has the lowest item number, is to be treated as 1 pathology service; and
(b) the pathology service in the set that is described in the item that specifies the highest fee, and has the second-lowest item number, is to be treated as 1 pathology service; and
(c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.

18. (5) If pathology services are to be treated as 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

19. 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

20. 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

21.

(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 metals testing

22.

Nutritional and toxicity metals testing
(1) For this rule:
nutritional metals testing group means items 66669 and 66670.
metal toxicity testing group means items 66672 and 66673.

(2) An item in the nutritional metals testing group or the metal toxicity testing group does not apply in relation to a service performed if medicare benefits are paid or payable for tests that are performed for the same patient in 3 patient episodes requested within 6 months before the request for that service, under any of:
(a) that item; or

(b) the other item in the same group; or
(c) an item in the other group.

Antineutrophil Cytoplasmic Antibody

23.

A request for ANCA shall be deemed to include requests for PR-3 ANCA and MPO ANCA where the immunofluorescence test for ANCA is abnormal, or has been abnormal, or these specific antibodies have been previously detected.

OUTLINE OF CLEFT LIP AND CLEFT PALATE SCHEME AND NOTES FOR GUIDANCE

CA. INTRODUCTION

CA.1 Medicare Benefits

CA.1.1 The Medicare Benefits Schedule includes certain professional services in respect of the treatment of cleft lip and cleft palate conditions for which Medicare benefits are payable. These services are normally described as dental services. However, for the purposes of these Notes the word "medical" is to be interpreted to include "dental". The definition of professional service as contained in the Health Insurance Act provides that such a service must be "clinically relevant". A clinically relevant service means a service rendered by a medical or dental practitioner or optometrist that is generally accepted in the medical, dental or optometrical profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered.

CA.1.2 Medicare benefits are payable in respect of services listed in the Schedule (contained in Section 2 of this booklet), when the services are rendered by eligible dental practitioners to prescribed patients (see paragraph CC).

CA.1.3 The Schedule lists three categories of professional services:

Group C1	Orthodontic Services
Group C2	Oral and Maxillofacial Surgical Services
Group C3	General and Prosthodontic Services

CB. DENTAL PRACTITIONER ELIGIBILITY

CB.1 Eligible Practitioners

CB.1.1 In order to attract Medicare benefits, all treatment must be carried out by eligible dental practitioners who are resident in Australia. Practitioner eligibility is covered under the provisions of Subsection 3(1) of the Health Insurance Act 1973 (the Act).

CB.1.2 All State registered dental practitioners are entitled to perform simple extraction services covered by Items 75200-75206 listed in Group C2 of the Schedule (see paragraph CG.6 of these notes) and the general and prosthodontic services listed in Group C3 of the Schedule. Practitioners do not need to apply for accreditation or approval to perform these services.

CB.1.3 Dental practitioners who wish to be accredited for the purposes of Subsection 3(1) of the Act to perform those orthodontic services listed in Group C1 of the Schedule must submit an application for consideration by the Medical Benefits (Dental Practitioners) Advisory Committee. This Committee will recommend to the Minister the names of those dental practitioners who, in its opinion, should be accredited by the Minister to provide orthodontic services.

CB.1.4 The criteria used in granting accreditation for orthodontic services are that the dental practitioner is a practitioner who is either -

- registered by one of the State Dental Boards as an orthodontist; or
- can substantiate by qualifications and experience a level of competence in the field of orthodontics equivalent to the above criterion.

CB.1.5 Oral and maxillofacial surgeons approved by the Minister for the purposes of Subsection 3 (1) of the Act to carry out prescribed medical services (oral and maxillofacial surgery) contained in the Medicare Benefits Schedule book are entitled (without the need to apply) to perform those items of oral and maxillofacial surgery listed in Group C2 of this Schedule (on referral by an accredited orthodontist).

CB.1.6 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.

CB.1.7 Practitioners who wish to be considered for approval or accreditation 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.

CB.1.8 Where the Minister decides that a dental practitioner should not be accredited for orthodontic services or approved for oral and maxillofacial surgical services, 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 Commitee's address is the same as the Advisory Committee.

CB.1.9 Both the Advisory and the Appeals Committees are composed of dental practitioners nominated by the Australian Dental Association.

CC. PATIENT ELIGIBILITY

CC.1 Eligible Patients

CC.1.1 To be eligible to claim benefits for Schedule services performed by eligible dental practitioners, a patient must satisfy the following criteria:

(a) The patient must be an Australian resident or any other person or class of persons whom the Minister declares to be eligible. All eligible persons will be issued with a Medicare card on application as evidence of their eligibility.

(b) The patient must be aged less than twenty-two years.

(c) Under the provisions of Subsection 3(1) of the Health Insurance Act a patient must be a prescribed dental patient, ie a person in respect of whom a certificate has been issued by a medical practitioner or dental practitioner approved by the Minister, stating that the person is suffering from a cleft lip or cleft palate condition*

* Conditions for which a patient may be prescribed include the following:

- Branchial Arch Syndrome
- Craniosynostosis Syndrome
- Apert's Syndrome
- Pierre Sequence
- Treacher-Collins' Syndrome
- Golden Har Syndrome
- Ectodermal Dysplasia

CC.1.2 The identification of the cleft condition and the issue of the Certificate can be undertaken through a special cleft lip and palate clinic or by a medical or dental practitioner authorised for this purpose by the Minister. Cleft lip and palate clinics operate in at least one public hospital in each Australian State/Territory capital city. A list of these clinics and their addresses appears at the end of these Notes.

CC.1.3 Practitioners whose patients are unable to attend the hospital clinic should send records of the cleft condition to the Clinic for identification of the condition and issue of the Certificate.

CC.1.4 The Certificate is a formal document required under the provisions of the Act. Because the Certificate may have to last for up to twenty-two years, each eligible patient will also be issued with a plastic identification card. These cards, which are more durable than the paper Certificates, can be used by patients (or parents or guardians) to claim Medicare benefits. Facsimiles of the Certificate and card appear at the end of these Notes.

CC.1.5 Patients are eligible for Medicare benefits for treatment received from the date of issue of their Certificate. Where treatment is required immediately after birth, practitioners should telephone a Clinic or approved practitioner so that a Certificate can be prepared which will be effective from that day.

CC.2 Visitors to Australia

CC.2.1 Medicare benefits are generally not payable to visitors to Australia or temporary residents. People visiting Australia specifically for medical or hospital treatment are not eligible for Medicare benefits.

CC.3 Health Care Expenses Incurred Overseas

CC.3.1 Medicare does not cover medical or hospital expenses incurred outside Australia.

CD. SCHEDULE FEES AND MEDICARE BENEFITS

CD.1 Schedule Fees and Medicare Benefits

CD.1.1 Medicare benefits are based on fees determined for each Schedule service. These fees are shown in the Schedule in Section 2 of this Book. 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.

CD.1.2 The Medicare benefits for each medical service are the amounts shown immediately after the Schedule fee. There are presently two levels of Medicare benefit payable, that is:-

(i) for professional services rendered while hospital treatment (ie 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 $55.60 (indexed annually) whichever is the greater.

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

CD.1.3 It should be noted that the Health Insurance Act makes provision for private medical insurance to cover the "patient gap" (ie., the difference between the Medicare benefit and the Schedule fee) for services attracting benefit at the 75% level. Patients may insure with private health insurance organisations for the gap between the 75% Medicare benefit and the Schedule fee or for amounts in excess of the Schedule fee where the patient has an agreement with their health fund.

CD.1.4 Where it can be established that payments for out-of-hospital services of $302.30 (indexed annually from 1 January) have been made for a family group or an individual during a calendar year in respect of the difference between the Medicare benefit and the Schedule fee, benefits will be paid for expenses incurred for professional services rendered during the rest of that year up to 100% of the Schedule fee. This does not apply to the Assignment of Benefit arrangements. A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25.

CD.2 Where Medicare Benefits are not Payable

CD.2.1 Medicare benefits are not payable in respect of a professional service in the following circumstances:-

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

(ii) 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;

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

CD.2.2 Unless the Minister otherwise directs, Medicare benefit is 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 for purposes connected with the operation of that undertaking; or

(d) the service was a health screening service.

CD.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.

CD.2.4 Benefits are not payable for items 75150 to 75621 unless the patient was referred in the manner outlined at paragraph CG.6.

CD.3 Workers' Compensation, Third Party Insurance, Damages etc.

CD.3.1 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, except where a person has entered into a "reimbursement arrangement" with a compensation insurer. The normal billing arrangements apply in respect of services rendered.

CD.3.2 Once a settlement or judgement is made on a compensation claim, recovery of benefits is undertaken between the insurer or compensation payer, the compensable person and the Health Insurance Commission. The recovery arrangements do not impact on practitioners.

CD.4 Limiting Rule

CD.4.1 In no circumstances will the benefit payable for a professional service exceed the fee charged for the service.

CE. PENALTIES

CE.1 Penalties

CE.1.1 Penalties of up to $10,000 or imprisonment for up to five years 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 an 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.

CE.1.2 A penalty of up to $1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct billing form without the necessary details having been entered on the form before signature or who fails to cause a copy of the completed form to be given to the patient.

CF. BILLING PROCEDURES

CF.1 Billing of the Patient - Itemised Accounts

CF.1.1 Where the practitioner bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to enable a claim to be made for Medicare benefits.

CF.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 is provided in a hospital or day-hospital facility (other than a Medicare hospital patient), that is, the words (ie, accommodation and

nursing care) "admitted patient" immediately preceding the description of the service or an asterisk "*" directly after an item number where used;

(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).

CF.1.3 Each account must also carry a certification by the accredited dental practitioner that:-

(i) the patient's eligibility certificate or identification card has been sighted (this can be done by quoting the number on the identification card); and

(ii) the service was required for the treatment associated with the cleft condition.

CF.1.4 Where a practitioner wishes to apportion the total fee between the appropriate professional fee for the particular service and any balance outstanding in respect of services rendered previously, the practitioner should ensure that the balance is described in such a way (eg balance of account) that it cannot be mistaken as being a separate service. In particular no item number should be shown against the balance.

CF.1.5 Only one original itemised account should be issued in respect of any one medical service and any duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

CF.2 Claiming Benefits

CF.2.1 The patient, upon receipt of a practitioner's account, has two courses open for paying the account and receiving benefits as outlined below.

CF.3 Paid Accounts

CF.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.

CF.3.2 In these circumstances, where a claimant personally attends a customer service centre, the claimant is not required to complete a Medicare Patient Claim Form (PC1).

CF.3.3 In circumstances where the claimant is seeking a cheque payment of the Medicare benefit or is arranging for an agent to receive the Medicare benefit on the claimant's behalf, completion of a Medicare Patient Claim Form (PC1) is still required.

CF.4 Unpaid Accounts

CF.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 practitioner.

CF.4.2 It will be the patient's responsibility to forward the cheque to the practitioner and make arrangements for payment of the balance of the account if any. "Pay doctor" cheques involving Medicare benefits cannot be sent direct to practitioners or to patients at a practitioner's address (even if requested by the patient to do so). "Pay doctor" cheques will be forwarded to the claimant's last known address.

CF.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 practitioner should indicate on the receipt that a "Medicare" cheque for $.....was involved in the payment of the account.

CF.5 Assignment of Benefits (Direct-Billing) Arrangements

CF.5.1 Under the Health Insurance Act the Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need. If a practitioner direct-bills, the practitioner undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:-

- The patient's Medicare card number must be quoted on all direct-bill forms for that patient.
- The basic forms provided are loose leaf to enable the patient details to be imprinted from the Medicare card.
- The forms include information required by Regulations under Subsection 19(6) of the Health Insurance Act.
- The practitioner must cause the particulars relating to the professional service to be set out on the assignment form before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it.
- Where a patient is unable to sign the assignment form the signature of the patient's parent, guardian or other responsible person (other than the practitioner, practitioner's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable. The reason the patient is unable to sign should also be stated. In the absence of a "responsible person" the patient signature section should be left blank and in the section headed "Practitioner's Use" or on the back of the assignment form, an explanation should be given as to why the patient was unable to sign (eg 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.

CF.5.2 The administration of the direct-billing arrangements under Medicare as well as the payment of Medicare benefits on patient claims is the responsibility of the Health Insurance Commission. Any enquires in regard to these matters should therefore be directed to the Commission's Medicare offices or enquiry points.

CF.5.3 Under Medicare any eligible dental practitioner can accept assignment of benefit and direct-bill for any eligible person.

CF.6 Use of Medicare Cards in Direct Billing

CF.6.1 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 identification number (reference number), the applicant's first given name, initial of second given name, surname and an effective "valid to" date. These cards may be issued on an individual or family basis. Up to 5 persons may be listed on the one Medicare card, and up to 9 persons may be listed under the one Medicare card number.

CF.6.2 The Medicare card plays an important part in direct billing as it can be used to imprint the patient details (including Medicare number) on the basic direct-billing forms. A special Medicare imprinter has been developed for this purpose and is available free of charge, on request, from Medicare.

CF.6.3 The patient details can of course be entered on the direct-bill forms by hand, but the use of a card to imprint patient details assists practitioners and ensures accuracy of information. The latter is essential to ensure that the processing of a claim by Medicare is expedited.

CF.6.4 The Medicare card number must be quoted on direct-bill forms. If the number is not available, then the assignment of benefit facility should not be used. To do so would incur a risk that the patient is not eligible and Medicare benefits not payable.

CF.6.5 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.

CF.7 Assignment of Benefit Forms

CF.7.1 To meet varying requirements the following types of stationery are available from Medicare. Note that these forms are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of the Health Insurance Commission.

(a) *Form DB2.* This form is used to assign benefits for services other than requested pathology. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Patient copy and a Practitioner copy.

(b) *Form DB4.* Is a continuous stationery version of Form DB2, and has been designed for use on most office accounting machines.

CF.8 The Claim for Assigned Benefits (Form DB1, DB1H)

CF.8.1 Practitioners who accept assigned benefits must claim on Medicare using Form DB1 or DB1H, the Claim for Assigned Benefits. 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 Medicare hospital 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 practitioner and setting the locum up with a provider number and pay-group link for the principal practitioner'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.

CF.8.2 The claim form must be accompanied by the Assignment forms to which the claim relates.

CF.8.3 Forms DB1 and DB1H are also loose leaf similar to form DB2 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.

CF.9 Direct-Bill Stationery

CF.9.1 Medical practitioners and eligible dental practitioners wishing to direct-bill may obtain direct-bill stationery by contacting any Medicare Office. Information on the completion of the forms and direct-bill procedures are provided with the forms. Information on direct-billing is available from any Medicare office.

CF.10 Time Limits Applicable to Lodgement of Claims for Assigned Benefits

CF.10.1 A time limit of six months applies to the lodgement of claims with Medicare under the direct-billing (assignment of benefit) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than six months earlier than the date the claim was lodged with Medicare.

CF.10.2 Provision exists whereby in certain circumstances (eg hardship cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

CG. COMPILATION AND INTERPRETATION OF THE SCHEDULE

CG.1 Compilation of the Schedule

CG.1.1 Section 2 of this Book lists the item number, description of medical service, the Schedule fee for those services in the treatment of cleft lip and cleft palate conditions for which Medicare benefits are payable and the Medicare benefits.

CG.1.2 The prescribed services have been grouped according to the general nature of the services: orthodontic, oral surgical and general and prosthodontic.

CG.2 Principles of Interpretation

CG.2.1 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.

CG.3 Multiple Operation Rule

CG.3.1 The Schedule fee 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 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.

CG.3.2 The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees and benefits specified in the Schedule apply. For these purposes the term "operation" includes items 75200- 75615.

CG.3.3 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.

CG.4 Administration of Anaesthetics by Medical Practitioners

CG.4.1 When a medical practitioner administers an anaesthetic in connection with a dental procedure prescribed for the payment of Medicare benefits (and the procedure has been performed by an eligible dental practitioner), Medicare benefits are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.

CG.4.2 To ascertain the Schedule fee for the anaesthetic, medical practitioners should refer to Group T6, Subgroup 3 of the Medicare Benefits Schedule Book.

CG.5 Definitions

CG.5.1 Orthodontic treatment planning is defined as the measurement and analysis of the face and jaws and occlusion providing a diagnosis and planned prescription of appliances and treatment required.

CG.5.2 Study models are defined as orthodontic plaster casts of the upper and lower teeth and alveolar processes.

CG.6 Oral and Maxillofacial Surgical Services - Referral (75150 - 75621)

CG.6.1 Benefits are payable for items 75150 to 75621 only where the service has been rendered to a patient who has been referred by letter of Referral by a dental practitioner accredited for orthodontic services.

CG.7 General and Prosthodontic Services (75800)

CG.7.1 Item number 75800 refers to a consultation by a dentist for prevention and prophylaxis and includes such services as dietary advice, oral hygiene and fluoride treatment.

CG.8 Over-servicing

CG.8.1 Over-servicing must be avoided. In the case of denture services, examples of over-servicing might be:-

- Unjustifiably frequent replacement of dentures;
- Provision of new dentures when relining or re-modelling of an existing prosthesis would meet the clinical need;
- Provision of metal dentures where an acrylic denture would meet the clinical need.

CG.8.2 The Schedule includes an item for metal dentures to allow for the provision of a precise, long-term prosthesis. The item is not intended for use during the period of growth, where prostheses must be replaced or altered frequently, unless there is some definite and extraordinary clinical requirement.

INTRODUCTION

This book provides information on the arrangements for the payment of Medicare benefits for optometric consultations by optometrists who undertake to participate in the benefits arrangements and by optometrists acting on their behalf. These arrangements operate under the Health Insurance Act 1973 (as amended).

Section 1 of this book contains an outline of the arrangements for optometric consultation benefits and notes for the guidance of participating optometrists, including addresses of the Department and the Health Insurance Commission.

The Schedule in Section 2 shows the item number, description of service, Schedule fee and Medicare benefit payable in respect of the optometric items.

Section 3 contains a copy of the ACommon Form of Undertaking≅ which optometrists are required to sign to participate in the arrangements.

This edition of the book has been printed for use by participating optometrists, the Health Insurance Commission and other interested authorities.

CHANGES INCLUDED IN THIS EDITION

General Fee Increase

Schedule fees for optometrical consultation items have increased by 2.4% from 1 November 2001.

This is comprised of a 1.6% general fee increase plus a 0.8% increase which has been agreed to by the Commonwealth and the Optometrists Association of Australia (OAA) to commence a return of savings that have been accrued over the period 1997-2001. Savings will be returned over the period 2001-2005. Optometrists should contact the OAA if they want further details.

OUTLINE OF PROVISIONS FOR MEDICARE BENEFITS FOR OPTOMETRIC CONSULTATIONS AND NOTES FOR GUIDANCE

O1. INTRODUCTION

O1.1 All Australian residents and certain categories of visitors to Australia can claim Medicare benefits for consultations with participating optometrists. The Health Insurance Act contains legislation covering the major elements of the Medicare program.

O1.2 Responsibility for regulating the Medicare program lies with the Commonwealth Government through the Department of Health and Aged Care. The Health Insurance Commission (HIC) is responsible for consideration of applications for the acceptance of optometric undertakings and for the day to day operation of Medicare and the payment of benefits. Addresses of the Department and the HIC (Medicare offices) are located at the end of these Notes.

O2. PARTICIPATION BY OPTOMETRISTS

O2.1 Medicare pays benefits for consultations with optometrists who have signed an agreement to participate in arrangements with the Commonwealth Government. This agreement is formally known as the "Common Form of Undertaking - Participating Optometrists" and is often referred to as the Participating Agreement. A copy of the Undertaking is contained in Section 3 of this book.

O2.2 An optometrist registered or licensed under a law in any State or Territory of Australia, who wishes to become a participating optometrist, is required to sign the Common Form of Undertaking and an employer of optometrists must sign a separate common form of undertaking except where the optometrist and the owner of the business are the same person.

O2.3 Where the optometric practice is conducted in a corporate form, such as a company or partnership, it is necessary for the corporation to become a "participating optometrist", and an additional undertaking must be signed by a person who has authority to give the undertaking on behalf of the organisation.

O2.4 The undertaking sets out the obligations to be met under the arrangements. Copies of the undertaking may be obtained from the Provider Liaison Section, Health Insurance Commission at the addresses listed at the end of these Notes.

O2.5 Where an employer of optometrists completes an undertaking, that undertaking must identify premises owned by them or in their possession. The relevant details are to be included in schedules 2 and 3 of the undertaking. An undertaking completed by an individual optometrist does not need to identify the premises from which services are to be provided as the Common Form of Undertaking applies to all premises from which the optometrists will provide services.

O2.6 When completed, the undertaking should be returned to the Manager (Eligibility), Health Insurance Commission, PO Box 1001, Tuggeranong, ACT 2901.

O2.7 The Minister may refuse to accept an undertaking given by an optometrist. In these circumstances the optometrist will be notified in writing of the refusal and is given 30 days to forward a written request to the Minister, to have the matter referred to the Professional Services Review Tribunal.

O2.8 After acceptance by the Minister, or his delegate, of the completed undertaking, a letter of acceptance of the undertaking will be forwarded to the optometrist. At the same time, the HIC will send the optometrist a supply of assignment forms and claim forms for assignment of Medicare benefits, together with the necessary instructions for direct-billing purposes.

O2.9 The Manager (Eligibility) must be notified in writing of any changes to the details furnished by an optometrist in schedule 2 and schedule 3 of the undertaking.

O2.10 Participating optometrists may at any time terminate undertakings either wholly or as they relate to particular premises, by notifying the Manager (Eligibility), Health Insurance Commission, PO Box 1001, Tuggeranong ACT 2901. The date of termination may not be earlier than 30 days after the date on which the notice is served.

O2.11 The names and addresses of participating optometrists may be obtained from the Manager (Eligibility), Health Insurance Commission, PO Box 1001, Tuggeranong ACT 2901, if the Minister or the Minister's delegate certifies in writing that this is necessary in the public interest.

O3. PROVIDER NUMBERS

O3.1 To ensure that benefits are paid only for services provided by optometrists registered in a State or Territory of Australia, each optometrist providing consultations for which a Medicare benefit is payable requires an individual provider number.

O3.2 Provider numbers will be issued only to individual participating optometrists registered in a State or Territory of Australia. Corporations, other business entities and individuals who are not registered optometrists will not be issued with provider numbers.

O3.3 Provider numbers are allocated to practitioners to enable claims for Medicare benefits to be processed and cheques to be correctly drawn in favour of the practitioner where applicable. The number may be up to eight characters. The second last character identifies the practice location, the last being a check character.

O3.4 Optometrists can obtain a provider number from Medicare. A separate provider number is issued for each location at which an optometrist practices and has current State/Territory registration. Provider numbers for additional practice locations may also be obtained from Medicare following confirmation of State/Territory registration. Optometrists cannot use another optometrist's provider number.

O3.5 If a practitioner wishes Medicare benefits cheques, which would normally be drawn in favour of the practitioner, to be made payable to another payee and/or another address, written authority can be given to Medicare to do this. This payment to another party is known as a pay group link. There can only be one pay group link for an individual practice location but multiple practitioners and practice locations can be linked to one pay group. Further information on pay group links may be obtained from Medicare (addresses at the end of the Notes).

Locum Tenens

O3.6 An optometrist who has signed a Common Form of Undertaking and is to provide services at a practice location as a locum for more than 2 weeks or will return to the practice on a regular basis for short periods should apply for a provider number for that location.

O3.7 If the locum is to provide services at a practice for less than 2 weeks, the locum can use their own provider number or can obtain an additional provider number for that location (see O3.4).

O3.8 Normally, Medicare benefits are payable for services rendered by an optometrist only when the optometrist has completed a Common Form of Undertaking. However, benefits may be claimed for services provided by an optometrist who has not signed the Undertaking if the optometrist has provided them on behalf of an optometrist who has signed the Common Form of Undertaking. To ensure benefits are payable when a locum practices in these circumstances, the locum optometrist should:

- Check that they will be providing optometry services on behalf of a participating optometrist i.e. their employer has a current “Common Form of Undertaking”
- Notify the HIC in writing, before commencing the locum arrangement of the name and address of the participating optometrist on whose behalf they will be providing services.

O3.9 Locums can direct Medicare payments to a third party e.g the principal of the practice, by either arranging a pay group link and/or by nominating the principal as the payee provider on direct bill stationery (see para 03.5,7.22).

O4. PATIENT ELIGIBILITY

Eligible persons

O4.1 For the purpose of the optometric arrangements, an eligible person is:

- a person who holds the normal Medicare card as issued to Australian residents; or
- a person who holds a Medicare card which shows "Visitor" and the period of eligibility.

O4.2 Medicare benefits are not payable for optometric consultations for persons holding a Medicare card which is endorsed "Reciprocal Health Care" on the face of the card.

O4.3 See paragraph O4.5 below for details on the various types of Medicare cards issued.

Medicare cards

O4.4 An eligible person who applies to enrol for Medicare benefits (using a Medicare Enrolment/ Amendment Application) will be issued with a uniquely numbered Medicare card which shows the Medicare Card number, the patient identification number (reference number), the applicant's first given name, initial of second given name, surname and an effective "valid to" date. These cards may be individual or family based. 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.

O4.5 Currently, there are three types of Medicare cards issued:

- the normal card for Australian residents which has only the month and year to which the card is valid at the bottom right hand side of the card and entitles the bearer to unrestricted access to Medicare benefits.
- a visitor card which entitles the bearer to unrestricted access to Medicare benefits. Persons who would be issued with this type of card are persons who have come to Australia under various longer term Government schemes which have special Government approval. The Medicare card shows "VISITOR" and an expiry date at the bottom of the card.
- a Reciprocal Health Care Agreement card for persons from countries which have an Agreement with Australia to provide access to Medicare for services that are "immediately necessary" medical and hospital treatment but NOT optometric consultations. The Medicare card differs in colour to the usual Medicare card, is endorsed "RECIPROCAL HEALTH CARE" and includes a "valid to" date.

Note: A Reciprocal Health Care Agreement card is NOT valid for optometric consultations.

Optometric expenses overseas

O4.6 Medicare benefits under the Health Insurance Act are not available in respect of services rendered outside Australia. It is recommended that Australian residents travelling overseas take out private travellers or health insurance, which offers adequate coverage for the countries to be visited.

O5. BENEFITS FOR SERVICES BY PARTICIPATING OPTOMETRISTS

What services are covered

O5.1 The services coming within the scope of the optometric consultation benefit arrangements are those clinically relevant services ordinarily rendered by the optometrist in relation to consultation on ocular or vision problems.

O5.2 Benefits may only be claimed when:

(a) a procedure has been performed and a clinical record of the consultation has been made;
(b) a significant consultation or examination procedure has been carried out;
(c) the consultation has been performed at premises listed in an undertaking;
(d) the consultation has involved the personal attendance of both the patient and the optometrist; and
(e) the service is "clinically relevant", (as defined in the Health Insurance Act,) i.e., a service rendered by an optometrist that is generally accepted in the optometric profession as being necessary for the appropriate treatment of the patient to whom it is rendered.

Where Medicare benefits are not payable

O5.3 Medicare benefits may not be claimed for attendances for:

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

O5.4 Benefits are not payable for optometrical services associated with:

(i) cosmetic surgery
(ii) refractive surgery
(iii) tests for fitness to undertake sporting, leisure or vocational activities
(iv) compulsory examinations or tests to obtain any commercial licence (eg flying or driving)
(v) entrance to schools or other educational facilities
(vi) compulsory examinations for admissions to aged care facilities
(vii) vision screening

O5.5 Medicare benefits are not payable for services in the following circumstances:

(a) where the expenses for the service are paid or payable to a recognised (public) hospital;
(b) where the service is provided by teaching institutions to patients of supervised students;
(c) where the service is not "clinically relevant" (as described in the Health Insurance Act, i.e. a service rendered by an optometrist that is generally accepted in the optometric profession as being necessary for the appropriate treatment of the patient to whom it is rendered).

O5.6 Unless the Minister otherwise directs, a benefit is not payable in respect of an optometric consultation where:

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

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

O5.7 A condition of the participating arrangement is that the optometrist agrees not to submit an account or a claim for services rendered to any dependants of the optometrist, to his or her employer or practice partner or any dependants of that employer or partner.

Workers' compensation, third party insurance, damages, etc.

O5.8 From 1 February 1996, Medicare benefits are payable for optometric expenses for professional services that are wholly covered by workers compensation or damages under a Commonwealth or State or Territory law.

O5.9 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 optometric expenses of the person will be paid by the insurer as and when they arise.)

O5.10 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.

O5.11 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 Medicare. These recovery arrangements do not impact on practitioners.

O6. SCHEDULE FEES AND MEDICARE BENEFITS

Schedule fees and Medicare benefits

O6.1 Optometrists participating in the scheme agree not to charge more than the Schedule fees for services covered by Medicare, and also, that charges for appliances shall not include any amount related to consultation procedures for which benefits are payable. The only exceptions are for Item 10907 and in relation to domiciliary visits - see paragraphs O6.13 and O6.18.

O6.2 The services provided by participating optometrists which attract benefits are set out in the Health Insurance Regulations. Details of the services, including the Schedule fee and Medicare benefits for each service are contained in Section 2 of this book.

O6.3 Medicare benefits are payable at 85% of the Schedule fee for services rendered with a maximum gap payment for any one service of $55.60 (indexed annually) between the Medicare rebate and the Schedule fee.

O6.4 Where it can be established that payments of $302.30 (indexed annually from 1 January) have been made for a family group or an individual during a calendar year in respect of the difference between the Medicare benefit and the Schedule fee for services rendered, benefits will be paid for expenses incurred for professional services rendered during the rest of that year up to 100% of the Schedule fee. This does not apply to the assignment of benefit arrangements. A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25.

Limiting rule for patient claims

O6.5 Where a fee charged for a consultation is less than the Medicare benefit, the benefit will be reduced to the amount of the fee actually charged. In no case will the benefit payable exceed the fee charged.

Multiple attendances

O6.6 Payment of benefit may be made for several attendances on a patient on the same day by the same optometrist provided that the subsequent attendances are not a continuation of the initial or earlier attendances. However, there should be a reasonable lapse of time between the consultations before they can be regarded as separate attendances.

O6.7 Where two or more attendances are made on the one day by the same optometrist the time of each attendance should be stated on the account (eg. 10.30 am and 3.15 pm) in order to assist in the payment of benefits.

O6.8 In some circumstances a subsequent consultation on the same day may be judged to be a continuation of an earlier attendance and a second benefit is not payable. For example, a preliminary eye examination may be concluded with the instillation of mydriatic or cycloplegic drops and some time later additional examination procedures are undertaken. These sessions are regarded as being one attendance for benefit purposes.

Referred comprehensive initial consultations (Item 10905)- Read in conjunction with 09.1 - 09.13

O6.9 For the purposes of Item 10905, the referring optometrist, having considered the patient's need for the referred consultation, is required to provide a written referral, dated and signed, and setting out the patient's condition and the reason for the referral.

O6.10 Benefits will be paid at the level of Item 10905 providing the referral is received before the provision of the service, and providing the account, receipt or bulk-billing form contains the name and provider number of the referring optometrist. Referrals from medical practitioners do not attract benefit under item 10905.

O6.11 The optometrist claiming the Item 10905 service is obliged to retain the written referral for a period of twenty-four months.

O6.12 Referrals must be at "arms length". That is to say, no commercial arrangements or connections should exist between the optometrists.

Second comprehensive initial consultation within 24 months of a previous comprehensive consultation (Item 10907)

O6.13 Where a patient receives a comprehensive initial consultation within 24 months of a previous comprehensive consultation provided by another optometrist an additional fee may be charged provided that the service is not direct-billed. The actual additional amount charged is a matter between the optometrist and the patient but it must not exceed an amount equal to the difference between the Schedule fees for Item 10900 and Item 10907.

O6.14 In circumstances where an additional fee is charged the optometrist must inform the patient of the benefit payable for Item 10907 at the time of the consultation and that the additional fee will not attract benefits.

O6.15 Where it is necessary for the optometrist to seek patient information from Medicare in order to determine appropriate itemisation of accounts, receipts or bulk-billed claims, the optometrist must ensure that:-

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

Significant change in visual function requiring comprehensive re-evaluation (Item 10912)

O6.16 Significant changes in visual function which justify the charging of Item 10912 include documented changes of:

- visual fields or previously undetected field loss
- binocular vision
- contrast sensitivity or previously undetected contrast sensitivity loss

New Signs or symptoms/progressive disorder requiring comprehensive re-evaluation (Items 10913 and 10914)

O6.17 When charging Item 10913 or Item 10914, the optometrist must document the new signs or symptoms or the nature of the progressive disorder suffered by the patient on the patient's record card. Progressive disorders may include conditions such as maculopathy (including age related maculopathy or diabetic retinopathy) cataract, corneal dystrophies, glaucoma etc.

Domiciliary visits

O6.18 A domiciliary visit is one conducted away from the optometrist's practice at the patient's place of residence, be it their home, nursing home or hospital.

O6.19 In the case of a domiciliary visit provided at the patient's request an extra fee may be charged, in addition to the Schedule fee provided the service is not direct-billed. The actual additional amount charged is a matter between the optometrist and the patient but it must not exceed an amount equal to the fee for Item 10900 - Initial Consultation.

O6.20 No Medicare benefits are payable for the additional amount that may be charged for a domiciliary visit. The patient must make up the difference between the rebate and the fee charged.

O6.21 Charges for domiciliary visits should be shown separately on accounts issued by optometrists and not included in the fee for the consultation (refer paragraph O7.11).

Release of prescription

O6.22 Where a spectacle prescription is prepared for the patient, it becomes the property of the patient, who is free to have the spectacles dispensed by a person of the patient's choice. The optometrist will ensure that the patient is made aware that he or she is entitled to a copy of the spectacle prescription.

O6.23 Contact lens prescriptions are excluded from the above provision, although the prescription remains the property of the patient and should be available to the patient at the completion of the prescription and fitting process.

Reminder notices

O6.24 The optometrist will ensure that any notice sent to a patient suggesting re-examination is sent solely on the basis of the clinical needs of the patient.

Aftercare period following surgery

O6.25 Medicare schedule items that apply to surgery include all professional attendances necessary for the post-operative treatment of the patient. The aftercare period includes all post-operative treatment, whether provided by a medical practitioner or an optometrist. The amount and duration of the aftercare may vary but includes all attendances until recovery from the operation. Attendances provided by an optometrist in the aftercare period do not attract a Medicare benefit.

O6.26 The rebate for cataract surgery includes payment for aftercare attendances so payment for aftercare services provided by an optometrist on behalf of a surgeon should be arranged with the surgeon. The optometrist should not

charge the patient. In the case of cataract surgery, the first visit following surgery for which the optometrist can charge a rebatable fee is generally the attendance at which a prescription for spectacles or contact lenses is written.

O6.27 Medicare benefits are not available for refractive surgery, consultations in preparation for the surgery or consultations in the aftercare period. Charges for attendances by optometrists may be made directly to the patient or to the surgeon depending on the arrangements made prior to surgery. Accounts and receipt issued to the patient should clearly indicate the fee is non-rebatable.

O7. BILLING PROCEDURES

O7.1 There are three ways benefits may be paid for optometric consultations:

(i) the patient may pay the optometrist's account and then claim benefits from a Medicare office by submitting the account and the receipt;

(ii) the patient may submit the unpaid account to Medicare which will then draw a cheque in favour of the optometrist; or

(iii) the optometrist may bill Medicare instead of the patient for the consultation. This mechanism is known as direct billing. If an optometrist direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the consultation. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient.

Note: Additional charges must not be levied in respect of domiciliary visits and consultations covered by Item 10907 if the services are direct-billed.

Claiming of benefits

O7.2 The patient, upon receipt of an optometrist's account, has two courses open for paying the account and receiving benefits.

Paid accounts

O7.3 If the account has been paid, the claimant can obtain a cash benefit (up to certain limits) from a Medicare office. Alternatively they may lodge a claim by post, by fax in selected pharmacies and Rural Transaction Centres, or telephone (in rural areas throughout Australia) for a payment by Electronic Funds Transfer (EFT) or cheque.

Unpaid accounts

O7.4 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 optometrist.

O7.5 It is the patient's responsibility to forward the cheque to the optometrist and make arrangements for payment of the balance of the account, if any. "Pay optometrist cheques" involving Medicare benefits cannot be sent direct to optometrists, or to patients at an optometrist's address (even if requested by the patient to do so). "Pay optometrist cheques" will be forwarded to the patient's normal address.

O7.6 When issuing a receipt to a patient for an account that is being paid wholly or in part by a Medicare "pay optometrist cheque" the optometrist should indicate on the receipt that a "Medicare" cheque for $..... was involved in the payment of the account.

Itemised accounts

O7.7 When an optometrist bills a patient for a consultation, the patient should be issued with a properly itemised account and receipt to enable him/her to claim Medicare benefits.

O7.8 Medicare benefits are not payable in respect of an optometric consultation unless there is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of each consultation to each patient, the following information:-

(i) patient's name;

(ii) date on which the consultation was rendered;

(iii) a description of the consultation (eg. "initial consultation, "subsequent consultation" or "contact lens consultation");

(iv) Medicare Benefits Schedule item number;

(v) the name and practice address or name and provider number of the optometrist who actually rendered the service. Where the optometrist has more than one practice location, the provider number used should be that which is applicable to the practice location where the service was given;

(vi) the fee charged for that consultation;

(vii) the time each consultation began if the optometrist attended the patient on more than one occasion on the same day and on each occasion rendered a professional service relating to an optometric item;

O7.9 The optometrist billing for the service bears responsibility for the accuracy and completeness of the information included on accounts, receipts and assignment of benefits forms even where such information has been recorded by an employee of the optometrist.

O7.10 Payment of benefits could be delayed or disallowed if the account does not clearly identify the service as one which qualifies for Medicare benefits or that the practitioner is a registered optometrist practising at the address where the service was rendered. It is important to ensure that an appropriate description of the service, the item number and the optometrist's provider number is included on accounts, receipts and assignment forms.

O7.11 Details of any charges made other than for consultations, eg. a dispensing charge, a charge for a domiciliary visit, should be shown separately either on the same account or on a separate account.

O7.12 Patients must be eligible to receive Medicare benefits and must also meet the clinical requirements outlined in the relevant item descriptors.

Duplicate accounts

O7.13 Only one original itemised account per consultation should be issued. Duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

Assignment of benefit (direct billing) arrangements

O7.14 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.

O7.15 If an optometrist direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the consultation. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:

- The patient's Medicare number must be quoted on all direct-bill forms for that patient.
- The basic forms provided are loose leaf to enable the patient details to be imprinted from the Medicare card.
- The optometrist must state the particulars relating to the consultation on the assignment form before the patient signs the form and give the patient 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 participating optometrist, participating optometrist's staff, hospital proprietor, hospital staff, nursing home proprietor or nursing home staff) is acceptable. The reason the patient was unable to sign should be stated.
- In the absence of a "responsible person" the patient signature section on the form should be left blank and an explanation as to why the patient was unable to sign should be given in the section headed "Practitioner Use" or on the back of the assignment form. The Attending Optometrist should initial the explanation. If the reason for the patient being unable to sign would be an unacceptable breach of confidentiality or would be unduly embarrassing or distressing, the optometrist may explain the situation using the concessional reason "due to medical condition". This wording should not be used routinely and in most cases it is expected that the reason given would be more specific.

Use of Medicare cards in direct billing

O7.16 The Medicare card plays an important part in direct-billing as it can be used to imprint the patient details (including Medicare number) on the basic direct-billing forms. A special Medicare imprinter is used for this purpose and is available free of charge, on request, from Medicare.

O7.17 The patient details can, of course, be entered on the direct-bill forms by hand, but the use of the card to imprint patient details assists optometrists and ensures accuracy of information. The latter is essential to ensure that the processing of a claim by Medicare is expedited.

O7.18 The Medicare card number must be quoted on direct-bill forms. If the number is not available, then the assignment of benefit facility should not be used. To do so would incur a risk that the patient may not be eligible and Medicare benefits not payable.

O7.19 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 optometrist may contact a Medicare telephone enquiry number to obtain the number.

O7.20 It is important for the optometrist to check the eligibility of patients for Medicare benefits by reference to the card, as entitlement is limited to the "valid to" date shown on the bottom of the card. Additionally the card will show if a person is enrolled through a Reciprocal Health Care Agreement. Benefits are not payable for this category.

Assignment of benefit forms

O7.21 Only the approved forms available from the HIC can be used to direct bill patients for optometric consultations and no other form can be used without the approval of the Commission.

(a) *Form DB2*
It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a patient copy and a practitioner copy.

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

The claim for assigned benefits (Form DB1)

O7.22 Optometrists who accept assigned benefits i.e., who direct bill on behalf of a patient, must claim from Medicare using Claim for Assigned Benefits form DB1. The form has been designed to enable the payment to be made to an optometrist other than the one who rendered the service. This facility is intended for use in situations such as where a short-term locum is acting on behalf of the principal optometrist and setting the locum up with a provider number and pay-group link is impractical. It should be noted that in order to use this facility, the provider number of the principal optometrist should be indicated in the section “Payee's Provider Number”. Optometrists should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.

O7.23 Each claim form must be accompanied by the assignment forms to which the claim relates.

O7.24 The DB1 is also loose leaf to enable imprinting of optometrists' details using the special Medicare imprinter. For this purpose, optometrist cards, showing the optometrist's name, practice address and provider number are available from the HIC on request.

O7.25 When an optometrist direct-bills Medicare, the assignment forms take the place of the conventional accounts and receipts. It is important therefore, that the assignment forms show for each service to each patient the information required on patient's accounts as mentioned in paragraph O7.8.

O7.26 Detailed instructions regarding requirements for completion and submission of claims for assigned benefits are included with the assignment stationery provided by the HIC.

O7.27 The assignment form should be signed by the patient. The name of the optometrist who conducted the examination should be shown in the space on the form titled "Name of practitioner who actually rendered the professional service being claimed" together with his/her provider number or address.

O7.28 The claim form must be signed and dated by the optometrist who rendered the services described on the assignment forms attached to the claim form. This claim form must also be witnessed and the witness identified.

O7.29 A claim form together with corresponding assignment forms should be forwarded to the HIC at the convenience of the optometrist. The only proviso is that there should be no more than fifty (50) assignment forms with each claim. If more than 50 are received processing may be delayed.

Time limits applicable to lodgement of claims for Medicare benefits

O7.30 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.

O7.31 Provision exists whereby in certain circumstances (eg. hardship cases, third party or 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.

O8. LIMITATIONS ON BENEFITS

Single Course of Attention

O8.1 A reference to a single course of attention means:-

(a) In the case of Items 10900 to 10918 - a course of attention by one or more optometrists in relation to a specific episode of optometric care.

(b) In relation to Items 10921 to 10930 - a course of attention, including all associated attendances, by one or more optometrists for the purpose of prescribing and fitting of contact lenses.

Initial consultations

O8.2 The initial consultation item (Item 10900) is payable once only within 24 months of the previous standard consultation (Item 10900, 10905, 10907, 10912, 10913 or 10914). However, a benefit is payable under Item 10912, 10913 or 10914 where the patient has an ocular condition which necessitates a further course of attention being started within 24 months of the previous initial consultation. The conditions which qualify for a further course of attention are contained in the descriptions of these items (see paragraphs 06.16 and O6.17).

O8.3 Where an attendance would have been covered by Item 10900, 10905, 10907, 10912, 10913, or 10914 but is of 15 minutes duration or less, Item 10916 (Short consultation) applies.

Second or subsequent consultations (Item 10918)

O8.4 Each consultation, apart from the initial consultation, in a single course of attention, other than a course of attention involving the fitting and prescription of contact lenses, is covered by Item 10918.

Contact lens consultations (Items 10921 to 10930)

O8.5 In the case of contact lens consultations, benefit is payable only where the patient is one of the prescribed classes of patient entitled to benefit for contact lens consultations as described in Items 10921 to 10929.
For claims under Items 10921, 10922,10923,10925 and 10930, eligibility is based on the patient's distance spectacle prescription, determining the spherical equivalent by adding to the spherical prescription, half the cylindrical correction.

O8.6 Medicare benefits are not payable for Item 10929 in circumstances where patients want contact lenses for:
reasons of appearance (because they do not want to wear spectacles);
sporting purposes;
work purposes; or
psychological reasons (because they cannot cope with spectacles).

O8.7 All attendances subsequent to the initial consultation in a course of attention involving the prescription and fitting of contact lenses are collectively regarded as a single service under Items 10921 to 10930, as appropriate. The date of service is deemed to be the date on which the contact lenses are delivered to the patient. Any visits related to the prescribing and fitting of lenses are regarded to be covered by the 10921 to 10930. The bulk item includes those aftercare visits necessary to ensure the satisfactory performance of the lenses. This interpretation is unaltered by the frequency of aftercare visits associated with various lens types including extended wear lenses. Consultations during the aftercare period that are unrelated to the prescription and fitting of contact lenses or that are not part of normal aftercare may be billed under other appropriate items (not Items 10921 to 10930).

O8.8 For patients not eligible for Medicare rebates for contact lens care, fees charged for contact lens consultations are a matter between the practitioner and the patient. Any account for consultations involving the fitting and prescription of contact lenses issued to a patient who does not fall into the specified categories should be prepared in such a way that it cannot be used to obtain benefits. No Medicare item number should be attached to any service that does not attract benefits and the optometrist should annotate the account with wording such as "Medicare benefits not payable".

O8.9 Where an optometrist wishes to apportion the total fee to show the appropriate optometric consultation benefit and the balance of the fee, he or she should ensure that the balance is described in such a way (eg. balance of account) that it cannot be mistaken as being a separate consultation. In particular no Medicare item number should be shown against the balance.

O8.10 When a patient receives a course of attention involving the prescription and fitting of contact lenses an account should not be issued (or an assignment form completed) until the date on which the patient takes delivery of the lenses.

O8.11 Benefit under Items 10921-10929 is payable once only in any period of 36 consecutive months except where circumstances are met under Item 10930 within a 36 month period.

Additional payments for optometrists visiting isolated areas (the Visiting Optometrical Scheme)

O8.12 Special arrangements exist under the provisions of Section 129A of the Health Insurance Act to enable optometrists who visit isolated areas where optometric services are not otherwise available to provide services without additional charge to patients. Optometrists are particularly encouraged to provide these services to Aboriginal and Torres Strait Islander communities in remote areas.

O8.13 Under these arrangements, assistance may be provided in the form of per capita payments directly related to the numbers of patients attended, with individual rates approved for each applicant who meets the criteria for assistance, in respect of visits to specified locations.

O8.14 This assistance is provided because the participating nature of the benefit arrangements does not permit optometrists to charge fees higher than Medicare Schedule fees to offset the additional costs involved in visiting remote areas.

O8.15 Visiting optometrists may obtain application forms for such assistance from the State Manager, Commonwealth Department of Health and Aged Care. Addresses of State offices are located at the end of these Notes.

08.16 Visiting optometrists should also note that Regional Eye Health Co-ordinators located in several Aboriginal Community Controlled Health Services in each State and Territory may be able to assist in arranging and establishing ongoing visits. Optometrists are advised to contact their State Office of the Commonwealth Department of Health and Aged Care.

O9. REFERRALS

General

O9.1 Optometrists are required to refer a patient for medical attention when it becomes apparent to them that the patient's condition is such that it would be more appropriate for treatment to be undertaken by a medical practitioner.

O9.2 Optometrists may refer patients directly to specialist ophthalmologists with the patient being able to claim benefits for the ophthalmologist's services at the referred specialist rate.

O9.3 Optometrists may refer patients directly to another optometrist, based on the clinical needs of the patient.

O9.4 A referral letter or note must have been issued by the optometrist for all such services provided by specialist ophthalmologists or optometrists in order for patients to be eligible for Medicare benefit at the referred rate. Unless such a letter or note has been provided, benefits will be paid at the unreferred rate.

O9.5 Medicare benefits at the referred rate are not paid for patients referred by optometrists to consultant physicians or to specialists other than ophthalmologists. See paragraph O9.13 regarding emergency situations.

What is a referral

O9.6 For the purposes of the optometric arrangements, a "referral" is a request to a specialist ophthalmologist or another optometrist for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

O9.7 Subject to the exceptions in paragraph O9.8 below, for a valid "referral" to take place:

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

(ii) the instrument of referral must be in writing by way of a letter or note and must be signed and dated by the referring optometrist; and

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

O9.8 The exceptions to the requirements in paragraph O9.7 are that:

(a) sub-paragraphs (ii) and (iii) do not apply to an emergency situation where the specialist ophthalmologist was of the opinion that the service be rendered as quickly as possible (see para O9.13); and

(b) sub-paragraph (iii) does not apply to instances where a written referral was completed by a referring optometrist but was lost, stolen or destroyed.

Period for which referral is valid

O9.9 If a referring optometrist wishes that a referral to a specialist ophthalmologist be for a period less than or more than 12 months (eg. 3, 6 or 18 months or valid indefinitely), he/she should indicate this to the specialist ophthalmologist.

O9.10 The referral is valid for the period specified (or 12 months where not otherwise indicated) from the date of the specialist ophthalmologist's first service.

O9.11 The purpose of permitting a referral for longer than 12 months is to obviate the necessity for a chronically ill patient, who is under the continuing care and management of a specialist for a specific condition(s), to obtain a new referral at the end of each 12 months.

Self referral

O9.12 Optometrists may refer themselves to specialist ophthalmologists or other optometrists and Medicare benefits are payable at referred rates.

Emergency situations

O9.13 In an emergency situation (as defined in the regulations) where the specialist or the consultant physician is of the opinion that the service be rendered as quickly as possible and endorses the account, receipt or assignment form "Emergency referral", Medicare benefits are payable even though there is no written referral. This provision only applies to the initial attendance. For subsequent attendances to attract benefits at the referred rate a referral must be obtained from a medical practitioner or, in the case of a specialist ophthalmologist, a medical practitioner or an optometrist.

O10. PROVISION FOR REVIEW AND INQUIRY

Optometric Benefits Consultative Committee (OBCC)

O10.1 The OBCC is an advisory committee established in 1990 by arrangement between the Minister and the Optometrical Association Australia.

O10.2 The OBCC's functions are:

(i) to consider the appropriateness of existing Medicare Benefits Schedule items, including the need to combine, delete or create items, and the need to amend item descriptions;

(ii) to undertake reviews of particular services and to report on the appropriateness of the existing structure of the Schedule, having regard to current optometric practice;

(iii) to provide a forum for the discussion on fees and fee relativities for individual optometric items in the Medicare Benefits Schedule (but not so as to involve a general review of the overall level of optometric fees);

(iv) to consider and advise on the appropriateness of the participating optometrists' arrangements and the Common Form of Undertaking (as specified in the Health Insurance Act and related legislation) and the administrative rules and interpretations which determine the payment of benefits for optometric services or the level of benefits;

(v) to investigate specific matters associated with the participating optometrists' arrangements and to advise on desirable changes.

O10.3 The OBCC comprises two representatives from the Department of Health and Aged Care, two representatives from the Health Insurance Commission, and three representatives from the Optometrical Association Australia.

Professional Services Review (PSR) Scheme

O10.4 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). A practitioner includes an optometrist.

O10.5 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.

O10.6 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.

O10.7 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.

O10.8 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.

O10.9 The Director also has the power to dismiss an investigative referral, set up a PSR Committee, negotiate a written agreement with the practitioner, or take no action.

O10.10 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. The quantum of that inappropriate practice can be reduced if the PSR Committee is satisfied that the practitioner has demonstrated exceptional circumstances in respect of any day or days on which services were rendered.

- 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.

O10.11 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. The standards which a record must meet to constitute an adequate and contemporaneous record are prescribed in regulations. A record should be completed at the time that the service was provided or as soon as

practicable afterwards. It should be sufficient to contribute to the quality and continuity of the patient's care. It should be clear and detailed enough to enable another practitioner to undertake the ongoing care of the patient. The record should also identify the service that was provided.

O10.12 If a Professional Services Review Committee finds that an optometrist has engaged in inappropriate practice, a determination must be made that the optometrist be : reprimanded; counselled; ordered to repay to the Commonwealth the whole or part of the Medicare benefits paid for the services; the optometrists undertaking be revoked either wholly or in relation to particular premises and/or partially or fully disqualified from Medicare.

O10.13 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.

010.14 Appeals against the Ministers decision to reject an application to become a Participating Optometrist may be made to the Administrative Appeals Tribunal..

O11. PENALTIES AND LIABILITIES

Penalties

O11.1 Penalties of up to $10,000 or imprisonment for up to five years 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 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.

O11.2 A penalty of up to $1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct-billing form without the necessary details having been entered on the form before the patient signs or who fails to give the patient a copy of the completed form.

Medicare Participation Review Committee (MPRC)

O11.3 The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who has been successfully prosecuted for defrauding Medicare.

O11.4 The Committees have a discretionary range of options from taking no action against the practitioner through counselling and reprimand to full or partial disqualification from participating in the Medicare benefit arrangements for up to five years.

Item	Service	Fee ($)
	ATTENDANCES	
	GROUP A1 - GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
1 NoteA.5 NoteA.10 Note DIA.6	Professional attendance being an attendance at other than consulting rooms, by a general practitioner on not more than 1 patient on the 1 occasion - each attendance, other than an attendance between 11pm and 7am, 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 day not being a Saturday, Sunday or public holiday, 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	$91.40
2 NoteA.5 NoteA.10	Professional attendance being an attendance at consulting rooms, by a general practitioner on not more than 1 patient on the 1 occasion - each attendance, other than an attendance between 11pm and 7am, 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 day not being a Saturday, Sunday or public holiday, 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	$91.40
3 NoteA.5	Professional attendance at consulting rooms (not being a service to which any other item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management each attendance	$13.10
4 NoteA.5	Professional attendance, other than a service to which any other item applies, and not being an attendance at consulting rooms, an institution, a hospital or a residential aged care facility by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management - an attendance on 1 or more patients on 1 occasion - each patient	Derived Fee
13 NoteA.5 NoteA.6	Professional attendance at an institution (not being a service to which any other item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management an attendance on 1 or more patients at 1 institution on 1 occasion each patient	Derived Fee
19 NoteA.5 NoteA.7	Professional attendance at a hospital (not being a service to which any other item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management an attendance on 1 or more patients at 1 hospital on 1 occasion each patient	Derived Fee

Item	Service	Fee ($)
20 NoteA.5 NoteA.8 NoteA.9	Professional attendance (not being a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in a residential aged care facility (not being accommodation in a self-contained unit) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion each patient	Derived Fee
23 NoteA.5	Professional attendance at consulting rooms (not being a service to which any other item applies) by a general practitioner 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 or 44 applies each attendance	$28.75
24 NoteA.5	Professional attendance, other than a service to which any other item applies, and not being an attendance at consulting rooms, an institution, a hospital or a residential aged care facility by a general practitioner 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 37 to 47 applies - an attendance on 1 or more patients on 1 occasion each patient	Derived Fee
25 NoteA.5 NoteA.6	Professional attendance at an institution (not being a service to which any other item applies) by a general practitioner 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 38 or 48 applies an attendance on 1 or more patients at 1 institution on 1 occasion each patient	Derived Fee
33 NoteA.5 NoteA.7	Professional attendance at a hospital (not being a service to which any other item applies) by a general practitioner 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 40 or 50 applies an attendance on 1 or more patients at 1 hospital on 1 occasion each patient	Derived Fee
35 NoteA.5 NoteA.8	Professional attendance (not being a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (not being accommodation in a self-contained unit) by a general practitioner 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 43 or 51 applies an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion each patient	Derived Fee

Item	Service	Fee ($)
36 NoteA.5	Professional attendance at consulting rooms (not being a service to which any other item applies) by a general practitioner 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 applies each attendance	$54.60
37 NoteA.5	Professional attendance, other than a service to which any other item applies, and not being an attendance at consulting rooms, an institution, a hospital or a residential aged care facility by a general practitioner 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, or a professional attendance of less than 40 minutes duration involving components of a service to which item 47 applies - an attendance on 1 or more patients on 1 occasion each patient	Derived Fee
38 NoteA.5 NoteA.6	Professional attendance at an institution (not being a service to which any other item applies) by a general practitioner 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 48 applies an attendance on 1 or more patients at 1 institution on 1 occasion each patient	Derived Fee
40 NoteA.5 NoteA.7	Professional attendance at a hospital (not being a service to which any other item applies) by a general practitioner 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 50 applies an attendance on 1 or more patients at 1 hospital on 1 occasion each patient	Derived Fee
43 NoteA.5 NoteA.8	Professional attendance (not being a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (not being accommodation in a self-contained unit) by a general practitioner 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 51 applies an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion each patient	Derived Fee
44 NoteA.5	Professional attendance at consulting rooms (not being a service to which any other item applies) by a general practitioner 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 each attendance	$80.40

Item	Service	Fee ($)
47 NoteA.5	Professional attendance, other than a service to which any other item applies, and not being an attendance at consulting rooms, an institution, a hospital or a residential aged care facility by a general practitioner 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 - an attendance on 1 or more patients on 1 occasion each patient	Derived Fee
48 NoteA.5 NoteA.6	Professional attendance at an institution (not being a service to which any other item applies) by a general practitioner 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 an attendance on 1 or more patients at 1 institution on 1 occasion each patient	Derived Fee
50 NoteA.5 NoteA.7	Professional attendance at a hospital (not being a service to which any other item applies) by a general practitioner 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 an attendance on 1 or more patients at 1 hospital on 1 occasion each patient	Derived Fee
51 NoteA.8	Professional attendance (not being a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (not being accommodation in a self-contained unit) by a general practitioner 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 an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion each patient	Derived Fee
	GROUP A2 - OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
52	Professional attendance at consulting rooms of not more than 5 minutes duration (not being a service to which any other item applies) by a medical practitioner (not being a general practitioner) each attendance	$11.00
53	Professional attendance at consulting rooms of more than 5 minutes duration but not more than 25 minutes duration (not being a service to which any other item applies) by a medical practitioner (not being a general practitioner) each attendance	$21.00
54	Professional attendance at consulting rooms of more than 25 minutes duration but not more than 45 minutes duration (not being a service to which any other item applies) by a medical practitioner (not being a general practitioner) each attendance	$38.00

Item	Service	Fee ($)
57	Professional attendance at consulting rooms of more than 45 minutes duration (not being a service to which any other item applies) by a medical practitioner (not being a general practitioner) each attendance	$61.00
58	Professional attendance (not being an attendance at consulting rooms, an institution, a hospital or a residential aged care facility) of not more than 5 minutes duration (not being a service to which any other item applies) by a medical practitioner (not being a general practitioner) - an attendance on 1 or more patients on 1 occasion each patient	Derived Fee
59	Professional attendance (not being an attendance at consulting rooms, an institution, a hospital or a residential aged care facility) of more than 5 minutes duration but not more than 25 minutes duration (not being a service to which any other item applies) by a medical practitioner (not being a general practitioner) - an attendance on 1 or more patients on 1 occasion each patient	Derived Fee
60	Professional attendance (not being an attendance at consulting rooms, an institution, a hospital or a residential aged care facility) of more than 25 minutes duration but not more than 45 minutes duration (not being a service to which any other item applies) by a medical practitioner (not being a general practitioner) - an attendance on 1 or more patients on 1 occasion each patient	Derived Fee
65	Professional attendance (not being an attendance at consulting rooms, an institution, a hospital or a residential aged care facility) of more than 45 minutes duration (not being a service to which any other item applies) by a medical practitioner (not being a general practitioner) - an attendance on 1 or more patients on 1 occasion each patient	Derived Fee
81 NoteA.6	Professional attendance at an institution of not more than 5 minutes duration (not being a service to which any other item applies) by a medical practitioner (not being a general practitioner) an attendance on 1 or more patients at 1 institution on 1 occasion each patient	Derived Fee
83 NoteA.6	Professional attendance at an institution of more than 5 minutes duration but not more than 25 minutes duration (not being a service to which any other item applies) by a medical practitioner (not being a general practitioner) an attendance on 1 or more patients at 1 institution on 1 occasion each patient	Derived Fee
84 NoteA.6	Professional attendance at an institution of more than 25 minutes duration but not more than 45 minutes duration (not being a service to which any other item applies) by a medical practitioner (not being a general practitioner) an attendance on 1 or more patients at 1 institution on 1 occasion each patient	Derived Fee
86 NoteA.6	Professional attendance at an institution of more than 45 minutes duration (not being a service to which any other item applies) by a medical practitioner (not being a general practitioner) an attendance on 1 or more patients at 1 institution on 1 occasion each patient	Derived Fee
87 NoteA.7	Professional attendance at a hospital of not more than 5 minutes duration (not being a service to which any other item applies) by a medical practitioner (not being a general practitioner) an attendance on 1 or more patients at 1 hospital on 1 occasion each patient	Derived Fee

Item	Service	Fee ($)
89 NoteA.7	Professional attendance at a hospital of more than 5 minutes duration but not more than 25 minutes duration (not being a service to which any other item applies) by a medical practitioner (not being a general practitioner) an attendance on 1 or more patients at 1 hospital on 1 occasion each patient	Derived Fee
90 NoteA.7	Professional attendance at a hospital of more than 25 minutes duration but not more than 45 minutes duration (not being a service to which any other item applies) by a medical practitioner (not being a general practitioner) an attendance on 1 or more patients at 1 hospital on 1 occasion each patient	Derived Fee
91 NoteA.7	Professional attendance at a hospital of more than 45 minutes duration (not being a service to which any other item applies) by a medical practitioner (not being a general practitioner) an attendance on 1 or more patients at 1 hospital on 1 occasion each patient	Derived Fee
92 NoteA.8	Professional attendance (not being a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (not being accommodation in a self-contained unit) of not more than 5 minutes duration by a medical practitioner (not being a general practitioner) an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion each patient	Derived Fee
93 NoteA.8	Professional attendance (not being a service to which any other item applies) at a residential aged care facility, (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (not being accommodation in a selfcontained unit) of more than 5 minutes duration but not more than 25 minutes duration by a medical practitioner (not being a general practitioner) an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion each patient	Derived Fee
95 NoteA.8	Professional attendance (not being a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (not being accommodation in a selfcontained unit) of more than 25 minutes duration but not more than 45 minutes duration) by a medical practitioner (not being a general practitioner) an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion each patient	Derived Fee
96 NoteA.8	Professional attendance (not being a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (not being accommodation in a selfcontained unit) of more than 45 minutes duration by a medical practitioner (not being a general practitioner) an attendance on 1 or more patients at 1 residential aged care facility on 1 occasion each patient	Derived Fee

Item	Service	Fee ($)
97 NoteA.10	Professional attendance being an attendance at other than consulting rooms, by a medical practitioner (not being a general practitioner) on not more than 1 patient on the 1 occasion - each attendance, other than an attendance between 11pm and 7am, 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 day not being a Saturday, Sunday or public holiday, 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	$78.35
98 NoteA.10	Professional attendance being an attendance at consulting rooms, by a medical practitioner (not being a general practitioner) on not more than 1 patient on the 1 occasion - each attendance, other than an attendance between 11pm and 7am, 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 day not being a Saturday, Sunday or public holiday, 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	$78.35
	GROUP A3 - SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
104 Note T1.3	Professional attendance by a specialist in the practice of his or her specialty where the patient is referred to him or her an attendance (other than a second or subsequent attendance in a single course of treatment) where that attendance is at consulting rooms or hospital, not being a service to which item 106 applies	$67.65
105 Note T1.3	Professional attendance by a specialist in the practice of his or her specialty where the patient is referred to him or her each attendance subsequent to the first in a single course of treatment where that attendance is at consulting rooms, hospital or residential aged care facility	$33.95
106	Professional attendance by a specialist in the practice of his or her speciality where the patient is referred to him or her - an attendance (other than a second or subsequent attendance in a single course of treatment) 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 (not being a service to which item 10801, 10802, 10803, 10804, 10805, 10806, 10807, 10808, 10809 or 10816 applies), where the attendance is at consulting rooms or hospital or residential aged care facility	$55.75
107	Professional attendance by a specialist in the practice of his or her specialty where the patient is referred to him or her an attendance (other than a second or subsequent attendance in a single course of treatment) where that attendance is at a place other than consulting rooms or hospital	$99.20
108	Professional attendance by a specialist in the practice of his or her specialty where the patient is referred to him or her each attendance subsequent to the first in a single course of treatment where that attendance is at a place other than consulting rooms or hospital or residential aged care facility	$62.80
	GROUP A4 - CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	

Item	Service	Fee ($)
110	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) where the patient is referred to him or her by a medical practitioner - initial attendance in a single course of treatment	$119.35
116	Professional attendance at consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than psychiatry) where the patient is referred to him or her by a medical practitioner each attendance (not being a service to which item 119 applies) subsequent to the first in a single course of treatment	$59.75
119 NoteA.11	Professional attendance at consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than psychiatry) where the patient is referred to him or her by a medical practitioner each minor attendance subsequent to the first in a single course of treatment	$33.95
122	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 psychiatry) where the patient is referred to him or her by a medical practitioner initial attendance in a single course of treatment	$144.90
128	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 psychiatry) where the patient is referred to him or her by a medical practitioner each attendance (other than a service to which item 131 applies) subsequent to the first in a single course of treatment	$87.55
131 NoteA.11	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 psychiatry) where the patient is referred to him or her by a medical practitioner each minor attendance subsequent to the first in a single course of treatment	$63.05
	GROUP A5 - PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
160 NoteA.12	Professional attendance for a period of not less than 1 hour but less than 2 hours (not being a service to which any other item applies) on a patient in imminent danger of death requiring continuous attendance on the patient to the exclusion of all other patients	$171.75
161 NoteA.12	Professional attendance for a period of not less than 2 hours but less than 3 hours (not being a service to which any other item applies) on a patient in imminent danger of death requiring continuous attendance on the patient to the exclusion of all other patients	$286.25
162 NoteA.12	Professional attendance for a period of not less than 3 hours but less than 4 hours (not being a service to which any other item applies) on a patient in imminent danger of death requiring continuous attendance on the patient to the exclusion of all other patients	$400.70
163 NoteA.12	Professional attendance for a period of not less than 4 hours but less than 5 hours (not being a service to which any other item applies) on a patient in imminent danger of death requiring continuous attendance on the patient to the exclusion of all other patients	$515.30

Item	Service	Fee ($)
164 NoteA.12	Professional attendance for a period of 5 hours or more (not being a service to which any other item applies) on a patient in imminent danger of death requiring continuous attendance on the patient to the exclusion of all other patients	$572.60
	GROUP A6 - GROUP THERAPY	
170 Note A.3 Note A.13	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	$93.45
171 Note A.3 Note A.13	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 3 patients	$98.50
172 Note A.3 Note A.13	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 4 or more patients	$119.80
	GROUP A7 - ACUPUNCTURE	
173 Note A.14	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	$21.65
193 NoteA.5 Note A.14	Professional attendance by a general practitioner at a place other than 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	$28.75
195 NoteA.5 Note A.14	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	Derived Fee

Item	Service	Fee ($)
	GROUP A8 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
300 Note A.15	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 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	$34.25
302 Note A.15	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 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	$68.45
304 Note A.15	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 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	$100.30
306 Note A.15	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 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	$138.45
308 Note A.15	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 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	$168.65
310	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 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.	$17.10
312	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 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.	$34.25

Item	Service	Fee ($)
314	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 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.	$50.15
316	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 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.	$69.25
318	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 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.	$84.40
319 Note A.15	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 - an attendance of more than 45 minutes duration at consulting rooms, where the patient has: (a) been diagnosed as suffering severe personality disorder, anorexia nervosa, bulimia nervosa, dysthymic disorder, substance-related disorder, somatoform disorder or a pervasive development disorder; and (b) 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.	$138.45
320	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 an attendance of not more than 15 minutes duration at hospital	$34.25
322	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 an attendance of more than 15 minutes duration but not more than 30 minutes duration at hospital	$68.45
324	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 an attendance of more than 30 minutes duration but not more than 45 minutes duration at hospital	$100.30
326	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 an attendance of more than 45 minutes duration but not more than 75 minutes duration at hospital	$138.45
328	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 an attendance of more than 75 minutes duration at hospital	$168.65

Item	Service	Fee ($)
330	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 an attendance of not more than 15 minutes duration where that attendance is at a place other than consulting rooms or hospital	$62.90
332	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 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	$98.65
334	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 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	$136.85
336	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 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	$165.55
338	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 an attendance of more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital	$197.35
342 Note A.3	Group psychotherapy (including any associated consultations 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, involving a group of 2 to 9 unrelated patients or a family group of more than 3 patients, each of whom is referred to the consultant physician by a medical practitioner each patient	$39.00
344 Note A.3	Group psychotherapy (including any associated consultations 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, involving a family group of 3 patients, each of whom is referred to the consultant physician by a medical practitioner each patient	$51.80
346 Note A.3	Group psychotherapy (including any associated consultations 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, involving a family group of 2 patients, each of whom is referred to the consultant physician by a medical practitioner each patient	$76.60

Item	Service	Fee ($)
348 Note A.3 Note A.16	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 but less than 45 minutes duration, in the course of initial diagnostic evaluation of a patient	$41.40
350 Note A.3 Note A.16	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 45 minutes duration, in the course of initial diagnostic evaluation of a patient	$93.05
352 Note A.3 Note A.16	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	$41.40
	GROUP A12 - CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
385 Note A.17	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	$67.65
386 Note A.17	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 - each attendance subsequent to the first in a single course of treatment	$33.95
387 Note A.17	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	$99.20
388 Note A.17	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- each attendance subsequent to the first in a single course of treatment	$62.80
	GROUP A13 - PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
410	Professional attendance at consulting rooms by a public health physician in the practice of his or her speciality 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	$13.10

Item	Service	Fee ($)
411	Professional attendance at consulting rooms by a public health physician in the practice of his or her speciality of public health medicine - 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	$28.75
412	Professional attendance at consulting rooms by a public health physician in the practice of his or her speciality of public health medicine - 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	$54.60
413	Professional attendance at consulting rooms by a public health physician in the practice of his or her speciality of public health medicine - 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	$80.40
414	Professional attendance at other than consulting rooms by a public health physician in the practice of his or her speciality 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	Derived Fee
415	Professional attendance at other than consulting rooms by a public health physician in the practice of his or her speciality of public health medicine - 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	Derived Fee
416	Professional attendance at other than consulting rooms by a public health physician in the practice of his or her speciality of public health medicine - 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	Derived Fee
417	Professional attendance at other than consulting rooms by a public health physician in the practice of his or her speciality of public health medicine - 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	Derived Fee

GROUP A16 - MEDICAL PRACTITIONER (SPORTS PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

Subgroup 1 - Surgery Consultations

Item	Service	Fee ($)
444 Note A.25	Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports 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	$13.10
	Subgroup 2 - Emergency Attendances - After Hours	
445 Note A.25	Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine 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 446 applies	$28.75
	Subgroup 1 - Surgery Consultations	
446 Note A.25	Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine 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 447 applies	$54.60
	Subgroup 2 - Emergency Attendances - After Hours	
447 Note A.25	Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine attendance involving taking an exhaustive history, an 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	$80.40
	Subgroup 1 - Surgery Consultations	
448 Note A.10 Note A.25	Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine 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	$91.40
	Subgroup 2 - Emergency Attendances - After Hours	
449 NoteA.10	Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine 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	$109.30

GROUP A1 - GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

Item	Service	Fee ($)
601 NoteA.5 NoteA.10	Professional attendance, being an attendance at other than consulting rooms, by a general practitioner on not more than 1 patient on the 1 occasion - each attendance on any day of the week between 11pm and 7am, 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	$109.30
602 NoteA.5 NoteA.10	Professional attendance, being an attendance at consulting rooms, by a general practitioner on not more than 1 patient on the 1 occasion - each attendance on any day of the week between 11pm and 7am, 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	$109.30
	GROUP A2 - OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
697 NoteA.10	Professional attendance, being an attendance at other than consulting rooms, by a medical practitioner, (not being a general practitioner) on not more than 1 patient on the 1 occasion - each attendance on any day of the week between 11pm and 7am, 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	$94.65
698 NoteA.10	Professional attendance, being an attendance at consulting rooms, by a medical practitioner (not being a general practitioner) on not more than 1 patient on the 1 occasion - each attendance on any day of the week between 11pm and 7am, 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	$94.65
	GROUP A14 - HEALTH ASSESSMENTS	
700 Note A.20	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	$149.90
702 Note A.20	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	$212.00

Item	Service	Fee ($)
704 Note A.20	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	$149.90
706 Note A.20	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	$212.00
	GROUP A15 - MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES	
	Subgroup 1 - Multidisciplinary Care Plans	
720 Note A.21	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	$192.75
722 Note A.21	Preparation by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), in consultation with a multidisciplinary discharge 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	$192.75
724 Note A.21	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	$96.40
726 Note A.21	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	$38.85
728 Note A.21	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, 734 to 779 apply)	$38.85

Item	Service	Fee ($)
730 Note A.21	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)	$38.85
	Subgroup 2 - Case Conferences	
734 Note A.22	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)	$75.00
736 Note A.22	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)	$112.45
738 Note A.22	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)	$149.90
740 Note A.22	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)	$75.00
742 Note A.22	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)	$112.45
744 Note A.22	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)	$149.90
746 Note A.22	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 item 720 to 730 apply) - payable not more than once for each hospital admission	$75.00

Item	Service	Fee ($)
749 Note A.22	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	$112.45
757 Note A.22	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	$149.90
759 Note A.22	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)	$53.50
762 Note A.22	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)	$85.65
765 Note A.22	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)	$117.75
768 Note A.22	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	$53.50
771 Note A.22	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	$85.65

Item	Service	Fee ($)
773 Note A.22	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	$117.75
775 Note A.22	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)	$53.50
778 Note A.22	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)	$85.65
779 Note A.22	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)	$117.75
801 Note A.24	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	$185.95
803 Note A.24	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	$247.90
805 Note A.24	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	$154.45
807 Note A.24	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	$205.85

Item	Service	Fee ($)
809 Note A.24	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	$185.95
811 Note A.24	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	$247.90
813 Note A.24	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	$154.45
815 Note A.24	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	$205.85
	GROUP A17 - DOMICILIARY MEDICATION MANAGEMENT REVIEW	
900 Note A.26	Participation by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) in a Domiciliary Medication Management Review (dmmr) for patients living in the community setting, where the medical practitioner: - assesses a patient's medication management needs, and following that assessment, refers the patient to a community pharmacy for a dmmr, and provides relevant clinical information required for the review, with the patient's consent; and - discusses with the reviewing pharmacist the results of that review including suggested medication management strategies; and - develops a written medication management plan following discussion with the patient. Benefits under this item are payable not more than once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new dmmr.	$120.00
	GROUP A18 - GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	
	Subgroup 1 - Taking Of A Cervical Smear From An Unscreened Or Significantly Underscreened Woman	

Item	Service	Fee ($)
2501 Note A.5 Note A.27	Level 'b' Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one 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; and at which a cervical smear is taken from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years surgery consultation (Professional attendance at consulting rooms)	$28.75
2503 Note A.5 Note A.27	Out-of-surgery consultation (Professional attendance at a place other than consulting rooms)	Derived Fee
2504 Note A.5 Note A.27	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 one 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; and at which a cervical smear is taken from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years surgery consultation (Professional attendance at consulting rooms)	$54.60
2506 Note A.5 Note A.27	Out-of-surgery consultation (Professional attendance at a place other than consulting rooms)	Derived Fee
2507 Note A.5 Note A.27	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 one 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; and at which a cervical smear is taken from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years surgery consultation (Professional attendance at consulting rooms)	$80.40
2509 NoteA.5 Note A.27	Out-of-surgery consultation (Professional attendance at a place other than consulting rooms)	Derived Fee

Subgroup 2 - Completion Of An Annual Cycle Of Care For Patients With Diabetes Mellitus

Item	Service	Fee ($)
2517 Note A.5 Note A.28	Level 'b' Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one 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; and which completes the requirements for a full year of care of a patient with established diabetes mellitus surgery consultation (Professional attendance at consulting rooms)	$28.75
2518 Note A.5 Note A.28	Out-of-surgery consultation (Professional attendance at a place other than consulting rooms)	Derived Fee
2521 Note A.5 Note A.28	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 one 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; and which completes the requirements for a full year of care of a patient with established diabetes mellitus surgery consultation (Professional attendance at consulting rooms)	$54.60
2522 Note A.5 Note A.28	Out-of-surgery consultation (Professional attendance at a place other than consulting rooms)	Derived Fee
2525 Note A.5 Note A.28	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 one 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 and which completes the requirements for a full year of care of a patient with established diabetes mellitus surgery consultation (Professional attendance at consulting rooms)	$80.40
2526 Note A.5	Out-of-surgery consultation (Professional attendance at a place other than consulting rooms)	Derived Fee

Subgroup 3 - Completion Of The Asthma 3+ Visit Plan

Item	Service	Fee ($)
2546 Note A.5 Note A.29	At a minimum the Asthma 3+ Visit Plan must include: - at least 3 asthma related consultations in the previous 4 weeks (minimum) to 4 months (maximum) for a patient with moderate to severe asthma - at least two of these consultations to have been planned recalls - diagnosis and assessment of severity - review of asthma related medication - provision of written asthma action plan and education to patient level 'b' Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one 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; and which completes the requirements of the Asthma 3+ Visit plan. surgery consultation (Professional attendance at consulting rooms	$28.75
2547 Note A.5 Note A.29	Out-of-surgery consultation (Professional attendance at a place other than consulting rooms)	Derived Fee
2552 Note A.5 Note A.29	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 one 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; and which completes the requirements of the Asthma 3+ Visit Plan. surgery consultation (Professional attendance at consulting rooms)	$54.60
2553 Note A.5 Note A.29	Out-of-surgery consultation (Professional attendance at a place other than consulting rooms)	Derived Fee
2558 Note A.5 Note A.29	Level 'd' Professional attendance involving taking a exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one 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 and which completes the requirements of the Asthma 3+ Visit Plan. surgery consultation (Professional attendance at consulting rooms)	$80.40
2559 NoteA.5 Note A.29	Out-of-surgery consultation (Professional attendance at a place other than consulting rooms)	Derived Fee

Item	Service	Fee ($)
	GROUP A19 - OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES	
	Subgroup 1 - Taking Of A Cervical Smear From An Unscreened Or Significantly Underscreened Woman	
2600 Note A.27	Surgery consultations (Professional attendance at consulting rooms) standard consultation of more than 5 minutes duration but not more than 25 minutes duration and at which a cervical smear is taken from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years	$21.00
2603 Note A.27	Long consultation of more than 25 minutes duration but not more than 45 minutes duration and at which a cervical smear is taken from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years	$38.00
2606 Note A.27	Prolonged consultation of more than 45 minutes duration and at which a cervical smear is taken from a woman between the ages of 20 and 69 inclusive who has not had a cervical smear in the last 4 years	$61.00
2610 Note A.27	Out-of-surgery consultations(Professional attendance at a place other than consulting rooms) standard consultation of more than 5 minutes duration but not more than 25 minutes duration and at which a cervical smear is taken from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years	Derived Fee
2613 Note A.27	Long consultation of more than 25 minutes duration but not more than 45 minutes duration and at which a cervical smear is taken from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years	Derived Fee
2616 Note A.27	Prolonged consultation of more than 45 minutes duration and at which a cervical smear is taken from a woman between the ages of 20 and 69 inclusive who has not had a cervical smear in the last 4 years	Derived Fee
	Subgroup 2 - Completion Of An Annual Cycle Of Care For Patients With Diabetes Mellitus	
2620 Note A.28	Surgery consultations (Professional attendance at consulting rooms) standard consultation of more than 5 minutes duration but not more than 25 minutes duration and which completes the requirements for a full year of care of a patient with established diabetes mellitus	$21.00

Item	Service	Fee ($)
2622 Note A.28	Long consultation of more than 25 minutes duration but not more than 45 minutes duration and which completes the requirements for a full year of care of a patient with established diabetes mellitus	$38.00
2624 Note A.28	Prolonged consultation of more than 45 minutes duration and which completes the requirements for a full year of care of a patient with established diabetes mellitus	$61.00
2631 Note A.28	Out-of-surgery consultations (Professional attendance at a place other than the consulting rooms) standard consultation of more than 5 minutes duration but not more than 25 minutes duration and which completes the requirements for a full year of care of a patient with established diabetes mellitus	Derived Fee
2633 Note A.28	Long consultation of more than 25 minutes duration but not more than 45 minutes duration and which completes the requirements for a full year of care of a patient with established diabetes mellitus	Derived Fee
2635 Note A.28	Prolonged consultation of more than 45 minutes duration and which completes the requirements for a full year of care of a patient with established diabetes mellitus	Derived Fee
	Subgroup 3 - Completion Of The Asthma 3+ Visit Plan	
2664 Note A.29	At a minimum the Asthma 3+ Visit Plan must include: - at least 3 asthma related consultations in the previous 4 weeks (minimum) to 4 months (maximum) for a patient with moderate to severe asthma - at least two of these consultations to have been planned recalls - diagnosis and assessment of severity - review of asthma related medication - provision of written asthma action plan and education to patient surgery consultations (Professional attendance at consulting rooms) standard consultations of more than 5 minutes duration but not more than 25 minutes duration and which completes the requirements of the Asthma 3+ Visit Plan.	$21.00

Item	Service	Fee ($)
2666 Note A.29	Long consultation or more than 25 minutes duration but not more than 45 minutes duration and which completes the requirements of the Asthma 3+ Visit Plan.	$38.00
2668 Note A.29	Prolonged consultation of more than 45 minutes duration and which completes the requirements of the Asthma 3+ Visit Plan.	$61.00
2673 Note A.29	Out-of-surgery consultations (Professional attendance at a place other than the consulting rooms) standard consultation of more than 5 minutes duration but not more than 25 minutes duration and which completes the requirements of the Asthma 3+ Visit Plan.	Derived Fee
2675 Note A.29	Long consultation of more than 25 minutes duration but not more than 45 minutes duration and which completes the requirements of the Asthma 3+ Visit Plan.	Derived Fee
2677 Note A.29	Prolonged consultation of more 45 minutes duration and which completes the requirements of the Asthma 3+ Visit Plan.	Derived Fee
	GROUP A9 - CONTACT LENSES - ATTENDANCES	
10801 Note A.18	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 months - patients with myopia of 5.0 dioptres or greater (spherical equivalent) in 1 eye	$96.30
10802 Note A.18	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 months - patients with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in 1 eye	$96.30
10803 Note A.18	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 months - patients with astigmatism of 3.0 dioptres or greater in 1 eye	$96.30

Item	Service	Fee ($)
10804 Note A.18	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 months - patients with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens	$96.30
10805 Note A.18	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 months - patients with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents)	$96.30
10806 Note A.18	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 months - 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	$96.30
10807 Note A.18	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 months - patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by pathological mydriasis, aniridia, coloboma of the iris, pupillary malformation or distortion, significant ocular deformity or corneal opacity - whether congenital, traumatic or surgical in origin	$96.30
10808 Note A.18	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 months - patients who, by reason of physical deformity, are unable to wear spectacles	$96.30
10809 Note A.18	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 months - 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	$96.30
10816 Note A.19 Note DIA.6	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	$96.30
	GROUP A10 - OPTOMETRIC CONSULTATIONS	
10900 Note O.6 Note O.8	Professional attendance of more than 15 minutes duration, being the first in a course of attention - not payable within 24 months of an attendance to which item 10900, 10905, 10907, 10912, 10913 or 10914 applied	$56.15

Item	Service	Fee ($)
10905 Note O.6 Note O.8	Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has been referred by another optometrist who is not associated with the optometrist to whom the patient is referred	$56.15
10907 Note O.6 Note O.7 Note O.8	Professional attendance of more than 15 minutes duration being the first in a course of attention where the patient has attended another optometrist within the previous 24 months for an attendance to which item 10900, 10905, 10907, 10912, 10913 or 10914 applied. The appropriate fee for the purpose of Section 23A (2)(c) of the Health Insurance Act 1973 is $54.85	$28.15
10912 Note O.6 Note O.8	Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has suffered a significant change of visual function requiring comprehensive reassessment within 24 months of initial consultation to which item 10900, 10905, 10907, 10912, 10913 or 10914 at the same practice applied	$56.15
10913 Note O.6 Note O.8	Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has new signs or symptoms, unrelated to the earlier course of attention, requiring comprehensive reassessment within 24 months of initial consultation to which item 10900, 10905, 10907, 10912, 10913 or 10914 at the same practice applied	$56.15
10914 Note O.6 Note O.8	Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has a progressive disorder (excluding presbyopia) requiring comprehensive reassessment within 24 months of initial consultation to which item 10900, 10905, 10907, 10912, 10913 or 10914 applied	$56.15
10916 Note O.8	Professional attendance, being the first in a course of attention, of not more than 15 minutes duration	$28.15
10918 Note O.8	Professional attendance being the second or subsequent in a course of attention not related to the prescription and fitting of contact lenses	$28.15
10921 Note O.8	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention in respect of which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10916 applies - payable only once in a period of 36 months - patients with myopia of 5.0 dioptres or greater (spherical equivalent) in 1 eye	$139.35
10922 Note O.8	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention in respect of which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10916 applies - payable only once in a period of 36 months - patients with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in 1 eye	$139.35
10923 Note O.8	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention in respect of which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10916 applies - payable only once in a period of 36 months - patients with astigmatism of 3.0 dioptres or greater in 1 eye	$139.35

Item	Service	Fee ($)
10924 Note O.8	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention in respect of which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10916 applies - payable only once in a period of 36 months - patients with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens	$175.85
10925 Note O.8	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention in respect of which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10916 applies - payable only once in a period of 36 months - patients with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents)	$139.35
10926 Note O.8	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention in respect of which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10916 applies - payable only once in a period of 36 months - 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	$139.35
10927 Note O.8 Note O.8	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention in respect of which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10916 applies - payable only once in a period of 36 months - patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by pathological mydriasis, aniridia, coloboma of the iris, pupillary malformation or distortion, significant ocular deformity or corneal opacity - whether congenital, traumatic or surgical in origin	$175.85
10928 Note O.8	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention in respect of which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10916 applies - payable only once in a period of 36 months - patients who, by reason of physical deformity, are unable to wear spectacles	$139.35
10929 Note O.8	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention in respect of which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10916 applies - payable only once in a period of 36 months - patients who have a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10926, 10927 or 10928 applies) requiring the use of a contact lens for correction, where the condition is specified on the patient's account	$175.85

Item	Service	Fee ($)
10930 Note O.8	All professional attendances regarded as a single service in a single course of attention involving the prescription and fitting of contact lenses where the patient meets the requirements of an item in the range 10921-10929 and requires a change in contact lens material or basic lens parameters, other than a simple power change, because of a structural or functional change in the eye or an allergic response within 36 months of the fitting of a contact lens covered by item 10921 to 10929	$139.35
	DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	
	GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	
	Subgroup 1 - Neurology	
11000 Note DIA.4.7 Note DIA.6	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.)	$97.35
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	$257.65
11006	Electroencephalography, temporosphenoidal, not being a service involving quantitative topographic mapping using neurometrics or similar devices	$132.10
11009	Electrocorticography	$180.15
11012 Note D1.1	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)	$88.55
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)	$118.60
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)	$177.15
11021	Neuromuscular electrodiagnosis repetitive stimulation for study of neuromuscular conduction or electromyography with quantitative computerised analysis or both of these examinations	$118.60
11024 Note D1.2	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	$90.10
11027 Note D1.2	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	$133.60
	Subgroup 2 - Ophthalmology	

Item	Service	Fee ($)
11200	Provocative test or tests for glaucoma, including water drinking	$32.25
11203	Tonography - in the investigation or management of glaucoma, of 1 or both eyes - using an electrical tonography machine producing a directly recorded tracing	$54.55
11204 Note D1.3	Electroretinography of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards	$85.60
11205 Note D1.3	Electrooculography of one or both eyes performed according to current professional guidelines or standards	$85.60
11210 Note D1.3	Pattern electroretinography of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards	$85.60
11211 Note D1.3	Dark adaptometry of one or both eyes with a quantitative (log cd/m2) estimation of threshold in log lumens at 45 minutes of dark adaptations	$85.60
11212	Optic fundi, examination of following intravenous dye injection	$55.50
11215	Retinal photography, multiple exposures, of 1 eye with intravenous dye injection	$97.25
11218	Retinal photography, multiple exposures of both eyes with intravenous dye injection	$120.15
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	$53.60
11222 Note D1.4	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) where there has been definite progression of damage over a 12 month period; established neurologic disease which may be progressive; or for the monitoring of systemic drug toxicity, where there is also other disease such as glaucoma or neurologic disease-each additional examination	$53.60
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	$32.30

Item	Service	Fee ($)
11225 Note D1.4	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) where there has been definite progression of damage over a 12 month period; established neurologic disease which may be progressive; or for the monitoring of systemic drug toxicity, where there is also other disease such as glaucoma or neurologic disease-each additional examination	$32.30
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	$97.00
11240 Note D1.5	Orbital contents, ultrasonic echography of, for one eye, not being a service associated with a service to which items in Group I1 apply	$64.40
11241 Note D1.5	Orbital contents, ultrasonic echography of, for both eyes, not being a service associated with a service to which items in Group I1 apply	$82.00
11242 Note D1.5	Orbital contents, ultrasonic echography of, for the measurement of an eye previously measured and lens surgery has been performed, and where further lens surgery is contemplated in that eye, not being a service associated with a service to which items in Group I1 apply	$63.40
11243 Note D1.5	Orbital contents, ultrasonic echography of, for the measurement of the second eye where surgery for the first eye has resulted in more than 1 dioptre of error or where more than 3 years have elapsed, not being a serivce associated with a service to which items in Group I1 apply	$63.40
	Subgroup 3 - Otolaryngology	
11300	Brain stem evoked response audiometry (Anaes.)	$152.25
11303	Electrocochleography, extratympanic method, 1 or both ears	$152.25
11304 Note D1.6	Electrocochleography, transtympanic membrane insertion technique, 1 or both ears	$250.70
11306 Note D1.7	Nondeterminate audiometry	$17.35
11309 Note D1.7 Note D1.8	Audiogram, air conduction	$20.80
11312 Note D1.8	Audiogram, air and bone conduction or air conduction and speech discrimination	$29.35
11315 Note D1.8	Audiogram, air and bone conduction and speech	$38.95
11318 Note D1.8	Audiogram, air and bone conduction and speech, with other cochlear tests	$48.00
11321 Note D1.7 Note D1.8	Glycerol induced cochlear function changes assessed by a minimum of 4 air conduction and speech discrimination tests (Klockoff's test)	$91.25

Item	Service	Fee ($)
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	$26.00
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	$15.60
11330	Impedance audiogram where the patient is not referred by a medical practitioner - 1 examination in any 4 week period	$6.25
11332 Note D1.9	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	$46.30
11333	Caloric test of labyrinth or labyrinths	$35.25
11336	Simultaneous bithermal caloric test of labyrinths	$35.25
11339	Electronystagmography	$35.25
	Subgroup 4 - Respiratory	
11500	Bronchospirometry, including gas analysis	$132.10
11503 Note D1.10	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	$109.70
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	$16.25
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	$28.25

Item	Service	Fee ($)
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	$48.85
	Subgroup 5 - Vascular	
11600 Note T1.7 Note T1.8	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.)	$54.80
11601 Note T1.7 Note T1.8	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.)	$54.80
11603 Note D1.11	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; straingauge plethysmography; impedance plethysmography; or photo plethysmography; (not being a service to which item 11612 or 11615 applies) - 1 examination and report	$40.90
11606 Note D1.11	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)	$57.95
11609 Note D1.11	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)	$75.20
11612 Note D1.11	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)	$75.20
11615 Note D1.11	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	$60.00
11618 Note D1.11	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	$53.35
11621 Note D1.11	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)	$80.35

Item	Service	Fee ($)
11624 Note D1.11	3 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)	$106.75
11627	Pulmonary artery pressure monitoring during open heart surgery, in a person under 12 years of age	$180.85
	Subgroup 6 - Cardiovascular	
11700 Note D1.12	Twelve-lead electrocardiography, tracing and report	$24.70
11701 Note D1.13	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	$12.35
11702	Twelve-lead electrocardiography, tracing only	$12.35
11706	Phonocardiography with electrocardiograph lead with indirect arterial or venous pulse tracing, with or without apex cardiogram interpretation and report	$57.00
11708 Note D1.14	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	$101.15
11709 Note D1.14	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	$132.50
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	$41.00
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	$22.35
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	$120.30

Item	Service	Fee ($)
11713 Note D.15	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	$55.15
11715	Blood dye dilution indicator test	$95.55
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	$27.45
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	$55.15
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	$133.60
	Subgroup 7 - Gastroenterology & Colorectal	
11800	Oesophageal motility test, manometric	$138.05
11810	Clinical assessment of gastro-oesophageal reflux disease involving 24 hour pH monitoring, including analysis, interpretation and report and including any associated consultation	$138.05
11830	Diagnosis of abnormalities of the pelvic floor involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex	$147.70
11833	Diagnosis of abnormalities of the pelvic floor and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency	$197.55
	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	$21.80
11903	Cystometrography, not being a service associated with a service to which item 11012-11027, 11912, 11915, 11918, 11921, 36800 or any item in Group I3 of the Diagnostic Imaging Services Table applies	$87.90
11906	Urethral pressure profilometry, not being a service associated with a service to which item 11012-11027, 11909, 11918, 11921, 36800 or any item in Group I3 of the Diagnostic Imaging Services Table applies	$87.90
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 of the Diagnostic Imaging Services Table applies	$130.55

Item	Service	Fee ($)
11912	Cystometrography with simultaneous measurement of rectal pressure, not being a service associated with a service to which item 11012-11027, 11903, 11915, 11918, 11921, 36800 or any item in Group I3 of the Diagnostic Imaging Services Table applies (Anaes.)	$130.55
11915	Cystometrography with simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which item 11012-11027, 11903, 11909, 11912, 11918, 11921, 36800 or any item in Group I3 of the Diagnostic Imaging Services Table applies (Anaes.)	$130.55
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.)	$338.80
11921	Bladder washout test for localisation of urinary infection not including bacterial counts for organisms in specimens	$59.35
	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	$30.80
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	$46.55
12012 Note D.16	Epicutaneous patch testing in the investigation of allergic dermatitis using less than the number of allergens included in a standard patch test battery	$16.45
12015 Note D.16	Epicutaneous patch testing in the investigation of allergic dermatitis using all of the allergens in a standard patch test battery	$49.40
12018 Note D.16	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	$63.60
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	$93.20
	Subgroup 10 - Other Diagnostic Procedures And Investigations	
12200	Collection of specimen of sweat by iontophoresis	$29.40

Item	Service	Fee ($)
12203 Note D.16	Overnight investigation for sleep apnoea for a period of at least 8 hours duration, for an adult aged 18 years and over where: (a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of eeg, eog, submental emg, anterior tibial emg, respiratory movement, airflow, oxygen saturation and ecg are performed;(b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; (c)the patient is referred by a medical practitioner; (d)the necessity for the investigation is determined by a qualified adult sleep medicine practitioner prior to the investigation; (e) polygraphic records are analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report ; and(f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient - payable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period.	$465.10
12207 Note D.16	Overnight investigation for sleep apnoea for a period of at least 8 hours duration, for an adult aged 18 years and over where:(a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of eg, eog, submental emg, anterior tibial emg, respiratory movement, airflow, oxygen saturation and ecg are performed;(b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; (c) the patient is referred by a medical practitioner; (d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner prior to the investigation;(e) polygraphic records are analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12203 applies for the adjustment and/or testing of the effectiveness of a positive pressure ventilatory support device (other than nasal continuous positive airway pressure) in sleep, in a patient with severe cardio-respiratory failure, and where previous studies have demonstrated failure of continuous positive airway pressure or oxygen - each additional investigation	$465.10

Item	Service	Fee ($)
12210 Note D.16	Overnight paediatric investigation for a period of at least 8 hours duration for a child aged 0 - 12 years, where:continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of eeg (minimum of 4 eeg leads with facility to increase to 6 in selected investigations), eog, emg submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum) airflow detection, measurement of co2 either end-tidal or transcutaneous, oxygen saturation and ecg are performed; a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner;the patient is referred by a medical practitioner;the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner prior to the investigation;polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; the interpretation and report to be provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient.payable only in relation to the first 3 occasions the investigation is performed in a 12 month period.	$555.10
12213 Note D.16	Overnight paediatric investigation for a period of at least 8 hours duration for a child aged between 12 and 18 years, where:continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of eeg (minimum of 4 eeg leads with facility to increase to 6 in selected investigations), eog, emg submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum), airflow detection, measurement of co2 either end-tidal or transcutaneous, oxygen saturation and ecg are performed; a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner;the patient is referred by a medical practitioner;the necessity for the investigation is determined by a qualified sleep medicine practitioner prior to the investigation;polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; the interpretation and report to be provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient.payable only in relation to the first 3 occasions the investigation is performed in a 12 month period.	$500.10

Item	Service	Fee ($)
12215 Note D.16	Overnight paediatric investigation for a period of at least 8 hours duration for a child aged 0 - 12 years, where:continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of eeg (minimum of 4 eeg leads with facility to increase to 6 in selected investigations), eog, emg submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum) airflow detection, measurement of co2 either end-tidal or transcutaneous, oxygen saturation and ecg are performed; (b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner;(c) the patient is referred by a medical practitioner;(d) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner prior to the investigation;(e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; (f) the interpretation and report to be provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient.where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12210 applies, for therapy with Continuous Positive Airway Pressure (cpap), bilevel pressure support and/or ventilation is instigated or in the presence of recurring hypoxia and supplemental oxygen is required – each additional investigation.	$555.10
12217 Note D.16	Overnight paediatric investigation for a period of at least 8 hours duration for a child aged between 12 and 18 years, where:continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of eeg (minimum of 4 eeg leads with facility to increase to 6 in selected investigations), eog, emg submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum), airflow detection, measurement of co2 either end-tidal or transcutaneous, oxygen saturation and ecg are performed; a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner;(c) the patient is referred by a medical practitioner;(d) the necessity for the investigation is determined by a qualified sleep medicine practitioner prior to the investigation;polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; the interpretation and report to be provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient.where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12213 applies, for therapy with Continuous Positive Airway Pressure (cpap), bilevel pressure support and/or ventilation is instigated or in the presence of recurring hypoxia and supplemental oxygen is required – each additional investigation.	$500.10

Item	Service	Fee ($)
12306 Note D1.18	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)	$81.00
12309 Note D1.18	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)	$81.00
12312 Note D1.18	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)	$81.00
12315 Note D1.18	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)	$81.00

Item	Service	Fee ($)
12318 Note D1.18	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)	$81.00
12321 Note D1.18	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).	$81.00
	GROUP D2 - NUCLEAR MEDICINE (NON-IMAGING)	
12500	Blood volume estimation	$171.30
12503	Erythrocyte radioactive uptake survival time test or iron kinetic test	$336.05
12506	Gastrointestinal blood loss estimation involving examination of stool specimens	$239.90
12509	Gastrointestinal protein loss	$171.30
12512	Radioactive B12 absorption test 1 isotope	$83.00
12515	Radioactive B12 absorption test 2 isotopes	$181.85
12518	Thyroid uptake (using probe)	$83.00
12521	Perchlorate discharge study	$100.20
12524	Renal function test (without imaging procedure)	$125.20
12527	Renal function test (with imaging and at least 2 blood samples)	$67.15
12530	Whole body count not being a service associated with a service to which another item applies	$100.20

Item	Service	Fee ($)
12533 Note DIA.6	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 where 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	$66.90
	THERAPEUTIC PROCEDURES	
	GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES	
	Subgroup 1 - Hyperbaric Oxygen Therapy	
13020 Note T1.1 Note DIA.6	Hyperbaric oxygen therapy, for treatment of decompression illness, gas gangrene, air or gas embolism; diabetic wounds including diabetic gangrene and diabetic foot ulcers; necrotising soft tissue infections including necrotising fasciitis, Fournier's gangrene or osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance	$204.70
13025 Note T1.1	Hyperbaric oxygen therapy for treatment of decompression illness, air or gas embolism, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber greater than 3 hours, including any associated attendance - per hour (or part of an hour)	$91.55
13030 Note T1.1	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)	$129.30
	Subgroup 2 - Dialysis	
13100 Note T1.2	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	$108.10
13103 Note T1.2	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	$56.30
13106	Declotting of an arteriovenous shunt	$96.05
13109	Indwelling peritoneal catheter (Tenckhoff or similar) for dialysis insertion and fixation of (Anaes.)	$180.15
13110	Tenckhoff peritoneal dialysis catheter, removal of (including catheter cuffs) (Anaes.)	$180.70

Item	Service	Fee ($)
13112	Peritoneal dialysis, establishment of, by abdominal puncture and insertion of temporary catheter (including associated consultation) (Anaes.)	$108.10
	Subgroup 3 - Assisted Reproductive Services	
13200 Note T1.3	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	$1,581.40
13203 Note T1.3	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	$395.35
13206 Note T1.3	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	$677.70
13209 Note T1.3	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	$67.65
13212 Note T1.3	Oocyte retrieval by any means including laparoscopy or ultrasoundguided ova flushing, for the purposes of assisted reproductive technologies including in vitro fertilisation, gamete intrafallopian transfer or similar procedures - only if rendered in conjunction with a service to which item 13200 or 13206 applies (Anaes.)	$288.05
13215 Note T1.3	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.)	$90.40
13218 Note T1.3	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.)	$677.70
13221 Note T1.3	Preparation of semen for the purposes of assisted reproductive technologies or for artificial insemination	$41.25

Item	Service	Fee ($)
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	$161.60
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.)	$323.20
	Subgroup 4 - Paediatric & Neonatal	
13300	Umbilical or scalp vein catheterisation in a neonate with or without infusion; or cannulation of a vein	$45.05
13303	Umbilical artery catheterisation with or without infusion	$66.80
13306	Blood transfusion with venesection and complete replacement of blood, including collection from donor	$264.25
13309	Blood transfusion with venesection and complete replacement of blood, using blood already collected	$225.30
13312	Blood for pathology test, collection of, by femoral or external jugular vein puncture in infants	$22.45
13318	Central vein catheterisation (via jugular or subclavian vein) - by open exposure, in a person under 12 years of age (Anaes.)	$179.95
13319	Central vein catheterisation in a neonate via peripheral vein (Anaes.)	$179.95
	Subgroup 5 - Cardiovascular	
13400	Restoration of cardiac rhythm by electrical stimulation (cardioversion), other than in the course of cardiac surgery (Anaes.)	$76.60
	Subgroup 6 - Gastroenterology	
13500	Gastric hypothermia by closed circuit circulation of refrigerant in the absence of gastrointestinal haemorrhage	$142.65
13503	Gastric hypothermia by closed circuit circulation of refrigerant for upper gastrointestinal haemorrhage	$285.30
13506	Gastro-oesophageal balloon intubation, minnesota, sengstaken-blakemore or similar, for control of bleeding from gastric oesophageal varices	$145.90
	Subgroup 8 - Haematology	
13700	Harvesting of homologous (including allogeneic) or autologous bone marrow for the purpose of transplantation (Anaes.)	$263.65
13703	Administration of blood including collection from donor	$94.50
13706 Note T1.4	Administration of blood or bone marrow already collected	$66.00
13709 Note T1.5	Collection of blood for autologous transfusion or when homologous blood is required for immediate transfusion in emergency situation	$38.30

Item	Service	Fee ($)
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 - each day	$108.10
13755	Donor haemapheresis for the collection of blood products for transfusion, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuous registered nurse attendance under the supervision of a consultant physician; not being a service associated with a service to which item 13750 applies - each day	$108.10
13757	Therapeutic venesection for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda	$57.70
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; or . germ cell tumours which have had an incomplete response to first line therapy. - performed under the supervision of a consultant physician - each day.	$603.25
	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.)	$67.40
13818 Note T1.7	Right heart balloon catheter, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.)	$89.95
13830	Intracranial pressure, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician - each day	$59.60
13839 Note T1.7	Arterial puncture and collection of blood for diagnostic purposes	$18.20
13842 Note T1.7	Intra-arterial cannulisation for the purpose of taking multiple arterial blood samples for blood gas analysis	$54.80
13845	Counterpulsation by intraaortic balloon management on the first day, including percutaneous insertion, initial and subsequent consultations and monitoring of parameters (Anaes.)	$427.90
13848	Counterpulsation by intraaortic balloon management on each day subsequent to the first, including associated consultations and monitoring of parameters	$103.65

Item	Service	Fee ($)
13851	Circulatory support device, management of, on first day	$390.50
13854	Circulatory support device, management of, on each day subsequent to the first	$90.80
13857 Note T1.7	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	$115.80
	Subgroup 10 - Management And Procedures Undertaken In An Intensive Care Unit	
13870 Note T1.6 Note T1.7 Note T1.8	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	$241.30
13873 Note T1.6 Note T1.7 Note T1.8	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	$179.70
13876 Note T1.6 Note T1.7 Note T1.8	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	$54.80
13879 Note T1.6	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	$175.10
13882 Note T1.6	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	$59.60
13885 Note T1.6	Continuous arterio venous or veno venous haemofiltration, management by a specialist or consultant physician - on the first day in an Intensive Care Unit	$107.80
13888 Note T1.6	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	$56.15
	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	$51.45
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	$77.40
13921	Cytotoxic chemotherapy, administration of, by intravenous infusion of more than 6 hours duration - for the first day of treatment	$87.60

Item	Service	Fee ($)
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	$51.65
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	$66.80
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	$93.15
13933	Cytotoxic chemotherapy, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment	$103.35
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	$67.30
13939 Note T1.9	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	$77.40
13942 Note T1.9	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	$51.65
13945	Long-term implanted drug delivery device for cytotoxic chemotherapy, accessing of	$41.55
13948	Cytotoxic agent, instillation of, into a body cavity	$51.65
	Subgroup 12 - Dermatology	
14050 Note T1.10	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	$41.75
14053 Note T1.10	PUVA therapy or UVB therapy administered to localised body areas in a 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	$41.75
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.)	$120.65

Item	Service	Fee ($)
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.)	$148.15
14106 Note T1.11	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.)	$120.65
14109 Note T1.11	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.)	$148.15
14112 Note T1.11	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.)	$175.45
14115 Note T1.11	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.)	$202.85
14118 Note T1.11	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 250cm^2 (Anaes.)	$257.70
14120 Note T1.11	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.)	$120.65

Item	Service	Fee ($)
14122 Note T1.11	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.)	$148.15
14124 Note T1.11	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.)	$120.65
14126 Note T1.11	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.)	$148.15
14128 Note T1.11	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.)	$175.45
14130 Note T1.11	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.)	$202.85
14132 Note T1.11	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.)	$257.70
	Subgroup 13 - Other Therapeutic Procedures	
14200	Gastric lavage in the treatment of ingested poison	$47.35
14203 Note T1.3	Hormone or living tissue implantation, by direct implantation involving incision and suture (Anaes.)	$40.45
14206 Note T1.3	Hormone or living tissue implantation by cannula	$28.20

Item	Service	Fee ($)
14209	Intraarterial infusion or retrograde intravenous perfusion of a sympatholytic agent	$70.20
14212	Intussusception, management of fluid or gas reduction for (Anaes.)	$146.60
14215	Long-term implanted reservoir associated with the adjustable gastric band, accessing of to add or remove fluid	$77.40
14218	Implanted pump or reservoir, loading of, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space	$77.40
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	$41.55
14224	Electroconvulsive therapy, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.)	$55.60
	GROUP T2 - RADIATION ONCOLOGY	
	Subgroup 1 - Superficial	
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	$33.70
15003	Radiotherapy, superficial (including treatment with x-rays, 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 - 2 or more fields up to a maximum of 5 additional fields	Derived Fee
15006	Radiotherapy, superficial attendance at which a single dose technique is applied - 1 field	$74.70
15009	Radiotherapy, superficial attendance at which a single dose technique is applied - 2 or more fields up to a maximum of 5 additional fields	Derived Fee
15012	Radiotherapy, superficial each attendance at which treatment is given to an eye	$42.25
	Subgroup 2 - Orthovoltage	
15100 Note T2.1	Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 3 or more treatments per week - 1 field	$37.75
15103 Note T2.1	Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 3 or more treatments per week - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)	Derived Fee
15106	Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 1 field	$44.55
15109	Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)	Derived Fee
15112	Radiotherapy, deep or orthovoltage attendance at which a single dose technique is applied - 1 field	$95.05

Item	Service	Fee ($)
15115	Radiotherapy, deep or orthovoltage attendance at which a single dose technique is applied - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)	Derived Fee
	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	$47.20
15204	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities - each attendance at which treatment is given 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)	Derived Fee
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	$47.20
15208	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 - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)	Derived Fee
15211	Radiation oncology treatment, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given 1 field	$43.25
15214	Radiation oncology treatment, using cobalt unit or caesium teletherapy unit - each attendance at which treatment is given 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)	Derived Fee
	Subgroup 4 - Brachytherapy	
15303	Intrauterine treatment alone using radioactive sealed sources having a halflife greater than 115 days using manual afterloading techniques (Anaes.)	$282.40
15304	Intrauterine treatment alone using radioactive sealed sources having a half life greater than 115 days using automatic afterloading techniques (Anaes.)	$282.40
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.)	$535.40
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.)	$535.40
15311	Intravaginal treatment alone using radioactive sealed sources having a halflife greater than 115 days using manual afterloading techniques (Anaes.)	$263.60
15312	Intravaginal treatment alone using radioactive sealed sources having a halflife greater than 115 days using automatic afterloading techniques (Anaes.)	$261.70
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.)	$517.50

Item	Service	Fee ($)
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.)	$517.50
15319	Combined intrauterine and intravaginal treatment using radioactive sealed sources having a halflife greater than 115 days using manual afterloading techniques (Anaes.)	$321.10
15320	Combined intrauterine and intravaginal treatment using radioactive sealed sources having a halflife greater than 115 days using automatic afterloading techniques (Anaes.)	$321.10
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.)	$571.05
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.)	$571.05
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.)	$621.30
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.)	$621.30
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.)	$589.95
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.)	$589.95
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.)	$535.40
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.)	$535.40

Item	Service	Fee ($)
15338 Note T2.3	Prostate, radioactive seed implantation of, radiation oncology component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages T1, T2a or T2b, with a Gleason score of less than or equal to 6 and a prostate specific antigen (psa) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed at an approved site in association with a urologist.	$740.00
15339	Removal of a sealed radioactive source under general anaesthesia, or under epidural or spinal nerve block (Anaes.)	$60.25
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	$150.55
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	$401.70
15348	Subsequent applications of radioactive mould referred to in item 15342 or 15345 each attendance	$46.20
15351	Construction and first application of a radioactive mould not exceeding 5 cm in diameter to an external surface	$92.25
15354	Construction and first application of a radioactive mould more than 5 cm in diameter to an external surface	$112.00
15357	Attendance upon a patient to apply a radioactive mould constructed for application to an external surface of the patient other than an attendance which is the first attendance to apply the mould each attendance	$31.60
	Subgroup 5 - Computerised Planning	
15500 Note T2.2	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)	$192.00
15503 Note T2.2	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)	$246.50
15506 Note T2.2	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)	$368.05
15509 Note T2.2	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)	$166.45

Item	Service	Fee ($)
15512 Note T2.2	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)	$214.45
15513 Note T2.2	Radiation source localisation using a simulator or x-ray machine of a single area, where views in more than 1 plane are required, for brachytherapy treatment planning for i125 seed implantation of localised prostate cancer, in association with item 15338	$242.60
15515 Note T2.2	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)	$310.45
15518 Note T2.2	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	$60.90
15521 Note T2.2	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	$268.85
15524 Note T2.2	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	$504.15
15527 Note T2.2	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	$62.40
15530 Note T2.2	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	$278.50
15533 Note T2.2	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	$528.10
15536 Note T2.2	Brachytherapy planning, computerised radiation dosimetry	$211.05
15539	Brachytherapy planning, computerised radiation dosimetry for i125 seed implantation of localised prostate cancer, in association with item 15338	$496.20
	Subgroup 6 - Stereotactic Radiosurgery	
15600	Stereotactic radiosurgery, including all radiation oncology consultations, planning, simulation, dosimetry and treatment	$1,346.55
	GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE	
16003	Intracavitary administration of a therapeutic dose of Yttrium 90 (not including preliminary paracentesis) **(Anaes.)**	$514.60

Item	Service	Fee ($)
16006	Administration of a therapeutic dose of Iodine 131 for thyroid cancer by single dose technique	$395.40
16009	Administration of a therapeutic dose of Iodine 131 for thyrotoxicosis by single dose technique	$269.85
16012	Intravenous administration of a therapeutic dose of Phosphorous 32	$233.45
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	$3,231.80
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	$1,931.95
	GROUP T4 - OBSTETRICS	
16500 Note T4.1	Antenatal attendance	$28.75
16501 Note T4.1 Note T4.2	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	$111.15
16502 Note T4.1	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	$28.75
16504 Note T4.1	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	$28.75
16505 Note T4.1	Threatened abortion, threatened miscarriage or hyperemesis gravidarum, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance	$28.75
16508 Note T4.1	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	$28.75
16509 Note T4.1	Preeclampsia, eclampsia or antepartum haemorrhage, treatment of each attendance that is not a routine antenatal attendance	$28.75
16511 Note T4.1	Cervix, purse string ligation of (Anaes.)	$173.95

Item	Service	Fee ($)
16512 Note T4.1	Cervix, removal of purse string ligature of (Anaes.)	$50.20
16514 Note T4.1	Antenatal cardiotocography in the management of high risk pregnancy (not during the course of the confinement)	$29.00
16515 Note T4.3 Note T4.6	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	$274.15
16518 Note T4.3 Note T4.6	Management of labour, incomplete, where the patient's care has been transferred to another medical practitioner for completion of the delivery	$269.85
16519 Note T4.3 Note T4.4 Note T4.6	Management of labour and delivery by any means (including Caesarean section) including post-partum care for 5 days	$422.25
16520 Note T4.3 Note T4.4 Note T4.6	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	$493.40
16522 Note T4.5	Management of labour and delivery, or delivery alone, (including Caesarean section), where in the course of antenatal supervision or intrapartum management one, 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.	$991.40
16525 Note T4.3	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	$233.90
16564 Note T4.6	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	$172.45
16567 Note T4.6	Management of postpartum haemorrhage by special measures such as packing of uterus, as an independent procedure	$252.25
16570 Note T4.6	Acute inversion of the uterus, vaginal correction of, as an independent procedure	$329.05
16571 Note T4.6	Cervix, repair of extensive laceration or lacerations	$252.25

Item	Service	Fee ($)
16573 Note T4.6	Third degree tear, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure	$205.55
16600 Note T4.1 Note T4.7	Amniocentesis, diagnostic	$50.20
16603 Note T4.1 Note T4.7	Chorionic villus sampling, by any route	$96.45
16606 Note T4.1 Note T4.7	Fetal blood sampling, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.)	$192.35
16609 Note T4.1 Note T4.7	Fetal intravascular blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling (Anaes.)	$392.35
16612 Note T4.1 Note T4.7	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.)	$308.70
16615 Note T4.1 Note T4.7	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.)	$164.35
16618 Note T4.1 Note T4.7	Amniocentesis, therapeutic, when indicated because of polyhydramnios with at least 500ml being aspirated	$164.35
16621 Note T4.1 Note T4.7	Amnioinfusion, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios	$164.35
16624 Note T4.1 Note T4.7	Fetal fluid filled cavity, drainage of	$236.60
16627 Note T4.1 Note T4.7	Feto-amniotic shunt, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis	$481.65
16633 Note T4.1 Note T4.7	Procedure on multiple pregnancies relating to items 16606, 16609, 16612, 16615 and 16627	Derived Fee
16636 Note T4.1 Note T4.7	Procedure on multiple pregnancies relating to items 16600, 16603, 16618, 16621 and 16624	Derived Fee
	GROUP T6 - ANAESTHETICS	
	Subgroup 1 - Examination By An Anaesthetist	
17603 Note T6.1 Note T10.4	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	$33.95
	GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS	
18213	Intravenous regional anaesthesia of limb by retrograde perfusion	$70.15
18216 Note T10.6	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	$150.20

Item	Service	Fee ($)
18219 Note T10.6	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
18222 Note T7.2 Note T10.6	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	$29.75
18225 Note T7.2 Note T10.6	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	$39.65
18228	Interpleural block, initial injection or commencement of infusion of a therapeutic substance	$49.45
18230	Intrathecal or epidural injection of neurolytic substance	$188.60
18232 Note T7.3	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	$150.20
18233	Epidural injection of blood for blood patch	$150.20
18234	Trigeminal nerve, primary division of, injection of an anaesthetic agent	$98.75
18236	Trigeminal nerve, peripheral branch of, injection of an anaesthetic agent	$49.45
18238	Facial nerve, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies	$29.75
18240	Retrobulbar or peribulbar injection of an anaesthetic agent	$74.00
18242	Greater occipital nerve, injection of an anaesthetic agent	$29.75
18244	Vagus nerve, injection of an anaesthetic agent	$79.70
18246	Glossopharyngeal nerve, injection of an anaesthetic agent	$79.70
18248	Phrenic nerve, injection of an anaesthetic agent	$70.15
18250	Spinal accessory nerve, injection of an anaesthetic agent	$49.45
18252	Cervical plexus, injection of an anaesthetic agent	$79.70
18254	Brachial plexus, injection of an anaesthetic agent	$79.70
18256	Suprascapular nerve, injection of an anaesthetic agent	$49.45
18258	Intercostal nerve (single), injection of an anaesthetic agent	$49.45
18260	Intercostal nerves (multiple), injection of an anaesthetic agent	$70.15
18262	Ilio-inguinal, iliohypogastric or genitofemoral nerves, 1 or more of, injection of an anaesthetic agent	$49.45

Item	Service	Fee ($)
18264	Pudendal nerve, injection of an anaesthetic agent	$79.70
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	$49.45
18268	Obturator nerve, injection of an anaesthetic agent	$70.15
18270	Femoral nerve, injection of an anaesthetic agent	$70.15
18272	Saphenous, sural, popliteal or posterior tibial nerve, main trunk of, 1 or more of, injection of an anaesthetic agent	$49.45
18274	Paravertebral, cervical, thoracic, lumbar, sacral or coccygeal nerves, injection of an anaesthetic agent, (single vertebral level)	$70.15
18276	Paravertebral nerves, injection of an anaesthetic agent, (multiple levels)	$98.75
18278	Sciatic nerve, injection of an anaesthetic agent	$70.15
18280	Sphenopalatine ganglion, injection of an anaesthetic agent	$98.75
18282	Carotid sinus, injection of an anaesthetic agent, as an independent percutaneous procedure	$79.70
18284	Stellate ganglion, injection of an anaesthetic agent, (cervical sympathetic block)	$116.80
18286	Lumbar or thoracic nerves, injection of an anaesthetic agent, (paravertebral sympathetic block)	$116.80
18288	Coeliac plexus or splanchnic nerves, injection of an anaesthetic agent	$116.80
18290	Cranial nerve other than trigeminal, destruction by a neurolytic agent	$197.55
18292 Note T7.4	Nerve branch, destruction by a neurolytic agent, not being a service to which any other item in this Group applies	$98.75
18294	Coeliac plexus or splanchnic nerves, destruction by a neurolytic agent	$139.20
18296	Lumbar sympathetic chain, destruction by a neurolytic agent	$119.00
18298	Cervical or thoracic sympathetic chain, destruction by a neurolytic agent	$139.20
	GROUP T10 - RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	
	Subgroup 1 - Head	
20100 Note T10.1	Initiation of management of anaesthesia for procedures on the skin, subcutaneous tissue, muscles, salivary glands or superficial vessels of the head including biopsy not being a service to which another item in this subgroup applies	$85.75
20102 Note T10.14	Initiation of management of anaesthesia for plastic repair of cleft lip	$102.90
20104	Initiation of management of anaesthesia for electroconvulsive therapy	$68.60

Item	Service	Fee ($)
20120	Initiation of management of anaesthesia for procedures on external, middle or inner ear, including biopsy, not being a service to which another item in this subgroup applies	$85.75
20124	Initiation of management of anaesthesia for otoscopy	$68.60
20140	Initiation of management of anaesthesia for procedures on eye, not being a service to which another item in this group applies	$85.75
20142	Initiation of management of anaesthesia for lens surgery	$102.90
20143	Initiation of management of anaesthesia for retinal surgery	$102.90
20144	Administration of anaesthesia for corneal transplant	$137.20
20145	Initiation of management of anaesthesia for vitrectomy	$137.20
20146	Initiation of management of anaesthesia for biopsy of conjunctiva	$85.75
20148	Initiation of management of anaesthesia for ophthalmoscopy	$68.60
20160	Initiation of management of anaesthesia for procedures on nose or accessory sinuses, not being a service to which another item in this subgroup applies	$85.75
20162	Initiation of management of anaesthesia for radical surgery on the nose and accessory sinuses	$120.05
20164	Initiation of management of anaesthesia for biopsy of soft tissue of the nose and accessory sinuses	$68.60
20170	Initiation of management of anaesthesia for intraoral procedures, including biopsy, not being a service to which another item in this subgroup applies	$85.75
20172 Note T10.14	Initiation of management of anaesthesia for repair of cleft palate	$120.05
20174	Initiation of management of anaesthesia for excision of retropharyngeal tumour	$154.35
20176	Initiation of management of anaesthesia for radical intraoral surgery	$171.50
20190	Initiation of management of anaesthesia for procedures on facial bones, not being a service to which another item in this subgroup applies	$85.75
20192	Initiation of management of anaesthesiafor radical surgery on facial bones (including prognathism and extensive facial bone reconstruction)	$171.50
20210	Initiation of management of anaesthesia for intracranial procedures, not being a service to which another item in this subgroup applies	$257.25
20212	Initiation of management of anaesthesia for subdural taps	$85.75
20214	Initiation of management of anaesthesia for burr holes of the cranium	$154.35
20216	Initiation of management of anaesthesia for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities	$343.00

Item	Service	Fee ($)
20220	Initiation of management of anaesthesia for spinal fluid shunt procedures	$171.50
20222	Initiation of management of anaesthesia for ablation of an intracranial nerve	$102.90
20225	Initiation of management of anaesthesia for all cranial bone procedures	$205.80
	Subgroup 2 - Neck	
20300	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the neck	$85.75
20305	Initiation of management of anaesthesia for incision and drainage of large haematoma, large abscess, cellulitis or similar lesion or epiglottitis causing life threatening airway obstruction	$257.25
20320	Initiation of management of anaesthesia for procedures on oesophagus, thyroid, larynx, trachea, lymphatic system, muscles, nerves or other deep tissues of the neck, not being a service to which another item in this subgroup applies	$102.90
20321	Initiation of management of anaesthesia for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy	$171.50
20330	Initiation of management of anaesthesia for laser surgery to the airway (excluding nose and mouth)	$137.20
20350	Initiation of management of anaesthesia for procedures on major vessels of neck, not being a service to which another item in this subgroup applies	$171.50
20352	Initiation of management of anaesthesia for simple ligation of major vessels of neck	$85.75
	Subgroup 3 - Thorax	
20400	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this subgroup applies	$51.45
20401	Initiation of management of anaesthesia for procedures on the breast, not being a service to which another item in this subgroup applies	$68.60
20402	Initiation of management of anaesthesia for reconstructive procedures on breast	$85.75
20403	Initiation of management of anaesthesia for removal of breast lump or for breast segmentectomy with axillary node dissection	$85.75
20404	Initiation of management of anaesthesia for mastectomy	$102.90
20405	Initiation of management of anaesthesia for reconstructive procedures on the breast using myocutaneous flaps	$137.20
20406	Initiation of management of anaesthesia for radical or modified radical procedures on breast with internal mammary node dissection	$222.95
20410	Initiation of management of anaesthesia for electrical conversion of arrhythmias	$85.75

Item	Service	Fee ($)
20420	Initiation of management of anaesthesia for procedures on the skin of the posterior part of the chest	$85.75
20450	Initiation of management of anaesthesia for procedures on clavicle, scapula or sternum, not being a service to which another item in this subgroup applies	$85.75
20452	Initiation of management of anaesthesia for radical surgery on clavicle, scapula or sternum	$102.90
20470	Initiation of management of anaesthesia for partial rib resection, not being a service to which another item in this subgroup applies	$102.90
20472	Initiation of management of anaesthesia for thoracoplasty	$171.50
20474 Note T10.20	Initiation of management of anaesthesia for radical procedures on chest wall	$222.95
	Subgroup 4 - Intrathoracic	
20500	Iinitiation of management of anaesthesia for open procedures on the oesophagus	$257.25
20520	Initiation of management of anaesthesia for all closed chest procedures (including rigid oesophagoscopy, bronchoscopy or transvenous pacemaker), not being a service to which another item in this subgroup applies	$102.90
20522	Initiation of management of anaesthesia for needle biopsy of pleura	$68.60
20524	Initiation of management of anaesthesia for pneumocentesis	$68.60
20526	Initiation of management of anaesthesia for thoracoscopy	$171.50
20528	Initiation of management of anaesthesia for mediastinoscopy	$137.20
20540	Initiation of management of anaesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, or mediastinum, not being a service to which another item in this subgroup applies	$222.95
20542	Initiation of management of anaesthesia for pulmonary decortication	$257.25
20546	Initiation of management of anaesthesia for pulmonary resection with thoracoplasty	$257.25
20548	Initiation of management of anaesthesia for intrathoracic repair of trauma to trachea and bronchi	$257.25
20560	Initiation of management of anaesthesia for open procedures on the heart, pericardium or great vessels of chest	$343.00
	Subgroup 5 - Spine And Spinal Cord	
20600 Note T10.21	Initiation of management of anaesthesia for procedures on cervical spine and/or cord , not being a service to which another item in this subgroup applies (for myelography and discography see Items 21906 and 21914)	$171.50
20604	Initiation of management of anaesthesia for posterior cervical laminectomy with the patient in the sitting position	$222.95

Item	Service	Fee ($)
20620 Note T10.21	Initiation of management of anaesthesia for procedures on thoracic spine and/or cord, not being a service to which another item in this subgroup applies	$171.50
20622	Initiation of management of anaesthesia for thoracolumbar sympathectomy	$222.95
20630 Note T10.21	Initiation of management of anaesthesia for procedures in lumbar region, not being a service to which another item in this subgroup applies	$137.20
20632	Initiation of management of anaesthesia for lumbar sympathectomy	$120.05
20634	Initiation of management of anaesthesia for chemonucleolysis	$171.50
20670 Note T10.21	Initiation of management of anaesthesia for extensive spine and/or spinal cord procedures	$222.95
20680	Initiation of management of anaesthesia for manipulation of spine when performed in the operating theatre of a hospital or day hospital facility	$51.45
20690	Initiation of management of anaesthesia for percutaneous spinal procedures, not being a service to which another item in this subgroup applies	$85.75
	Subgroup 6 - Upper Abdomen	
20700	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the upper anterior abdominal wall, not being a service to which another item in this subgroup applies	$51.45
20702 Note T10.1	Initiation of management of anaesthesia for percutaneous liver biopsy	$68.60
20705	Initiation of management of anaesthesia for diagnostic laparoscopy procedures	$102.90
20706	Initiation of management of anaesthesia for laparoscopic procedures in the upper abdomen, not being a service to which another item in this subgroup applies	$120.05
20730	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, not being a service to which another item in this subgroup applies	$85.75
20740	Initiation of management of anaesthesia for upper gastrointestinal endoscopic procedures	$85.75
20745	Initiation of management of anaesthesia for upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage	$102.90
20750	Initiation of management of anaesthesia for hernia repairs in upper abdomen, not being a service to which another item in this subgroup applies	$68.60
20752 Note T10.4	Initiation of management of anaesthesia for repair of incisional hernia and/or wound dehiscence	$102.90
20754	Initiation of management of anaesthesia for procedures on an omphalocele	$120.05
20756	Initiation of management of anaesthesia for transabdominal repair of diaphragmatic hernia	$154.35

Item	Service	Fee ($)
20770	Initiation of management of anaesthesiaa for procedures on major upper abdominal blood vessels	$257.25
20790 Note T10.4	Initiation of management of anaesthesia for procedures within the peritoneal cavity in upper abdomen including cholecystectomy, gastrectomy, laparoscopic nephrectomy or bowel shunts	$137.20
20791	Initiation of management of anaesthesia for gastric reduction or gastroplasty for the treatment of morbid obesity	$171.50
20792	Initiation of management of anaesthesia for partial hepatectomy (excluding liver biopsy)	$222.95
20793	Initiation of management of anaesthesia for extended or trisegmental hepatectomy	$257.25
20794	Initiation of management of anaesthesia for pancreatectomy, partial or total	$205.80
20798	Initiation of management of anaesthesia for neuro endocrine tumour removal in the upper abdomen	$171.50
	Subgroup 7 - Lower Abdomen	
20800	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the lower anterior abdominal walls, not being a service to which another item in this subgroup applies	$51.45
20802	Initiation of management of anaesthesia for lipectomy of the lower abdomen	$85.75
20805	Initiation of management of anaesthesia for diagnostic laparoscopic procedures	$102.90
20806	Initiation of management of anaesthesia for laparoscopic procedures in the lower abdomen	$120.05
20810	Initiation of management of anaesthesia for lower intestinal endoscopic procedures	$68.60
20815	Initiation of management of anaesthesia for extracorporeal shock wave lithotripsy to urinary tract	$102.90
20820	Initiation of management of anaesthesia for procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall	$85.75
20830	Initiation of management of anaesthesia for hernia repairs in lower abdomen, not being a service to which another item in this subgroup applies	$68.60
20832	Initiation of management of anaesthesia for repair of incisional herniae and/or wound dehiscence of the lower abdomen	$102.90
20840 Note T10.4	Initiation of management of anaesthesia for all procedures within the peritoneal cavity in lower abdomen including appendicectomy, not being a service to which another item in this subgroup applies	$102.90
20841	Initiation of management of anaesthesia for bowel resection, including laparoscopic bowel resection not being a service to which another item in this subgroup applies	$137.20

Item	Service	Fee ($)
20842	Initiation of management of anaesthesia for amniocentesis	$68.60
20844	Initiation of management of anaesthesia for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir	$171.50
20845	Initiation of management of anaesthesia for radical prostatectomy	$171.50
20846	Initiation of management of anaesthesia for radical hysterectomy	$171.50
20848	Initiation of management of anaesthesia for pelvic exenteration	$171.50
20850	Initiation of management of anaesthesia for caesarean section	$205.80
20855	Initiation of management of anaesthesia for caesarean hysterectomy	$257.25
20860	Initiation of management of anaesthesia for extraperitoneal procedures in lower abdomen, including those on the urinary tract, not being a service to which another item in this subgroup applies	$102.90
20862	initiation of management of anaesthesia for renal procedures, including upper 1/3 of ureter	$120.05
20864	Initiation of management of anaesthesia for total cystectomy	$171.50
20866	Initiation of management of anaesthesia for adrenalectomy	$171.50
20867	Initiation of management of anaesthesia for neuro endocrine tumour removal in the lower abdomen	$171.50
20868	Initiation of management of anaesthesia for renal transplantation (donor or recipient)	$171.50
20880 Note T10.22	Initiation of management of anaesthesia for procedures on major lower abdominal vessels, not being a service to which another item in this Subgroup applies	$257.25
20882	Initiation of management of anaesthesia for inferior vena cava ligation	$171.50
20884	Initiation of management of anaesthesia for percutaneous umbrella insertion	$85.75
	Subgroup 8 - Perineum	
20900	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the perineum (including biopsy of male genital system), not being a service to which another item in this subgroup applies	$51.45
20902	Initiation of management of anaesthesia for anorectal procedures (including endoscopy and/or biopsy)	$68.60
20904	Initiation of management of anaesthesia for radical perineal procedures including radical perineal prostatectomy or radical vulvectomy	$120.05
20906	Initiation of management of anaesthesia for vulvectomy	$68.60

Item	Service	Fee ($)
20910	Initiation of management of anaesthesia for transurethral procedures (including urethrocyctoscopy), not being a service to which another item in this subgroup applies	$68.60
20912	Initiation of management of anaesthesia for transurethral resection of bladder tumour(s)	$85.75
20914	Initiation of management of anaesthesia for transurethral resection of prostate	$120.05
20916	Initiation of management of anaesthesia for bleeding post-transurethral resection	$120.05
20920	Initiation of management of anaesthesia for procedures on male external genitalia, not being a service to which another item in this Subgroup applies	$51.45
20924	Initiation of management of anaesthesia for procedures on undescended testis, unilateral or bilateral	$68.60
20926	Initiation of management of anaesthesia for radical orchidectomy, inguinal approach	$68.60
20928	Initiation of management of anaesthesia for radical orchidectomy, abdominal approach	$102.90
20930	Initiation of management of anaesthesia for orchiopexy, unilateral or bilateral	$68.60
20932	Initiation of management of anaesthesia for complete amputation of penis	$68.60
20934	Initiation of management of anaesthesia for complete amputation of penis with bilateral inguinal lymphadenectomy	$102.90
20936	Initiation of management of anaesthesia for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy	$137.20
20938	Initiation of management of anaesthesia for insertion of penile prosthesis	$68.60
20940	Initiation of management of anaesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium), not being a service to which another item in this subgroup applies	$51.45
20942	Initiation of management of anaesthesia for colpotomy, colpectomy or colporrhaphy	$68.60
20943	Initiation of management of anaesthesia for transvaginal oocyte collection	$68.60
20944	Initiation of management of anaesthesia for vaginal hysterectomy	$102.90
20946	Initiation of management of anaesthesia for vaginal delivery	$137.20
20948	Initiation of management of anaesthesia for purse string ligation of cervix, or removal of purse string ligature, or removal of purse string ligature	$68.60
20950	Initiation of management of anaesthesia for culdoscopy	$85.75
20952	Initiation of management of anaesthesia for hysteroscopy	$68.60

Item	Service	Fee ($)
20954	Initiation of management of anaesthesia for correction of inverted uterus	$171.50
	Subgroup 9 - Pelvis (Except Hip)	
21100	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the anterior pelvic region (anterior to iliac crest), except external genitalia	$51.45
21110	Initiation of management of anaesthesia for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum	$85.75
21120	Initiation of management of anaesthesia for procedures on the bony pelvis	$102.90
21130	Initiation of management of anaesthesia for body cast application or revision when performed in the operating theatre of a hospital or day hospital facility	$51.45
21140	Initiation of management of anaesthesia for interpelviabdominal (hind-quarter) amputation	$257.25
21150	Initiation of management of anaesthesia for radical procedures for tumour of the pelvis, except hind-quarter amputation	$171.50
21160	Initiation of management of anaesthesia for closed procedures involving symphysis pubis or sacroiliac joint when performed in the operating theatre of a hospital or day hospital facility	$68.60
21170	Initiation of management of anaesthesia for open procedures involving symphysis pubis or sacroiliac joint	$68.60
	Subgroup 10 - Upper Leg (Except Knee)	
21195	Initiation of management of anaesthesia for procedures on the skins or subcutaneous tissue of the upper leg	$51.45
21199	Initiation of management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg	$68.60
21200	Initiation of management of anaesthesia for closed procedures involving hip joint when performed in the operating theatre of a hospital or day hospital facility	$68.60
21202	Initiation of management of anaesthesia for arthroscopic procedures of the hip joint	$68.60
21210	Initiation of management of anaesthesia for open procedures involving hip joint, not being a service to which another item in this subgroup applies	$102.90
21212	Initiation of management of anaesthesia for hip disarticulation	$171.50
21214	Initiation of management of anaesthesia for total hip replacement or revision	$171.50
21220	Initiation of management of anaesthesia for closed procedures involving upper 2/3 of femur when performed in the operating theatre of a hospital or day hospital facility	$68.60

Item	Service	Fee ($)
21230	Initiation of management of anaesthesia for open procedures involving upper 2/3 of femur, not being a service to which another item in this subgroup applies	$102.90
21232	Initiation of management of anaesthesia for above knee amputation	$85.75
21234	Initiation of management of anaesthesia for radical resection of the upper 2/3 of femur	$137.20
21260	Initiation of management of anaesthesia for procedures involving veins of upper leg, including exploration	$68.60
21270	Initiation of management of anaesthesia for procedures involving arteries of upper leg, including bypass graft, not being a service to which another item in this subgroup applies	$137.20
21272	Initiation of management of anaesthesia for femoral artery ligation	$68.60
21274	Initiation of management of anaesthesia for femoral artery embolectomy	$102.90
Note T10.22		
21280	Initiation of management of anaesthesia for microsurgical reimplantation of upper leg	$257.25
	Subgroup 11 - Knee And Popliteal Area	
21300	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the knee and/or popliteal area	$51.45
21321	Initiation of management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of knee and/or popliteal area	$68.60
21340	Initiation of management of anaesthesia for closed procedures on lower 1/3 of femur when performed in the operating theatre of a hospital or day hospital facility	$68.60
21360	Initiation of management of anaesthesia for open procedures on lower 1/3 of femur	$85.75
21380	Initiation of management of anaesthesia for closed procedures on knee joint when performed in the operating theatre of a hospital or day hospital facility	$51.45
21382	Initiation of management of anaesthesia for arthroscopic procedures of knee joint	$68.60
21390	Initiation of management of anaesthesia for closed procedures on upper ends of tibia, fibula, and/or patella when performed in the operating theatre of a hospital or day hospital facility	$51.45
21392	Initiation of management of anaesthesia for open procedures on upper ends of tibia, fibula, and/or patella	$68.60
21400	Initiation of management of anaesthesia for open procedures on knee joint, not being a service to which another item in this subgroup applies	$68.60
21402	Initiation of management of anaesthesia for total knee replacement	$120.05
21403	Initiation of management of anaesthesia for bilateral knee replacement	$171.50

Item	Service	Fee ($)
21404	Initiation of management of anaesthesia for disarticulation of knee	$85.75
21420	Initiation of management of anaesthesia for cast application, removal, or repair involving knee joint, undertaken in a hospital or approved day hospital facility	$51.45
21430	Initiation of management of anaesthesia for procedures on veins of knee or popliteal area, not being a service to which another item in this subgroup applies	$68.60
21432	Initiation of management of anaesthesia for repair of arteriovenous fistula of knee or popliteal area	$85.75
21440	Initiation of management of anaesthesia for procedures on arteries of knee or popliteal area, not being a service to which another item in this subgroup applies	$137.20
	Subgroup 12 - Lower Leg (Below Knee)	
21460	initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of lower leg, ankle, or foot	$51.45
21461	Initiation of management of anaesthesia for procedures on nerves, muscles, tendons, or fascia of lower leg, ankle, or foot, not being a service to which another item in this subgroup applies	$68.60
21462	Initiation of management of anaesthesia for all closed procedures on lower leg, ankle, or foot	$51.45
21464	Initiation of management of anaesthesia for arthroscopic procedure of ankle joint	$68.60
21472	Initiation of management of anaesthesia for repair of achilles tendon	$85.75
21474	Initiation of management of anaesthesia for gastrocnemius recession	$85.75
21480	Initiation of management of anaesthesia for open procedures on bones of lower leg, ankle, or foot, including amputation, not being a service to which another item in this subgroup applies	$68.60
21482	Initiation of management of anaesthesia for radical resection of bone involving lower leg, ankle or foot	$85.75
21484	Initiation of management of anaesthesia for osteotomy or osteoplasty of tibia or fibula	$85.75
21486	Initiation of management of anaesthesia for total ankle replacement	$120.05
21490	Initiation of management of anaesthesiaa for lower leg cast application, removal or repair, undertaken in a hospital or approved day hospital facility	$51.45
21500	Initiation of management of anaesthesia for procedures on arteries of lower leg, including bypass graft, not being a service to which another item in this subgroup applies	$137.20
21502	Initiation of management of anaesthesia for embolectomy of the lower leg	$102.90

Item	Service	Fee ($)
21520	Initiation of management of anaesthesia for procedures on veins of lower leg, not being a service to which another item in this subgroup applies	$68.60
21522	Initiation of management of anaesthesia for venous thrombectomy of the lower leg	$85.75
21530	Initiation of management of anaesthesia for microsurgical reimplantation of lower leg, ankle or foot	$257.25
21532	Initiation of management of anaesthesia for microsurgical reimplantation of toe	$137.20
	Subgroup 13 - Shoulder And Axilla	
21600	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the shoulder or axilla	$51.45
21610	Initiation of management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection	$85.75
21620	Initiation of management of anaesthesia for closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, or shoulder joint when performed in the operating theatre of a hospital or day hospital facility	$68.60
21622	Initiation of management of anaesthesia for arthroscopic procedures of shoulder joint	$85.75
21630	Initiation of management of anaesthesia for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint, not being a service to which another item in this subgroup applies	$85.75
21632	Initiation of management of anaesthesia for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint	$102.90
21634	Initiation of management of anaesthesia for shoulder disarticulation	$154.35
21636	Initiation of management of anaesthesia for interthoracoscapular (forequarter) amputation	$257.25
21638	Initiation of management of anaesthesia for total shoulder replacement	$171.50
21650	Initiation of management of anaesthesia for procedures on arteries of shoulder or axilla, not being a service to which another item in this subgroup applies	$137.20
21652	Initiation of management of anaesthesia for procedures for axillary-brachial aneurysm	$171.50
21654	Initiation of management of anaesthesia for bypass graft of arteries of shoulder or axilla	$137.20
21656	Initiation of management of anaesthesia for axillary-femoral bypass graft	$171.50
21670	Initiation of management of anaesthesia for procedures on veins of shoulder or axilla	$68.60

Item	Service	Fee ($)
21680	Initiation of management of anaesthesia for shoulder cast application, removal or repair, not being a service to which another item in this subgroup applies, when undertaken in a hospital or approved day hospital facility	$51.45
21682	Initiation of management of anaesthesia for shoulder spica application when undertaken in a hospital or approved day hospital facility	$68.60
	Subgroup 14 - Upper Arm And Elbow	
21700	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the upper arm or elbow	$51.45
21710	Initiation of management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of upper arm or elbow, not being a service to which another item in this subgroup applies	$68.60
21712	Initiation of management of anaesthesia for open tenotomy of the upper arm or elbow	$85.75
21714	Initiation of management of anaesthesia for tenoplasty of the upper arm or elbow	$85.75
21716	Initiation of management of anaesthesia for tenodesis for rupture of long tendon of biceps	$85.75
21730	Initiation of management of anaesthesia for closed procedures on the upper arm or elbow when performed in the operating theatre of a hospital or day hospital facility	$51.45
21732	Initiation of management of anaesthesia for arthroscopic procedures of elbow joint	$68.60
21740	Initiation of management of anaesthesia for open procedures on the upper arm or elbow, not being a service to which another item in this subgroup applies	$85.75
21756	Initiation of management of anaesthesia for radical procedures on the upper arm or elbow	$102.90
21760	Initiation of management of anaesthesia for total elbow replacement	$120.05
21770	Initiation of management of anaesthesia for procedures on arteries of upper arm, not being a service to which another item in this subgroup applies	$137.20
21772	Initiation of management of anaesthesia for embolectomy of arteries of the upper arm	$102.90
21780	Initiation of management of anaesthesia for procedures on veins of upper arm, not being a service to which another item in this subgroup applies	$68.60
21790	Initiation of management of anaesthesia for microsurgical reimplantation of upper arm	$257.25
	Subgroup 15 - Forearm Wrist And Hand	
21800	Initiation of management of anaesthesia for procedures on the skin or subcutaneous tissue of the forearm, wrist or hand	$51.45

Item	Service	Fee ($)
21810	Initiation of management of anaesthesia for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand	$68.60
21820	Initiation of management of anaesthesia for closed procedures on the radius, ulna, wrist, or hand bones when performed in the operating theatre of a hospital or day hospital facility	$51.45
21830	Initiation of management of anaesthesia for open procedures on the radius, ulna, wrist, or hand bones, not being a service to which another item in this subgroup applies	$68.60
21832	Initiation of management of anaesthesia for total wrist replacement	$120.05
21834	Initiation of management of anaesthesia for arthroscopic procedures of the wrist joint	$68.60
21840	Initiation of management of anaesthesia for procedures on the arteries of forearm, wrist or hand, not being a service to which another item in this subgroup applies	$137.20
21842	Initiation of management of anaesthesia for embolectomy of artery of forearm, wrist or hand	$102.90
21850	Initiation of management of anaesthesia for procedures on the veins of forearm, wrist or hand, not being a service to which another item in this subgroup applies	$68.60
21860	Initiation of management of anaesthesia for forearm, wrist, or hand cast application, removal, or repair when undertaken in a hospital or approved day hospital facility	$51.45
21870	Initiation of management of anaesthesia for microsurgical reimplantation of forearm, wrist or hand	$257.25
21872	Initiation of management of anaesthesia for microsurgical reimplantation of a finger	$137.20
	Subgroup 16 - Anaesthesia For Burns	
21878	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting where the area of burn involves not more than 3% of total body surface	$51.45
21879	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves more than 3% but less than 10% of total body surface	$85.75
21880	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 10% or more but less than 20% of total body surface	$120.05
21881	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 20% or more but less than 30% of total body surface	$154.35

Item	Service	Fee ($)
21882	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 30% or more but less than 40% of total body surface	$188.65
21883	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 40% or more but less than 50% of total body surface	$222.95
21884	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 50% or more but less than 60% of total body surface	$275.25
21885	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 60% or more but less than 70% of total body surface	$291.55
21886	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 70% or more but less than 80% of total body surface	$325.85
21887	Initiation of management of anaesthesia for excision or debridement of burns, with or without skin grafting, where the area of burn involves 80% or more of total body surface	$360.15
	Subgroup 17 - Anaesthesia For Radiological Or Other Diagnostic Or Therapeutic Procedures	
21900	Initiation of management of anaesthesia for injection procedure for hysterosalpingography	$51.45
21906	Initiation of management of anaesthesia for injection procedure for myelography: lumbar or thoracic	$85.75
21908	Initiation of management of anaesthesia for injection procedure for myelography: cervical	$102.90
21910	Initiation of management of anaesthesia for injection procedure for myelography: posterior fossa	$154.35
21912	Initiation of management of anaesthesia for injection procedure for discography: lumbar or thoracic	$85.75
21914	Initiation of management of anaesthesia for injection procedure for discography cervical	$102.90
21915	Initiation of management of anaesthesia for peripheral arteriogram	$85.75
21916	Initiation of management of anaesthesia for arteriograms: cerebral, carotid or vertebral	$85.75
21918	Initiation of management of anaesthesia for retrograde arteriogram: brachial or femoral	$85.75
21922	Initiation of management of anaesthesia for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning	$120.05

Item	Service	Fee ($)
21925	Initiation of management of anaesthesia for retrograde cystography, retrograde urethrography or retrograde cystourethrography	$68.60
21926	Initiation of management of anaesthesia for fluoroscopy	$85.75
21927	Initiation of management of anaesthesiafor barium enema or other opaque study of the small bowel	$85.75
21930	Initiation of management of anaesthesia for bronchography	$102.90
21935	Initiation of management of anaesthesia for phlebography	$85.75
21936 Note T10.24	Initiation of management of anaesthesia for heart, 2 dimensional real time transoesophageal examination	$102.90
21939	Initiation of management of anaesthesia for peripheral venous cannulation	$51.45
21941 Note T10.23	Initiation of management of anaesthesia for cardiac catheterisation including coronary arteriography, ventriculography, or cardiac mapping	$120.05
21943	Initiation of management of anaesthesia for central vein catheterisation or insertion of right heart balloon catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure	$85.75
21945	Initiation of management of anaesthesia for lumbar puncture, cisternal puncture, or epidural injection	$85.75
21949	Initiation of management of anaesthesia for harvesting of bone marrow for the purpose of transplantation	$85.75
21952	Initiation of management of anaesthesia for muscle biopsy for malignant hyperpyrexia	$171.50
21955	Initiation of management of anaesthesia for electroencephalography	$85.75
21959	Initiation of management of anaesthesia for brain stem evoked response audiometry	$85.75
21962	Initiation of management of anaesthesia for electrocochleography by extratympanic method or transtympanic membrane insertion method	$85.75
21965 Note T10.10	Initiation of management of anaesthesia as a therapeutic procedure where it can be demonstrated that there is a clinical need for anaesthesia	$85.75
21969	Initiation of management of anaesthesia during hyperbaric therapy where the medical practitioner is not confined in the chamber (including the administration of oxygen)	$137.20
21970	Initiation of management of anaesthesia during hyperbaric therapy where the medical practitioner is confined in the chamber (including the administration of oxygen)	$257.25
21973	Initiation of management of anaesthesia for brachytherapy using radioactive sealed sources	$85.75

Item	Service	Fee ($)
21976	Initiation of management of anaesthesia for therapeutic nuclear medicine	$85.75
21980	Initiation of management of anaesthesia for radiotherapy	$85.75
	Subgroup 18 - Miscellaneous	
21990 Note T10.11	Initiation of management of anaesthesia when no procedure ensues	$51.45
21992	Initiation of management of anaesthesia performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic	$68.60
21997 Note T10.11	Initiation of management of anaesthesia in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic rebate, not being a service to which item 21992 or 21965 applies where it can be demonstrated that there is a clinical need for anaesthesia	$68.60
	Subgroup 19 - Therapeutic And Diagnostic Services	
22001	Collection of blood for autologous transfusion or when homologous blood is required for immediate transfusion in an emergency situation, when performed in association with the administration of anaesthesia	$51.45
22002	Administration of blood or bone marrow already collected when performed in association with the administration of anaesthesia	$68.60
22007	Awake endotracheal intubation with flexible fibreoptic scope associated with difficult airway when performed in association with the administration of anaesthesia	$68.60
22008	Double lumen endobronchial tube or bronchial blocker, insertion of when performed in association with the administration of anaesthesia	$68.60
22012 Note T10.1 Note T10.4 Note T10.7	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) when performed in association with the administration of anaesthesia	$51.45
22014	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) when performed in association with the administration of anaesthesia relating to another discrete operation on the same day	$51.45
22015	Right heart balloon catheter, insertion of, including pulmonary wedge pressure and cardiac output measurement, when performed in association with the administration of anaesthesia	$102.90
22020 Note T10.1	Central vein catheterisation (via jugular, subclavian or femoral vein) by percutaneous or open exposure, not being a service to which item 13318 applies, when performed in association with the administration of anaesthesia	$68.60
22025 Note T10.7	Intraarterial cannulation when performed in association with the administration of anaesthesia	$68.60

Item	Service	Fee ($)
22030 Note T10.7 Note T10.16 Note T10.17	Introduction of a narcotic, for the control of postoperative pain, into the epidural or intrathecal space in conjunction with an operation	$34.30
22035 Note T10.7 Note T10.16 Note T10.18	Introduction of a local anaesthetic, for control of postoperative pain, into the epidural or intrathecal space, in conjunction with an operation	$34.30
22040 Note T10.7 Note T10.16 Note T10.19	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	$34.30
22045 Note T10.7 Note T10.16 Note T10.19	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	$51.45
22050 Note T10.7 Note T10.16 Note T10.19	Introduction of a regional of 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	$34.30
22055 Note T10.7 Note T10.9	Perfusion of limb or organ using heart-lung machine or equivalent	$205.80
22060 Note T10.1 Note T10.3 Note T10.7 Note T10.9	Whole body perfusion, cardiac bypass, using heart-lung machine or equivalent	Derived Fee
22065 Note T10.7 Note T10.9	Induced controlled hypothermia total body	$85.75
22070 Note T10.7 Note T10.9	Cardioplegia, blood or crystalloid, administration by any route	$171.50
22075 Note T10.7 Note T10.9	Deep hypothermic circulatory arrest, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed	$257.25
	Subgroup 20 - Administration Of Anaesthesia In Connection With A Dental Service	
22900 Note T10.13	Initiation of management by a medical practitioner of anaesthesia for extraction of tooth or teeth with or without incision of soft tissue or removal of bone	$85.75
22905 Note T10.13	Initiation of management of anaesthesi afor restorative dental work	$85.75
	Subgroup 21 - Anaesthesia/Perfusion Time Units	
23010 Note T10.3	Anaesthesia, perfusion or assistance at anaesthesia (a) administration of anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or (b) perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 For a period of: (fifteen minutes or less)	$17.15

Item	Service	Fee ($)
23021 Note T10.3	16 minutes to 20 minutes	$34.30
23022 Note T10.3	21 minutes to 25 minutes	$34.30
23023 Note T10.3	26 minutes to 30 minutes	$34.30
23031 Note T10.3	31 minutes to 35 minutes	$51.45
23032 Note T10.3	36 minutes to 40 minutes	$51.45
23033 Note T10.1 Note T10.3	41 minutes to 45 minutes	$51.45
23041	46 minutes to 50 minutes	$68.60
23042	51 minutes to 55 minutes	$68.60
23043	56 minutes to 1:00 hour	$68.60
23051	1:01 hours to 1:05 hours	$85.75
23052	1:06 hours to 1:10 hours	$85.75
23053	1:11 hours to 1:15 hours	$85.75
23061	1:16 hours to 1:20 hours	$102.90
23062	1:21 hours to 1:25 hours	$102.90
23063	1:26 hours to 1:30 hours	$102.90
23071	1:31 hours to 1:35 hours	$120.05
23072	1:36 hours to 1:40 hours	$120.05
23073	1:41 hours to 1:45 hours	$120.05
23081	1:46 hours to 1:50 hours	$137.20
23082	1:51 hours to 1:55 hours	$137.20
23083	1:56 hours to 2:00 hours	$137.20
23090	2:01 hours to 2:15 hours	$154.35
23100 Note T10.4	2:16 hours to 2:30 hours	$171.50
23110	2:31 hours to 2:45 hours	$188.65
23120	2:46 hours to 3:00 hours	$205.80
23130	3:01 hours to 3:15 hours	$222.95
23140	3:16 hours to 3:30 hours	$240.10

Item	Service	Fee ($)
23150	3:31 hours to 3:45 hours	$257.25
23160	3:46 hours to 4:00 hours	$274.40
23170	4:01 hours to 4:10 hours	$291.55
23180	4:11 hours to 4:20 hours	$308.70
23190	4:21 hours to 4:30 hours	$325.85
Note T10.4 23200	4:31 hours to 4:40 hours	$343.00
23210	4:41 hours to 4:50 hours	$360.15
23220	4:51 hours to 5:00 hours	$377.30
23230	5:01 hours to 5:10 hours	$394.45
23240	5:11 hours to 5:20 hours	$411.60
23250	5:21 hours to 5:30 hours	$428.75
23260	5:31 hours to 5:40 hours	$445.90
23270	5:41 hours to 5:50 hours	$463.05
23280	5:51 hours to 6:00 hours	$480.20
23290	6:01 hours to 6:10 hours	$497.35
23300	6:11 hours to 6:20 hours	$514.50
23310	6:21 hours to 6:30 hours	$531.65
23320	6:31 hours to 6:40 hours	$548.80
23330	6:41 hours to 6:50 hours	$565.95
23340	6:51 hours to 7:00 hours	$583.10
23350	7:01 hours to 7:10 hours	$600.25
23360	7:11 hours to 7:20 hours	$617.40
23370	7:21 hours to 7:30 hours	$634.55
23380	7:31 hours to 7:40 hours	$651.70
23390	7:41 hours to 7:50 hours	$668.85
23400	7:51 hours to 8:00 hours	$686.00
23410	8:01 hours to 8:10 hours	$703.15
23420	8:11 hours to 8:20 hours	$720.30

Item	Service	Fee ($)
23430	8:21 hours to 8:30 hours	$737.45
23440	8:31 hours to 8:40 hours	$754.60
23450	8:41 hours to 8:50 hours	$771.75
23460	8:51 hours to 9:00 hours	$788.90
23470	9:01 hours to 9:10 hours	$806.05
23480	9:11 hours to 9:20 hours	$823.20
23490	9:21 hours to 9:30 hours	$840.35
23500	9:31 hours to 9:40 hours	$857.50
23510	9:41 hours to 9:50 hours	$874.65
23520	9:51 hours to 10:00 hours	$891.80
23530	10:01 hours to 10:10 hours	$908.95
23540	10:11 hours to 10:20 hours	$926.10
23550	10:21 hours to 10:30 hours	$943.25
23560	10:31 hours to 10:40 hours	$960.40
23570	10:41 hours to 10:50 hours	$977.55
23580	10:51 hours to 11:00 hours	$994.70
23590	11:01 hours to 11:10 hours	$1,011.85
23600	11:11 hours to 11:20 hours	$1,029.00
23610	11:21 hours to 11:30 hours	$1,046.15
23620	11:31 hours to 11:40 hours	$1,063.30
23630	11:41 hours to 11:50 hours	$1,080.45
23640	11:51 hours to 12:00 hours	$1,097.60
23650	12:01 hours to 12:10 hours	$1,114.75
23660	12:11 hours to 12:20 hours	$1,131.90
23670	12:21 hours to 12:30 hours	$1,149.05
23680	12:31 hours to 12:40 hours	$1,166.20
23690	12:41 hours to 12:50 hours	$1,183.35
23700	12:51 hours to 13:00 hours	$1,200.50

Item	Service	Fee ($)
23710	13:01 hours to 13:10 hours	$1,217.65
23720	13:11 hours to 13:20 hours	$1,234.80
23730	13:21 hours to 13:30 hours	$1,251.95
23740	13:31 hours to 13:40 hours	$1,269.10
23750	13:41 hours to 13:50 hours	$1,286.25
23760	13:51 hours to 14:00 hours	$1,303.40
23770	14:01 hours to 14:10 hours	$1,320.55
23780	14:11 hours to 14:20 hours	$1,337.70
23790	14:21 hours to 14:30 hours	$1,354.85
23800	14:31 hours to 14:40 hours	$1,372.00
23810	14:41 hours to 14:50 hours	$1,389.15
23820	14:51 hours to 15:00 hours	$1,406.30
23830	15:01 hours to 15:10 hours	$1,423.45
23840	15:11 hours to 15:20 hours	$1,440.60
23850	15:21 hours to 15:30 hours	$1,457.75
23860	15:31 hours to 15:40 hours	$1,474.90
23870	15:41 hours to 15:50 hours	$1,492.05
23880	15:51 hours to 16:00 hours	$1,509.20
23890	16:01 hours to 16:10 hours	$1,526.35
23900	16:11 hours to 16:20 hours	$1,543.50
23910	16:21 hours to 16:30 hours	$1,560.65
23920	16:31 hours to 16:40 hours	$1,577.80
23930	16:41 hours to 16:50 hours	$1,594.95
23940	16:51 hours to 17:00 hours	$1,612.10
23950	17:01 hours to 17:10 hours	$1,629.25
23960	17:11 hours to 17:20 hours	$1,646.40
23970	17:21 hours to 17:30 hours	$1,663.55
23980	17:31 hours to 17:40 hours	$1,680.70

Item	Service	Fee ($)
23990	17:41 hours to 17:50 hours	$1,697.85
24100	17:51 hours to 18:00 hours	$1,715.00
24101	18:01 hours to 18:10 hours	$1,732.15
24102	18:11 hours to 18:20 hours	$1,749.30
24103	18:21 hours to 18:30 hours	$1,766.45
24104	18:31 hours to 18:40 hours	$1,783.60
24105	18:41 hours to 18:50 hours	$1,800.75
24106	18:51 hours to 19:00 hours	$1,817.90
24107	19:01 hours to 19:10 hours	$1,835.05
24108	19:11 hours to 19:20 hours	$1,852.20
24109	19:21 hours to 19:30 hours	$1,869.35
24110	19:31 hours to 19:40 hours	$1,886.50
24111	19:41 hours to 19:50 hours	$1,903.65
24112	19:51 hours to 20:00 hours	$1,920.80
24113	20:01 hours to 20:10 hours	$1,937.95
24114	20:11 hours to 20:20 hours	$1,955.10
24115	20:21 hours to 20:30 hours	$1,972.25
24116	20:31 hours to 20:40 hours	$1,989.40
24117	20:41 hours to 20:50 hours	$2,006.55
24118	20:51 hours to 21:00 hours	$2,023.70
24119	21:01 hours to 21:10 hours	$2,040.85
24120	21:11 hours to 21:20 hours	$2,058.00
24121	21:21 hours to 21:30 hours	$2,075.15
24122	21:31 hours to 21:40 hours	$2,092.30
24123	21:41 hours to 21:50 hours	$2,109.45
24124	21:51 hours to 22:00 hours	$2,126.60
24125	22:01 hours to 22:10 hours	$2,143.75
24126	22:11 hours to 22:20 hours	$2,160.90

Item	Service	Fee ($)
24127	22:21 hours to 22:30 hours	$2,178.05
24128	22:31 hours to 22:40 hours	$2,195.20
24129	22:41 hours to 22:50 hours	$2,212.35
24130	22:51 hours to 23:00 hours	$2,229.50
24131	23:01 hours to 23:10 hours	$2,246.65
24132	23:11 hours to 23:20 hours	$2,263.80
24133	23:21 hours to 23:30 hours	$2,280.95
24134	23:31 hours to 23:40 hours	$2,298.10
24135	23:41 hours to 23:50 hours	$2,315.25
24136	23:51 hours to 24:00 hours	$2,332.40
	Subgroup 22 - Anaesthesia/Perfusion Modifying Units - Physical Status	
25000 Note T10.1 Note T10.3 Note T10.4	Anaesthesia, perfusion or assistance at anaesthesia (a) for anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or (b) for perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 - where the patient has severe systemic disease equivalent to asa physical status indicator 3	$17.15
25005 Note T10.1 Note T10.3	Where the patient has severe systemic disease which is a constant threat to life equivalent to asa physical status indicator 4	$34.30
25010 Note T10.1 Note T10.3	For a patient who is not expected to survive for 24 hours with or without the operation, equivalent to asa physical status indicator 5	$51.45
	Subgroup 23 - Anaesthesia/Perfusion Modifying Units - Other	
25015 Note T10.1 Note T10.3 Note T10.4	Anaesthesia, perfusion or assistance at anaesthesia - where the patient's age is one year or less or 70 years or greater	$17.15
25020 Note T10.1 Note T10.3 Note T10.4	Anaesthesia, perfusion or assistance at anaesthesia - where the patient requires immediate treatment without which there would be significant threat to life or body part - not being a service associated with a service to which item 25025 or 25030 or 25050 applies	$34.30
	Subgroup 24 - Anaesthesia After Hours Emergency Modifier	
25025 Note T10.3 Note T10.4	Emergency anaesthesia performed in the after hours period where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for the emergency anaesthesia service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25030 or 25050 applies	Derived Fee

Item	Service	Fee ($)
25030 Note T10.3	Assistance at after hours emergency anaesthesia where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for which the assistant is in professional attendance on the patient is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25050 applies	Derived Fee
	Subgroup 25 - Perfusion After Hours Emergency Modifier	
25050 Note T10.3	After hours emergency perfusion where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the perfusion service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25030 applies	Derived Fee
	Subgroup 26 - Assistance At Anaesthesia	
25200 Note T10.1 Note T10.8	Assistance in the administration of anaesthesia requiring continuous anaesthesia on a patient in imminent danger of death requiring continuous life saving emergency treatment, to the exclusion of all other patients	Derived Fee
25205 Note T10.8	Assistance in the administration of elective anaesthesia, where: (i) the patient has complex airway problems; or (ii) the patient is a neonate or a complex paediatric case; or (iii) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or (iv) the patient is critically ill, with multiple organ failure; or (v)where the anaesthesia time exceeds 6 hours and the assistance is provided to the exclusion of all other patients	Derived Fee
	GROUP T8 - SURGICAL OPERATIONS	
	Subgroup 1 - General	
30001 Note T8.8	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	Derived Fee
30003	Localised burns, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation	$28.75
30006	Extensive burns, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation	$36.80
30009	Localised burns, dressing of, under general anaesthesia (not involving grafting) (Anaes.)	$48.00
30010	Localised burns, dressing of, under general anaesthesia (not involving grafting) (Anaes.)	$58.45
30013	Extensive burns, dressing of, under general anaesthesia (not involving grafting) (Anaes.)	$103.50
30014	Extensive burns, dressing of, under general anaesthesia (not involving grafting) (Anaes.)	$122.95

Item	Service	Fee ($)
30017	Burns, excision of, under general anaesthesia, involving not more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.)(Assist.)	$257.85
30020	Burns, excision of, under general anaesthesia, involving more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.)(Assist.)	$502.25
30023 Note T8.2 Note T8.9 Note T8.64	Wound of soft tissue, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.)(Assist.)	$257.85
30026 Note T8.9 Note T8.64	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 7cm long), superficial, not being a service to which another item in Group T4 applies (Anaes.)	$41.30
30029 Note T8.9 Note T8.64	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 7cm in length), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)	$71.15
30032 Note T8.9 Note T8.64	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 7cm long), superficial (Anaes.)	$65.25
30035 Note T8.9 Note T8.64	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 7cm long), involving deeper tissue (Anaes.)	$92.95
30038 Note T8.9 Note T8.64	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 7cm long), superficial, not being a service to which another item in Group T4 applies (Anaes.)	$71.15
30041 Note T8.9 Note T8.64	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 7cm long), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)	$113.95
30042 Note T8.9 Note T8.64	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, other than on face or neck, large (more than 7cm long), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)	$146.90
30045 Note T8.9 Note T8.64	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 7cm long), superficial (Anaes.)	$92.95
30048 Note T8.9 Note T8.64	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 7cm long), involving deeper tissue (Anaes.)	$118.45

Item	Service	Fee ($)
30049 Note T8.9 Note T8.64	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 7cm long), involving deeper tissue (Anaes.)	$146.90
30052 Note T8.64	Full thickness laceration of ear, eyelid, nose or lip, repair of, with accurate apposition of each layer of tissue (Anaes.)(Assist.)	$200.90
30055	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.)	$58.45
30058	Postoperative haemorrhage, control of, under general anaesthesia, as an independent procedure (Anaes.)	$113.95
30061	Superficial foreign body, removal of, (including from cornea or sclera) as an independent procedure (Anaes.)	$18.55
30064	Subcutaneous foreign body, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.)	$86.95
30067 Note T8.2	Foreign body in muscle, tendon or other deep tissue, removal of, as an independent procedure (Anaes.)(Assist.)	$176.90
30068 Note T8.2	Foreign body in muscle, tendon or other deep tissue, removal of, as an independent procedure (Anaes.)(Assist.)	$218.90
30071	Biopsy of skin or mucous membrane, as an independent procedure (Anaes.)	$41.30
30074	Biopsy of lymph gland, muscle or other deep tissue or organ, as an independent procedure (Anaes.)	$92.95
30075	Biopsy of lymph gland, muscle or other deep tissue or organ, as an independent procedure (Anaes.)	$118.45
30078 Note T8.10	Drill biopsy of lymph gland, deep tissue or organ, as an independent procedure (Anaes.)	$38.30
30081	Biopsy of bone marrow by trephine using an open approach (Anaes.)	$86.95
30084	Biopsy of bone marrow by trephine using a percutaneous approach with a Jamshidi needle or similar device (Anaes.)	$46.50
30087	Biopsy of bone marrow by aspiration or punch biopsy of synovial membrane (Anaes.)	$23.30
30090	Biopsy of pleura, percutaneous 1 or more biopsies on any 1 occasion (Anaes.)	$101.65
30093	Needle biopsy of vertebra (Anaes.)	$135.70
30094	Percutaneous aspiration biopsy of deep organ using interventional imaging techniques - but not including imaging (Anaes.)	$149.80
30096	Scalene node biopsy (Anaes.)	$145.45
30099 Note T8.64	Sinus, excision of, involving superficial tissue only (Anaes.)	$71.15

Item	Service	Fee ($)
30102 Note T8.64	Sinus, excision of, involving muscle and deep tissue (Anaes.)	$118.45
30103 Note T8.64	Sinus, excision of, involving muscle and deep tissue (Anaes.)	$145.45
30104 Note T8.64	Pre-auricular sinus, excision of (Anaes.)	$100.45
30106 Note T8.3 Note T8.64	Ganglion or small bursa, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.)	$122.95
30107 Note T8.64	Ganglion or small bursa, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.)	$173.95
30110 Note T8.64	Bursa (large), including olecranon, calcaneum or patella, excision of (Anaes.)(Assist.)	$224.95
30111 Note T8.64	Bursa (large), including olecranon, calcaneum or patella, excision of (Anaes.)(Assist.)	$293.85
30114 Note T8.64	Bursa, semimembranosus (Baker's cyst), excision of (Anaes.)(Assist.)	$293.85
30165 Note T8.64	Lipectomy transverse wedge excision of abdominal apron (Anaes.)(Assist.)	$359.80
30168 Note T8.64	Lipectomy wedge excision of skin or fat (not being a service to which item 30165 applies) 1 excision (Anaes.)(Assist.)	$359.80
30171 Note T8.11 Note T8.64	Lipectomy wedge excision of skin or fat (not being a service to which item 30165 applies) 2 or more excisions (Anaes.)(Assist.)	$547.25
30174 Note T8.64	Lipectomy subumbilical excision with undermining of skin edges and strengthening of musculoaponeurotic wall (Anaes.)(Assist.)	$547.25
30177 Note T8.64	Lipectomy radical abdominoplasty (Pitanguy type or similar) with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus (Anaes.)(Assist.)	$779.70
30180 Note T8.64	Axillary hyperhidrosis, wedge excision for (Anaes.)	$107.95
30183	Axillary hyperhidrosis, total excision of sweat gland bearing area (Anaes.)	$194.95
30186 Note T8.12 Note T8.64	Palmar or plantar warts, removal of, not being a service to which item 30187 applies (Anaes.)	$37.55
30187 Note T8.12	Palmar or plantar warts, removal of, by carbon dioxide laser or erbium laser, requiring admission to a hospital or day-hospital facility, or when performed by a specialist in the practice of his/her specialty, (5 or more warts) (Anaes.)	$203.25
30189 Note T8.12	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.)	$116.50
30190	Angiofibromas, trichoepitheliomas or other severely disfiguring tumours suitable for laser excision as confirmed by specialist opinion, of the face or neck, removal of, by carbon dioxide laser or erbium laser excision-ablation including associated resurfacing (10 or more tumours) (Anaes.)(Assist.)	$314.65

Item	Service	Fee ($)
30192 Note T8.12	Premalignant skin lesions, treatment of, by galvanocautery or electrodesiccation or cryocautery (10 or more lesions) (Anaes.)	$31.35
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.)	$50.20
30196 Note T8.13	Cancer of skin or mucous membrane proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser or erbium laser excision-ablation, including any associated cryotherapy, or diathermy, not being a service to which item 30197 applies (Anaes.)	$99.90
30197 Note T8.13	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.)	$348.10
30202 Note T8.13	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	$38.20
30203 Note T8.13	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)	$134.70
30205	Cancer of skin proven by histopathology, removal of, by liquid nitrogen cryotherapy using repeat freeze-thaw cycles where cancer extends into cartilage (Anaes.)	$99.90
30207	Skin lesions, multiple injections with hydrocortisone or similar preparations (Anaes.)	$35.25
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.)	$128.95
30213 Note T8.14	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.)	$86.85
30214 Note T8.14	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	$86.85
30216	Haematoma, aspiration of (Anaes.)	$21.60
30219 Note T8.7	Haematoma, furuncle, small abscess or similar lesion not requiring admission to a hospital or day-hospital facility - incision with drainage of (excluding aftercare)	$21.60

Item	Service	Fee ($)
30223 Note T8.7	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.)	$128.95
30224	Percutaneous drainage of deep abscess using interventional imaging techniques - but not including imaging (Anaes.)	$187.95
30225	Abscess drainage tube, exchange of using interventional imaging techniques - but not including imaging (Anaes.)	$211.70
30226	Muscle, excision of (limited) or fasciotomy (Anaes.)	$118.45
30229	Muscle, excision of (extensive) (Anaes.)(Assist.)	$215.90
30232	Muscle, ruptured, repair of (limited), not associated with external wound (Anaes.)	$176.90
30235	Muscle, ruptured, repair of (extensive), not associated with external wound (Anaes.)(Assist.)	$233.90
30238	Fascia, deep, repair of, for herniated muscle (Anaes.)	$118.45
30241	Bone tumour, innocent, excision of, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$281.90
30244	Styloid process of temporal bone, removal of (Anaes.)(Assist.)	$281.90
30246	Parotid duct, repair of, using micro-surgical techniques (Anaes.)(Assist.)	$545.60
30247	Parotid gland, total extirpation of (Anaes.)(Assist.)	$584.80
30250	Parotid gland, total extirpation of with preservation of facial nerve (Anaes.)(Assist.)	$989.55
30251	Recurrent parotid tumour, excision of, with preservation of facial nerve (Anaes.)(Assist.)	$1,520.05
30253	Parotid gland, superficial lobectomy of, with exposure of facial nerve (Anaes.)(Assist.)	$659.80
30255	Submandibular ducts, relocation of, for surgical control of drooling (Anaes.)(Assist.)	$878.55
30256	Submandibular gland, extirpation of (Anaes.)(Assist.)	$352.35
30259	Sublingual gland, extirpation of (Anaes.)	$155.90
30262	Salivary gland, dilatation or diathermy of duct (Anaes.)	$46.50
30265	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.)	$92.95
30266	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.)	$118.45

Item	Service	Fee ($)
30269 Note T8.64	Salivary gland, repair of cutaneous fistula of (Anaes.)	$118.45
30272	Tongue, partial excision of (Anaes.)(Assist.)	$233.90
30275	Radical excision of intraoral tumour involving resection of mandible and lymph glands of neck (commandotype operation) (Anaes.)(Assist.)	$1,394.40
30278	Tongue tie, repair of, not being a service to which another item in this Group applies (Anaes.)	$36.80
30281	Tongue tie, mandibular frenulum or maxillary frenulum, repair of, in a person aged 2 years and over, under general anaesthesia (Anaes.)	$94.50
30282	Ranula or mucous cyst of mouth, removal of (Anaes.)	$122.95
30283	Ranula or mucous cyst of mouth, removal of (Anaes.)	$161.95
30286	Branchial cyst, removal of (Anaes.)(Assist.)	$314.75
30289	Branchial fistula, removal of (Anaes.)(Assist.)	$397.30
30293	Cervical oesophagostomy; or closure of cervical oesophagostomy with or without plastic repair (Anaes.)(Assist.)	$352.35
30294	Cervical oesophagectomy with tracheostomy and oesophagostomy, with or without plastic reconstruction; or laryngopharyngectomy with tracheostomy and plastic reconstruction (Anaes.)(Assist.)	$1,394.40
30296	Thyroidectomy, total (Anaes.)(Assist.)	$809.80
30297	Thyroidectomy following previous thyroid surgery (Anaes.)(Assist.)	$809.80
30306	Total hemithyroidectomy (Anaes.)(Assist.)	$631.70
30308	Bilateral subtotal thyroidectomy (Anaes.)(Assist.)	$631.70
30309	Thyroidectomy, subtotal for thyrotoxicosis (Anaes.)(Assist.)	$809.80
30310	Thyroid, unilateral subtotal thyroidectomy or equivalent partial thyroidectomy (Anaes.)(Assist.)	$361.80
30313	Thyroglossal cyst, removal of (Anaes.)(Assist.)	$215.90
30314	Thyroglossal cyst or fistula or both, radical removal of, including thyroglossal duct and portion of hyoid bone (Anaes.)(Assist.)	$361.80
30315	Parathyroid operation for hyperparathyroidism (Anaes.)(Assist.)	$901.65
30317	Cervical reexploration for recurrent or persistent hyperparathyroidism (Anaes.)(Assist.)	$1,079.70
30318	Mediastinum, exploration of, via the cervical route, for hyperparathyroidism (including thymectomy) (Anaes.)(Assist.)	$717.90

Item	Service	Fee ($)
30320	Mediastinum, exploration of, via mediastinotomy, for hyperparathyroidism (including thymectomy) (Anaes.)(Assist.)	$1,079.70
30321	Retroperitoneal neuroendocrine tumour, removal of (Anaes.)(Assist.)	$717.90
30323	Retroperitoneal neuroendocrine tumour, removal of, requiring complex and extensive dissection (Anaes.)(Assist.)	$1,079.70
30324	Adrenal gland tumour, excision of (Anaes.)(Assist.)	$1,079.70
30329	Lymph glands of groin, limited excision of (Anaes.)	$195.30
30330	Lymph glands of groin, radical excision of (Anaes.)(Assist.)	$568.55
30332	Lymph nodes of axilla, limited excision of (sampling) (Anaes.)(Assist.)	$274.30
30335 Note T8.15	Lymph nodes of axilla, complete excision of, to level I (Anaes.)(Assist.)	$685.70
30336 Note T8.15	Lymph nodes of axilla, complete excision of, to level II or level III (Anaes.)(Assist.)	$822.90
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.)	$205.70
30340	Breast, benign lesion more than 50mm in diameter, excision of (Anaes.)(Assist.)	$274.30
30343	Breast, abnormality detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes.)(Assist.)	$308.60
30344	Breast, malignant tumour, open surgical biopsy of, with or without frozen section histology (Anaes.)	$274.30
30347	Breast, malignant tumour, complete local excision of, with or without frozen section histology (Anaes.)(Assist.)	$514.30
30348	Breast, tumour site, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes.)(Assist.)	$345.00
30351	Breast (female), total mastectomy (Anaes.)(Assist.)	$582.40
30352	Breast (male), total mastectomy (Anaes.)(Assist.)	$342.90
30354 Note T8.16	Breast (female), subcutaneous mastectomy (Anaes.)(Assist.)	$822.90
30355 Note T8.16	Breast (male), subcutaneous mastectomy (Anaes.)(Assist.)	$411.45
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	$471.15

Item	Service	Fee ($)
30360 Note T8.17	Fine needle aspiration of an impalpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes.)	$109.05
30361	Breast, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques - but not including imaging (Anaes.)	$149.80
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.)	$109.05
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.)	$171.40
30366	Breast, microdochotomy of, for benign or malignant condition (Anaes.)(Assist.)	$342.90
30367	Breast central ducts, excision of, for benign condition (Anaes.)(Assist.)	$274.30
30369	Accessory breast tissue, excision of (Anaes.)(Assist.)	$274.30
30370	Inverted nipple, surgical eversion of (Anaes.)	$205.50
30372	Accessory nipple, excision of (Anaes.)	$102.85
30373	Laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.)(Assist.)	$382.25
30375 Note T8.18	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.)(Assist.)	$412.30
30376	Laparotomy involving division of peritoneal adhesions (where no other intraabdominal procedure is performed) (Anaes.)(Assist.)	$412.30
30378	Laparotomy involving division of adhesions in association with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours (Anaes.)(Assist.)	$414.20
30379	Laparotomy with division of extensive adhesions (duration greater than 2 hours) with or without insertion of long intestinal tube (Anaes.)(Assist.)	$734.20
30382	Enterocutaneous fistula, radical repair of, involving extensive dissection and resection of bowel (Anaes.)(Assist.)	$1,033.75
30384	Laparotomy for grading of lymphoma, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (Anaes.)(Assist.)	$869.60
30385	Laparotomy for control of postoperative haemorrhage, where no other procedure is performed (Anaes.)(Assist.)	$445.55

Item	Service	Fee ($)
30387 Note T8.4 Note T8.21	Laparotomy involving operation on abdominal viscera (including pelvic viscera), not being a service to which another item in this Group applies (Anaes.)(Assist.)	$502.25
30388	Laparotomy for trauma involving 3 or more organs (Anaes.)(Assist.)	$1,263.55
30390	Laparoscopy, diagnostic (Anaes.)	$173.95
30391	Laparoscopy, with biopsy (Anaes.)(Assist.)	$224.95
30392	Radical or debulking operation for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Anaes.)(Assist.)	$533.55
30393	Laparoscopic division of adhesions in association with another intra-abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes (Anaes.)(Assist.)	$414.20
30394	Laparotomy for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess, ruptured appendix or for peritonitis from any cause, with or without appendicectomy (Anaes.)(Assist.)	$389.80
30396	Laparotomy for gross intra peritoneal sepsis requiring debridement of fibrin, with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity via a major abdominal incision with or without closure of abdomen and with or without mesh or zipper insertion (Anaes.)(Assist.)	$804.10
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.)	$183.80
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.)(Assist.)	$252.80
30400	Laparotomy with insertion of portacath for administration of cytotoxic therapy including placement of reservoir (Anaes.)(Assist.)	$500.30
30402	Retroperitoneal abscess, drainage of, not involving laparotomy (Anaes.)(Assist.)	$367.50
30403	Ventral, incisional, or recurrent hernia or burst abdomen, repair of (Anaes.)(Assist.)	$412.30
30405 Note T8.67	Ventral, or incisional hernia, repair of requiring muscle transposition, mesh hernioplasty or resection of strangulated bowel (Anaes.)(Assist.)	$723.70
30406	Paracentesis abdominis (Anaes.)	$41.30
30408	Peritoneo venous (Leveen) shunt, insertion of (Anaes.)(Assist.)	$310.15
30409 Note T10	Liver biopsy, percutaneous (Anaes.)	$138.05
30411	Liver biopsy by wedge excision when performed in association with another intraabdominal procedure (Anaes.)	$70.25

Item	Service	Fee ($)
30412	Liver biopsy by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.)	$41.40
30414	Liver, subsegmental resection of, (local excision), other than for trauma (Anaes.)(Assist.)	$545.60
30415	Liver, segmental resection of, other than for trauma (Anaes.)(Assist.)	$1,091.25
30416	Liver cyst, laparoscopic marsupialisation of, where the size of the cyst is greater than 5cm in diameter (Anaes.)(Assist.)	$592.50
30417	Liver cysts, laparoscopic marsupialisation of 5 or more, including any cyst greater than 5cm in diameter (Anaes.)(Assist.)	$888.70
30418	Liver, lobectomy of, other than for trauma (Anaes.)(Assist.)	$1,263.55
30419	Liver tumours, destruction of, by hepatic cryotherapy (Anaes.)(Assist.)	$646.40
30421	Liver, tri-segmental resection (extended lobectomy) of, other than for trauma (Anaes.)(Assist.)	$1,579.30
30422	Liver, repair of superficial laceration of, for trauma (Anaes.)(Assist.)	$534.15
30425	Liver, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes.)(Assist.)	$1,033.75
30427	Liver, segmental resection of, for trauma (Anaes.)(Assist.)	$1,234.75
30428	Liver, lobectomy of, for trauma (Anaes.)(Assist.)	$1,320.95
30430	Liver, extended lobectomy (tri-segmental resection) of, for trauma (Anaes.)(Assist.)	$1,837.75
30431	Liver abscess, open abdominal drainage of (Anaes.)(Assist.)	$412.30
30433	Liver abscess (multiple), open abdominal drainage of (Anaes.)(Assist.)	$574.35
30434	Hydatid cyst of liver, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles (Anaes.)(Assist.)	$465.25
30436	Hydatid cyst of liver, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles, with omentoplasty or myeloplasty (Anaes.)(Assist.)	$516.90
30437	Hydatid cyst of liver, total excision of, by cysto-pericystectomy (membrane plus fibrous wall) (Anaes.)(Assist.)	$643.25
30438	Hydatid cyst of liver, excision of, with drainage and excision of liver tissue (Anaes.)(Assist.)	$910.30
30439	Operative cholangiography or operative pancreatography or intra operative ultrasound of the biliary tract (including 1 or more examinations performed during the 1 operation) (Anaes.)(Assist.)	$146.90

Item	Service	Fee ($)
30440	Cholangiogram, percutaneous transhepatic, and biliary drainage, using interventional imaging techniques - but not including imaging (Anaes.)(Assist.)	$416.35
30441	Intra operative ultrasound for staging of intra abdominal tumours (Anaes.)	$107.75
30442	Choledochoscopy in conjunction with another procedure (Anaes.)	$146.90
30443	Cholecystectomy (Anaes.)(Assist.)	$584.80
30445	Laparoscopic cholecystectomy (Anaes.)(Assist.)	$584.80
30446	Laparoscopic cholecystectomy when procedure is completed by laparotomy (Anaes.)(Assist.)	$584.80
30448	Laparoscopic cholecystectomy, involving removal of common duct calculi via the cystic duct (Anaes.)(Assist.)	$769.60
30449	Laparoscopic cholecystectomy with removal of common duct calculi via laparoscopic choledochotomy (Anaes.)(Assist.)	$855.75
30450	Calculus of biliary or renal tract, extraction of, using interventional imaging techniques - not being a service associated with a service to which items 36627, 36630, 36645 or 36648 applies (Anaes.)(Assist.)	$414.75
30451	Biliary drainage tube, exchange of, using interventional imaging techniques - but not including imaging (Anaes.)(Assist.)	$211.70
30452	Choledochoscopy with balloon dilatation of a stricture or passage of stent or extraction of calculi (Anaes.)(Assist.)	$298.65
30454	Choledochotomy (with or without cholecystectomy), with or without removal of calculi (Anaes.)(Assist.)	$682.20
30455	Choledochotomy (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (Anaes.)(Assist.)	$802.15
30457	Choledochotomy, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.)(Assist.)	$1,091.25
30458	Transduodenal operation on sphincter of Oddi, involving 1 or more of, removal of calculi, sphincterotomy, sphincteroplasty, biopsy, local excision of peri-ampullary or duodenal tumour, sphincteroplasty of the pancreatic duct, pancreatic duct septoplasty, with or without choledochotomy (Anaes.)(Assist.)	$802.15
30460	Cholecystoduodenostomy, cholecystoenterostomy, choledochojejunostomy or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes.)(Assist.)	$682.20
30461	Radical resection of porta hepatis with biliary-enteric anastomoses, not being a service associated with a service to which item 30443, 30454, 30455, 30458 or 30460 applies (Anaes.)(Assist.)	$1,169.45
30463	Radical resection of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses (Anaes.)(Assist.)	$1,435.75

Item	Service	Fee ($)
30464	Radical resection of common hepatic duct and right and left hepatic ducts, involving more than 2 anastomoses or resection of segment or major portion of segment of liver (Anaes.)(Assist.)	$1,723.00
30466	Intrahepatic biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.)(Assist.)	$993.60
30467	Intraheptic bypass of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.)(Assist.)	$1,229.00
30469	Biliary stricture, repair of, after 1 or more operations on the biliary tree (Anaes.)(Assist.)	$1,361.15
30472	Hepatic or common bile duct, repair of, as the primary procedure subsequent to partial or total transection of bile duct or ducts (Anaes.)(Assist.)	$735.10
30473 Note T8.19	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.)	$140.10
30475 Note T8.19	Endoscopy with balloon dilatation of gastric or gastroduodenal stricture (Anaes.)	$253.30
30476 Note T8.19	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.)	$194.25
30478 Note T8.19	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.)	$194.25
30479 Note T8.19	Endoscopic laser therapy for neoplasia and benign vascular lesions or strictures of the gastrointestinal tract (Anaes.)	$376.60
30481 Note T8.19	Percutaneous gastrostomy (initial procedure), including any associated imaging services (Anaes.)	$282.40
30482	Percutaneous gastrostomy (repeat procedure), including any associated imaging services (Anaes.)	$200.80
30483	Gastrostomy button, non-endoscopic insertion of, or non-endoscopic replacement of (Anaes.)	$140.05
30484 Note T8.19	Endoscopic retrograde cholangiopancreatography (Anaes.)	$288.65
30485 Note T8.19	Endoscopic sphincterotomy with or without extraction of stones from common bile duct (Anaes.)	$445.55

Item	Service	Fee ($)
30487 Note T8.19	Small bowel intubation with biopsy (Anaes.)	$143.10
30488	Small bowel intubation as an independent procedure (Anaes.)	$71.15
30490 Note T8.19	Oesophageal prosthesis, insertion of, including endoscopy and dilatation (Anaes.)	$416.35
30491 Note T8.19	Bile duct, endoscopic stenting of (including endoscopy and dilatation) (Anaes.)	$439.25
30493 Note T8.19	Biliary manometry (Anaes.)	$263.60
30494 Note T8.19	Endoscopic biliary dilatation (Anaes.)	$332.60
30496	Vagotomy, truncal or selective, with or without pyloroplasty or gastroenterostomy (Anaes.)(Assist.)	$465.25
30497	Vagotomy and antrectomy (Anaes.)(Assist.)	$554.70
30499	Vagotomy, highly selective (Anaes.)(Assist.)	$659.80
30500	Vagotomy, highly selective with duodenoplasty for peptic stricture (Anaes.)(Assist.)	$706.40
30502	Vagotomy, highly selective, with dilatation of pylorus (Anaes.)(Assist.)	$779.70
30503	Vagotomy or antrectomy, or both, for peptic ulcer following previous operation for peptic ulcer (Anaes.)(Assist.)	$873.05
30505	Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision (Anaes.)(Assist.)	$436.45
30506	Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (Anaes.)(Assist.)	$763.90
30508	Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy (Anaes.)(Assist.)	$804.10
30509	Bleeding peptic ulcer, control of, involving gastric resection (other than wedge resection) (Anaes.)(Assist.)	$804.10
30511	Morbid obesity, gastric reduction or gastroplasty for, by any method (Anaes.)(Assist.)	$672.00
30512	Morbid obesity, gastric bypass for, by any method including anastomosis (Anaes.)(Assist.)	$826.95
30514	Morbid obesity, surgical reversal of procedure to which item 30511 or 30512 applies (Anaes.)(Assist.)	$1,217.50
30515	Gastroenterostomy (including gastroduodenostomy) or enterocolostomy or enteroenterostomy (Anaes.)(Assist.)	$557.05
30517	Gastroenterostomy, pyloroplasty or gastroduodenostomy, reconstruction of (Anaes.)(Assist.)	$729.40

Item	Service	Fee ($)
30518	Partial gastrectomy (Anaes.)(Assist.)	$781.10
30520	Gastric tumour, removal of, by local excision, not being a service to which item 30518 applies (Anaes.)(Assist.)	$534.15
30521	Gastrectomy, total, for benign disease (Anaes.)(Assist.)	$1,142.95
30523 Note T8.20	Gastrectomy, subtotal radical, for carcinoma, (including splenectomy when performed) (Anaes.)(Assist.)	$1,194.50
30524 Note T8.20	Gastrectomy, total radical, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (Anaes.)(Assist.)	$1,315.15
30526	Gastrectomy, total, and including lower oesophagus, performed by left thoraco-abdominal incision or opening of diaphragmatic hiatus, (including splenectomy when performed) (Anaes.)(Assist.)	$1,705.65
30527list30518_31355 Note T8.21	Antireflux operation by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus not being a service to which item 30601 applies (Anaes.)(Assist.)	$689.20
30529 Note T8.21	Antireflux operation by fundoplasty, with oesophagoplasty for stricture or short oesophagus (Anaes.)(Assist.)	$1,033.75
30530 Note T8.21	Antireflux operation by cardiopexy, with or without fundoplasty (Anaes.)(Assist.)	$620.30
30532 Note T8.21	Oesophagogastric myotomy (Heller's operation) via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus by laparoscopy or open operation (Anaes.)(Assist.)	$712.25
30533 Note T8.21	Oesophagogastric myotomy (Heller's operation) via abdominal or thoracic approach, with fundoplasty, with or without closure of the diaphragmatic hiatus by laparoscopy or open operation (Anaes.)(Assist.)	$847.20
30535	Oesophagectomy with gastric reconstruction by abdominal mobilisation and thoracotomy (Anaes.)(Assist.)	$1,342.00
30536	Oesophagectomy involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - 1 surgeon (Anaes.)(Assist.)	$1,361.15
30538	Oesophagectomy involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest- conjoint surgery, principal surgeon (including aftercare) (Anaes.)(Assist.)	$941.90
30539	Oesophagectomy involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - conjoint surgery, co-surgeon(Assist.)	$689.20
30541	Oesophagectomy, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - 1 surgeon (Anaes.)(Assist.)	$1,200.35

Item	Service	Fee ($)
30542	Oesophagectomy, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, principal surgeon (including aftercare) (Anaes.)(Assist.)	$815.50
30544	Oesophagectomy, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, co-surgeon(Assist.)	$597.30
30545	Oesophagectomy with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - 1 surgeon (Anaes.)(Assist.)	$1,453.10
30547	Oesophagectomy with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, principal surgeon (including aftercare) (Anaes.)(Assist.)	$999.30
30548	Oesophagectomy with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, co-surgeon(Assist.)	$746.60
30550	Oesophagectomy with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - 1 surgeon (Anaes.)(Assist.)	$1,631.10
30551	Oesophagectomy with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, principal surgeon (including aftercare) (Anaes.)(Assist.)	$1,125.70
30553	Oesophagectomy with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, co-surgeon(Assist.)	$832.70
30554	Oesophagectomy with reconstruction by free jejunal graft - 1 surgeon (Anaes.)(Assist.)	$1,814.90
30556	Oesophagectomy with reconstruction by free jejunal graft - conjoint surgery, principal surgeon (including aftercare) (Anaes.)(Assist.)	$1,252.00
30557	Oesophagectomy with reconstruction by free jejunal graft - conjoint surgery, co-surgeon(Assist.)	$924.65
30559	Oesophagus, local excision for tumour of (Anaes.)(Assist.)	$672.00
30560	Oesophageal perforation, repair of, by thoracotomy (Anaes.)(Assist.)	$746.60
30562	Enterostomy or colostomy, closure of not involving resection of bowel (Anaes.)(Assist.)	$470.70
30563	Colostomy or ileostomy, refashioning of (Anaes.)(Assist.)	$470.70
30564	Small bowel strictureplasty for chronic inflammatory bowel disease (Anaes.)(Assist.)	$610.90
30565	Small intestine, resection of, without anastomosis (including formation of stoma) (Anaes.)(Assist.)	$689.20
30566	Small intestine, resection of, with anastomosis (Anaes.)(Assist.)	$765.60

Item	Service	Fee ($)
30568	Intraoperative enterotomy for visualisation of the small intestine by endoscopy (Anaes.)(Assist.)	$574.35
30569	Endoscopic examination of small bowel with flexible endoscope passed at laparotomy, with or without biopsies (Anaes.)(Assist.)	$292.85
30571	Appendicectomy, not being a service to which item 30574 applies (Anaes.)(Assist.)	$352.35
30572	Laparoscopic appendicectomy (Anaes.)(Assist.)	$352.35
30574	Appendicectomy, when performed in conjunction with any other intraabdominal procedure through the same incision (Anaes.)	$97.50
30575	Pancreatic abscess, laparotomy and external drainage of, not requiring retro-pancreatic dissection (Anaes.)(Assist.)	$405.60
30577	Pancreatic necrosectomy for pancreatic necrosis or abscess formation requiring major pancreatic or retro-pancreatic dissection, excluding aftercare (Anaes.)(Assist.)	$861.50
30578	Endocrine tumour, exploration of pancreas or duodenum, followed by local excision of pancreatic tumour (Anaes.)(Assist.)	$907.45
30580	Endocrine tumour, exploration of pancreas or duodenum, followed by local excision of duodenal tumour (Anaes.)(Assist.)	$826.95
30581	Endocrine tumour, exploration of pancreas or duodenum for, but no tumour found (Anaes.)(Assist.)	$603.05
30583	Distal pancreatectomy (Anaes.)(Assist.)	$944.70
30584	Pancreatico-duodenectomy, Whipple's operation, with or without preservation of pylorus (Anaes.)(Assist.)	$1,394.40
30586	Pancreatic cyst anastomosis to stomach or duodenum - by open or endoscopic means (Anaes.)(Assist.)	$554.70
30587	Pancreatic cyst, anastomosis to Roux loop of jejunum (Anaes.)(Assist.)	$574.35
30589	Pancreatico-jejunostomy for pancreatitis or trauma (Anaes.)(Assist.)	$989.55
30590	Pancreatico-jejunostomy following previous pancreatic surgery (Anaes.)(Assist.)	$1,091.25
30593	Pancreatectomy, near total or total (including duodenum), with or without splenectomy (Anaes.)(Assist.)	$1,493.25
30594	Pancreatectomy for pancreatitis following previously attempted drainage procedure or partial resection (Anaes.)(Assist.)	$1,723.00
30596	Splenorrhaphy or partial splenectomy (Anaes.)(Assist.)	$709.75
30597	Splenectomy (Anaes.)(Assist.)	$569.70

Item	Service	Fee ($)
30599	Splenectomy, for massive spleen (weighing more than 1500gms) or involving thoraco-abdominal incision (Anaes.)(Assist.)	$1,033.75
30600	Diaphragmatic hernia, traumatic, repair of (Anaes.)(Assist.)	$614.75
30601	Diaphragmatic hernia, congenital, repair of, by thoracic or abdominal approach) (Anaes.)(Assist.)	$757.20
30602	Portal hypertension, porto-caval shunt for (Anaes.)(Assist.)	$1,229.00
30603	Portal hypertension, meso-caval shunt for (Anaes.)(Assist.)	$1,298.00
30605	Portal hypertension, selective spleno-renal shunt for (Anaes.)(Assist.)	$1,476.05
30606	Portal hypertension, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Anaes.)(Assist.)	$878.70
30609	Femoral or inguinal hernia, laparoscopic repair of, not being a service associated with a service to which item 30612 or 30614 applies (Anaes.)(Assist.)	$367.40
30612	Femoral or inguinal hernia or infantile hydrocele, repair of, not being a service to which item 30403 or 30615 applies (Anaes.)(Assist.)	$281.90
30614	Femoral or inguinal hernia or infantile hydrocele, repair of, not being a service to which item 30403 or 30615 applies (Anaes.)(Assist.)	$367.40
30615	Strangulated, incarcerated or obstructed hernia, repair of, without bowel resection (Anaes.)(Assist.)	$412.30
30616	Umbilical, epigastric or linea alba hernia, repair of, in a person under 10 years of age (Anaes.)	$209.85
30617	Umbilical, epigastric or linea alba hernia, repair of, in a person under 10 years of age (Anaes.)	$281.90
30620	Umbilical, epigastric or linea alba hernia, repair of, in a person 10 years of age or over (Anaes.)(Assist.)	$236.90
30621	Umbilical, epigastric or linea alba hernia, repair of, in a person 10 years of age or over (Anaes.)(Assist.)	$322.40
30628	Hydrocele, tapping of	$28.20
30631	Hydrocele, removal of, not being a service associated with a service to which items 30638, 30641 and 30644 apply (Anaes.)	$187.15
30634	Varicocele, surgical correction of, not being a service associated with a service to which items 30638, 30641 and 30644 apply, 1 procedure (Anaes.)(Assist.)	$185.95
30635	Varicocele, surgical correction of, not being a service associated with a service to which items 30638, 30641 and 30644 apply, 1 procedure (Anaes.)(Assist.)	$230.90
30638	Orchidectomy, simple or subcapsular, unilateral with or without insertion of testicular prosthesis (Anaes.)(Assist.)	$236.90

Item	Service	Fee ($)
30641	Orchidectomy, simple or subcapsular, unilateral with or without insertion of testicular prosthesis (Anaes.)(Assist.)	$322.40
30644	Exploration of spermatic cord, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis (Anaes.)(Assist.)	$412.30
30653	Circumcision of a male under 6 months of age (Anaes.)	$36.80
30656	Circumcision of a male under 10 years of age but not less than 6 months of age (Anaes.)	$85.50
30659	Circumcision of a male 10 years of age or over (Anaes.)	$118.45
30660	Circumcision of a male 10 years of age or over (Anaes.)	$146.90
30663	Haemorrhage, arrest of, following circumcision requiring general anaesthesia (Anaes.)	$114.20
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.)	$37.55
30672	Coccyx, excision of (Anaes.)(Assist.)	$352.35
30675	Pilonidal sinus or cyst, or sacral sinus or cyst, excision of (Anaes.)	$236.90
30676	Pilonidal sinus or cyst, or sacral sinus or cyst, excision of (Anaes.)	$299.85
30679	Pilonidal sinus, injection of sclerosant fluid under anaesthesia (Anaes.)	$76.15
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.)	$459.45
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.)	$574.35
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.)	$689.20
31200 Note T8.22 Note T8.64	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	$26.90

Item	Service	Fee ($)
31205 Note T8.22 Note T8.64	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.)	$75.45
31210 Note T8.22 Note T8.64	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.)	$97.35
31215 Note T8.22 Note T8.64	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.)	$113.50
31220 Note T8.22 Note T8.64	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.)	$169.70
31225 Note T8.22 Note T8.64	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.)	$301.60
31230 Note T8.22 Note T8.64	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 for histological examination (not being a service to which item 30195 applies) (Anaes.)	$132.95
31235 Note T8.22 Note T8.23 Note T8.64	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.)	$113.50

Item	Service	Fee ($)
31240 Note T8.22 Note T8.23 Note T8.64	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.)	$132.95
31245 Note T8.22 Note T8.23 Note T8.64	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.)	$291.85
31250 Note T8.22 Note T8.64	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.)	$291.85
31255 Note T8.22 Note T8.64	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.)	$175.10
31260 Note T8.22 Note T8.64	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.)	$249.70
31265 Note T8.22 Note T8.23 Note T8.64	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal from face, neck (anterior to the steromastoid 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.)	$145.90
31270 Note T8.22 Note T8.23 Note T8.64	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal from face, neck (anterior to the steromastoid 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.)	$204.30
31275 Note T8.22 Note T8.23 Note T8.64	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal from face, neck (anterior to the steromastoid 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.)	$236.75
31280 Note T8.22 Note T8.64	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.)	$123.25
31285 Note T8.22 Note T8.64	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.)	$168.55

Item	Service	Fee ($)
31290 Note T8.22 Note T8.64	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.)	$194.50
31295 Note T8.22 Note T8.64	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.)	$231.65
31300 Note T8.22 Note T8.64	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.)	$253.00
31305 Note T8.22 Note T8.64	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.)	$311.25
31310 Note T8.22 Note T8.23 Note T8.64	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.)	$220.45
31315 Note T8.22 Note T8.23 Note T8.64	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.)	$278.85
31320 Note T8.22 Note T8.23 Note T8.64	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.)	$311.25
31325 Note T8.22 Note T8.64	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.)	$214.05

Item	Service	Fee ($)
31330 Note T8.22 Note T8.64	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 31315 - 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.)	$253.00
31335 Note T8.22 Note T8.64	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.)	$291.85
31340 Note T8.22 Note T8.64	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.)	Derived Fee
31345 Note T8.22	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.)	$166.80
31350 Note T8.22	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.)(Assist.)	$342.80
31355 Note T8.22	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.)(Assist.)	$565.10
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.)(Assist.)	$206.50
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.)(Assist.)	$238.35
31406	Malignant upper aerodigestive tract tumour more than 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.)(Assist.)	$397.20
31409	Parapharyngeal tumour, excision of, by cervical approach (Anaes.)(Assist.)	$1,234.05
31412	Recurrent or persistent parapharyngeal tumour, excision of, by cervical approach (Anaes.)(Assist.)	$1,520.05
31420	Lymph node of neck, biopsy of (Anaes.)	$145.45
31423 Note T8.24	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.)(Assist.)	$317.75

Item	Service	Fee ($)
31426 Note T8.24	Lymph nodes of neck, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.)(Assist.)	$635.55
31429 Note T8.24	Lymph nodes of neck, selective dissection of 4 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes.)(Assist.)	$990.40
31432 Note T8.24	Lymph nodes of neck, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections) (Anaes.)(Assist.)	$1,059.25
31435 Note T8.24	Lymph nodes of neck, comprehensive dissection of all 5 lymph node levels on one side of the neck (Anaes.)(Assist.)	$778.55
31438 Note T8.24	Lymph nodes of neck, comprehensive dissection of all 5 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes.)(Assist.)	$1,234.05
31441	Long-term implanted reservoir associated with the adjustable gastric band, repair, revision or replacement of (Anaes.)	$199.05
31450	Laparoscopic division of adhesions, as an independent procedure, where the time taken is 1 hour or less (Anaes.)(Assist.)	$321.65
31452	Laparoscopic division of adhesions, as an independent procedure, where the time taken is more than 1 hour (Anaes.)(Assist.)	$562.85
31454	Laparoscopy with drainage of pus, bile or blood, as an independent procedure (Anaes.)(Assist.)	$445.55
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.)	$194.25
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.)	$233.10
31460	Percutaneous gastrostomy tube, jejunal extension to, including any associated imaging services (Anaes.)(Assist.)	$282.40
31462	Operative feeding jejunostomy performed in conjunction with major upper gastro-intestinal resection (Anaes.)(Assist.)	$412.30
31464 Note T8.21	Antireflux operation by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopic technique - not being a service to which item 30601 applies (Anaes.)(Assist.)	$689.20
31466 Note T8.21	Antireflux operation by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, revision procedure, by laparoscopy or open operation (Anaes.)(Assist.)	$1,033.80

Item	Service	Fee ($)
31468	Para-oesophageal hiatus hernia, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication (Anaes.)(Assist.)	$1,135.80
31470	Laparoscopic splenectomy (Anaes.)(Assist.)	$569.70
31472	Cholecystoduodenostomy, cholecystoenterostomy, choledochojejunostomy or Roux-en-y as a bypass procedure where prior biliary surgery has been performed (Anaes.)(Assist.)	$925.35
	Subgroup 2 - Colorectal	
32000	Large intestine, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.)(Assist.)	$815.80
32003	Large intestine, resection of, with anastomosis, including right hemicolectomy (Anaes.)(Assist.)	$853.40
32004	Large intestine, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32005 or 32006 applies (Anaes.)(Assist.)	$909.95
32005	Large intestine, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004 or 32006 applies (Anaes.)(Assist.)	$1,027.95
32006	Left hemicolectomy, including the descending and sigmoid colon (including formation of stoma) (Anaes.)(Assist.)	$909.95
32009	Total colectomy and ileostomy (Anaes.)(Assist.)	$1,079.40
32012	Total colectomy and ileorectal anastomosis (Anaes.)(Assist.)	$1,192.35
32015	Total colectomy with excision of rectum and ileostomy 1 surgeon (Anaes.)(Assist.)	$1,465.30
32018	Total colectomy with excision of rectum and ileostomy, combined synchronous operation; abdominal resection (including aftercare) (Anaes.)(Assist.)	$1,242.50
32021	Total colectomy with excision of rectum and ileostomy, combined synchronous operation; perineal resection(Assist.)	$445.55
32024	Rectum, high restorative anterior resection with intraperitoneal anastomosis (of the rectum) greater than 10cm from the anal verge excluding resection of sigmoid colon alone (Anaes.)(Assist.)	$1,079.40
32025	Rectum, low restorative anterior resection with extraperitoneal anastomosis (of the rectum) less than 10 cm from the anal verge, with or without covering stoma (Anaes.)(Assist.)	$1,443.80
32026	Rectum, ultra low restorative resection, with or without covering stoma, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge (Anaes.)(Assist.)	$1,554.85
32028	Rectum, low or ultra low restorative resection, with peranal sutured coloanal anastomosis, with or without covering stoma (Anaes.)(Assist.)	$1,665.95

Item	Service	Fee ($)
32029	Colonic reservoir, construction of, being a service associated with a service to which any other item in this Subgroup applies (Anaes.)(Assist.)	$333.15
32030	Rectosigmoidectomy (Hartmann's operation) (Anaes.)(Assist.)	$815.80
32033	Restoration of bowel following Hartmann's or similar operation, including dismantling of the stoma (Anaes.)(Assist.)	$1,192.35
32036	Sacrococcygeal and presacral tumour excision of (Anaes.)(Assist.)	$1,512.30
32039	Rectum and anus, abdominoperineal resection of - 1 surgeon (Anaes.)(Assist.)	$1,214.25
32042	Rectum and anus, abdominoperineal resection of, combined synchronous operation, abdominal resection (Anaes.)(Assist.)	$1,022.90
32045	Rectum and anus, abdominoperineal resection of, combined synchronous operation - perineal resection(Assist.)	$382.85
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.)	$591.55
32047	Perineal proctectomy (Anaes.)(Assist.)	$689.20
32051	Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy 1 surgeon (Anaes.)(Assist.)	$1,832.45
32054	Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.)(Assist.)	$1,681.80
32057	Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon(Assist.)	$445.55
32060	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy 1 surgeon (Anaes.)(Assist.)	$1,832.45
32063	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.)(Assist.)	$1,681.80
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.)	$445.55
32069	Ileostomy reservoir, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.)	$1,355.50
32072	Sigmoidoscopic examination (with rigid sigmoidoscope), with or without biopsy	$37.90

Item	Service	Fee ($)
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.)	$59.40
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.)	$133.30
32081	Sigmoidoscopic examination with diathermy or resection of 1 or more polyps where the time taken is greater than 45 minutes (Anaes.)	$183.05
32084 Note T8.19	Flexible fibreoptic sigmoidoscopy or fibreoptic colonoscopy up to the hepatic flexure, with or without biopsy (Anaes.)	$88.10
32087 Note T8.19	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.)	$161.95
32090 Note T8.19	Fibreoptic colonoscopy examination of colon beyond the hepatic flexure with or without biopsy (Anaes.)	$264.40
32093 Note T8.19	Fibreoptic colonoscopy examination of colon beyond the hepatic flexure with removal of 1 or more polyps (Anaes.)	$371.10
32094 Note T8.19	Endoscopic dilatation of colorectal strictures including colonoscopy (Anaes.)	$436.45
32095 Note T8.19	Endoscopic examination of small bowel with flexible endoscope passed by stoma, with or without biopsies (Anaes.)	$101.10
32096	Rectal biopsy, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital or approved dayhospital facility (Anaes.)(Assist.)	$203.25
32099	Rectal tumour of 5cm or less in diameter, per anal submucosal excision of (Anaes.)(Assist.)	$263.60
32102	Rectal tumour of greater than 5cm in diameter, indicated by pathological examination, per anal submucosal excision of (Anaes.)(Assist.)	$502.00
32105	Anorectal carcinoma per anal full thickness excision of (Anaes.)(Assist.)	$382.85
32108	Rectal tumour, transsphincteric excision of (Kraske or similar operation) (Anaes.)(Assist.)	$790.75
32111	Rectal prolapse, Delorme procedure for (Anaes.)(Assist.)	$502.00
32112	Rectal prolapse, perineal recto-sigmoidectomy for (Anaes.)(Assist.)	$610.90
32114	Rectal stricture, per anal release of (Anaes.)	$138.05
32115	Rectal stricture, dilatation of (Anaes.)	$100.40
32117	Rectal prolapse, abdominal rectopexy of (Anaes.)(Assist.)	$790.75
32120	Rectal prolapse, perineal repair of (Anaes.)(Assist.)	$203.25

Item	Service	Fee ($)
32123	Anal stricture, anoplasty for (Anaes.)(Assist.)	$263.60
32126	Anal incontinence, Parks' intersphincteric procedure for (Anaes.)(Assist.)	$382.85
32129	Anal sphincter, direct repair of (Anaes.)(Assist.)	$502.00
32131	Rectocele, transanal repair of rectocele (Anaes.)(Assist.)	$422.10
32132	Haemorrhoids or rectal prolapse sclerotherapy for (Anaes.)	$35.70
32135	Haemorrhoids or rectal prolapse rubber band ligation of, with or without sclerotherapy, cryosurgery or infrared therapy for (Anaes.)	$53.35
32138	Haemorrhoidectomy including excision of anal skin tags when performed (Anaes.)	$290.90
32139	Haemorrhoidectomy involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed (Anaes.)(Assist.)	$290.90
32142	Anal skin tags or anal polyps, excision of 1 or more of (Anaes.)	$53.35
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.)	$106.85
32147	Perianal thrombosis, incision of (Anaes.)	$35.70
32150	Operation for fissureinano, including excision or sphincterotomy but excluding dilatation only (Anaes.)(Assist.)	$203.25
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.)	$55.50
32156	Fistula-in-ano, subcutaneous, excision of (Anaes.)	$104.20
32159	Anal fistula, excision of, involving lower half of the anal sphincter mechanism (Anaes.)(Assist.)	$263.60
32162	Anal fistula, excision of, involving the upper half of the anal sphincter mechanism (Anaes.)(Assist.)	$382.85
32165	Anal fistula, repair of by mucosal flap advancement (Anaes.)(Assist.)	$502.00
32166	Anal fistula - readjustment of Seton (Anaes.)	$163.05
32168	Fistula wound, review of, under general or regional anaesthetic, as an independent procedure (Anaes.)	$104.20
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.)	$70.25
32174	Intra-anal, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.)	$70.25

Item	Service	Fee ($)
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.)	$128.65
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.)	$137.85
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.)	$203.25
32183	Intestinal sling procedure prior to radiotherapy (Anaes.)(Assist.)	$444.30
32186	Colonic lavage, total, intraoperative (Anaes.)(Assist.)	$444.30
32200	Distal muscle, devascularisation of (Anaes.)(Assist.)	$233.90
32203	Anal or perineal graciloplasty (Anaes.)(Assist.)	$502.25
32206	Stimulator and electrodes, insertion of, following previous graciloplasty (Anaes.)(Assist.)	$453.75
32209	Anal or perineal graciloplasty with insertion of stimulator and electrodes (Anaes.)(Assist.)	$729.20
32210	Gracilis neosphincter pacemaker, replacement of (Anaes.)	$202.05
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.)	$107.75
	THERAPEUTIC PROCEDURES	
	GROUP T8 - SURGICAL OPERATIONS	
	Subgroup 3 - Vascular	
32500 Note T8.7 Note T8.25	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 aftercare) - to a maximum of 6 treatments in a 12 month period (Anaes.)	$86.85
32501 Note T8.25	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	$86.85

Item	Service	Fee ($)
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.)	$211.70
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.)(Assist.)	$422.10
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.)(Assist.)	$422.10
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.)(Assist.)	$627.50
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.)(Assist.)	$733.05
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.)(Assist.)	$943.95
32700	Artery of neck, bypass using vein or synthetic material (Anaes.)(Assist.)	$1,136.15
32703	Internal carotid artery, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Anaes.)(Assist.)	$939.85
32708	Aortic bypass for occlusive disease using a straight non-bifurcated graft (Anaes.)(Assist.)	$1,124.30
32710	Aortic bypass for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Anaes.)(Assist.)	$1,249.25
32711	Aortic bypass for occlusive disease using a bifurcated graft with 1 or both anastomoses to the common femoral or profunda femoris arteries (Anaes.)(Assist.)	$1,374.20
32712	Ilio-femoral bypass grafting (Anaes.)(Assist.)	$993.40
32715	Axillary or subclavian to femoral bypass grafting to 1 or both femoral arteries (Anaes.)(Assist.)	$993.40
32718	Femoro-femoral or ilio-femoral cross-over bypass grafting (Anaes.)(Assist.)	$939.85
32721	Renal artery, bypass grafting to (Anaes.)(Assist.)	$1,492.90
32724	Renal arteries (both), bypass grafting to (Anaes.)(Assist.)	$1,695.20
32730	Mesenteric vessel (single), bypass grafting to (Anaes.)(Assist.)	$1,284.85

Item	Service	Fee ($)
32733	Mesenteric vessels (multiple), bypass grafting to (Anaes.)(Assist.)	$1,492.90
32736	Inferior mesenteric artery, operation on, when performed in conjunction with another intra-abdominal vascular operation (Anaes.)(Assist.)	$327.10
32739	Femoral artery bypass grafting using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (Anaes.)(Assist.)	$1,023.10
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.)(Assist.)	$1,171.85
32745	Femoral artery bypass grafting using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal artery (Anaes.)(Assist.)	$1,338.30
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.)(Assist.)	$1,451.35
32751	Femoral artery bypass grafting using synthetic graft, with lower anastomosis above or below the knee (Anaes.)(Assist.)	$939.85
32754	Femoral artery bypass grafting, using a composite graft (synthetic material and vein) with lower anastomosis above or below the knee, including use of a cuff or sleeve of vein at 1 or both anastomoses (Anaes.)(Assist.)	$1,171.85
32757	Femoral artery sequential bypass grafting (using a vein or synthetic material) where an additional anastomosis is made to separately revascularise more than 1 artery - each additional artery revascularised beyond a femoral bypass (Anaes.)(Assist.)	$327.10
32760	Vein, harvesting of, from leg or arm for bypass or replacement graft when not performed on the limb which is the subject of the bypass or graft - each vein (Anaes.)(Assist.)	$321.10
32763	Arterial bypass grafting, using vein or synthetic material, not being a service to which another item in this Sub-group applies (Anaes.)(Assist.)	$939.85
32766	Arterial or venous anastomosis, not being a service to which another item in this Sub-group applies, as an independent procedure (Anaes.)(Assist.)	$624.60
32769	Arterial or venous anastomosis not being a service to which another item in this Sub-group applies, when performed in combination with another vascular operation (including graft to graft anastomosis) (Anaes.)(Assist.)	$216.50
33050	Bypass grafting to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Anaes.)(Assist.)	$1,151.10
33055	Bypass grafting to replace a popliteal aneurysm using a synthetic graft (Anaes.)(Assist.)	$923.15

Item	Service	Fee ($)
33070	Aneurysm in the extremities, ligation, suture closure or excision of, without bypass grafting (Anaes.)(Assist.)	$666.05
33075	Aneurysm in the neck, ligation, suture closure or excision of, without bypass grafting (Anaes.)(Assist.)	$847.25
33080	Intra-abdominal or pelvic aneurysm, ligation, suture closure or excision of, without bypass grafting (Anaes.)(Assist.)	$1,034.20
33100	Aneurysm of common or internal carotid artery, or both, replacement by graft of vein or synthetic material (Anaes.)(Assist.)	$1,136.15
33103	Thoracic aneurysm, replacement by graft (Anaes.)(Assist.)	$1,594.05
33109	Thoraco-abdominal aneurysm, replacement by graft including re-implantation of arteries (Anaes.)(Assist.)	$1,927.25
33112	Suprarenal abdominal aortic aneurysm, replacement by graft including re-implantation of arteries (Anaes.)(Assist.)	$1,671.40
33115	Infrarenal abdominal aortic aneurysm, replacement by tube graft not being a service associated with a service to which item 33116 applies (Anaes.)(Assist.)	$1,124.30
33116 Note T8.26	Infrarenal abdominal aortic aneurysm, replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Ministerial Determination) (Anaes.)(Assist.)	$1,106.60
33118 Note T8.26	Infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to iliac arteries (with or without excision of common iliac aneurysms) not being a service associated with a service to which item 33119 applies (Anaes.)(Assist.)	$1,249.25
33119 Note T8.26	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.)(Assist.)	$1,229.60
33121	Infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to 1 or both femoral arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.)(Assist.)	$1,374.20
33124	Aneurysm of iliac artery (common, external or internal), replacement by graft - unilateral (Anaes.)(Assist.)	$957.65
33127	Aneurysms of iliac arteries (common, external or internal), replacement by graft - bilateral (Anaes.)(Assist.)	$1,255.05
33130	Aneurysm of visceral artery, excision and repair by direct anastomosis or replacement by graft (Anaes.)(Assist.)	$1,094.45
33133	Aneurysm of visceral artery, dissection and ligation of arteries without restoration of continuity (Anaes.)(Assist.)	$820.85
33136	False aneurysm, repair of, at aortic anastomosis following previous aortic surgery (Anaes.)(Assist.)	$2,069.90

Item	Service	Fee ($)
33139	False aneurysm, repair of, in iliac artery and restoration of arterial continuity (Anaes.)(Assist.)	$1,255.05
33142	False aneurysm, repair of, in femoral artery and restoration of arterial continuity (Anaes.)(Assist.)	$1,171.85
33145	Ruptured thoracic aortic aneurysm, replacement by graft (Anaes.)(Assist.)	$2,016.45
33148	Ruptured thoraco-abdominal aortic aneurysm, replacement by graft (Anaes.)(Assist.)	$2,504.20
33151	Ruptured suprarenal abdominal aortic aneurysm, replacement by graft (Anaes.)(Assist.)	$2,379.25
33154	Ruptured infrarenal abdominal aortic aneurysm, replacement by tube graft (Anaes.)(Assist.)	$1,760.75
33157	Ruptured infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.)(Assist.)	$1,962.90
33160	Ruptured infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to 1 or both femoral arteries (Anaes.)(Assist.)	$1,962.90
33163	Ruptured iliac artery aneurysm, replacement by graft (Anaes.)(Assist.)	$1,665.60
33166	Ruptured aneurysm of visceral artery, replacement by anastomosis or graft (Anaes.)(Assist.)	$1,665.60
33169	Ruptured aneurysm of visceral artery, simple ligation of (Anaes.)(Assist.)	$1,296.75
33172	Aneurysm of major artery, replacement by graft, not being a service to which another item in this Sub-group applies (Anaes.)(Assist.)	$1,011.15
33175	Ruptured aneurysm in the extremities, ligation, suture closure or excision of, without bypass grafting (Anaes.)(Assist.)	$931.90
33178	Ruptured aneurysm in the neck, ligation, suture closure or excision of, without bypass grafting (Anaes.)(Assist.)	$1,185.05
33181	Ruptured intra-abdominal or pelvic aneurysm, ligation, suture closure or excision of, without bypass grafting (Anaes.)(Assist.)	$1,448.90
33500 Note T8.27	Artery or arteries of neck, endarterectomy of, including closure by suture (where endarterectomy of 1 or more arteries is undertaken through 1 arteriotomy incision) (Anaes.)(Assist.)	$898.15
33506 Note T8.27	Innominate or subclavian artery, endarterectomy of, including closure by suture (Anaes.)(Assist.)	$1,005.30
33509 Note T8.27	Aortic endarterectomy, including closure by suture, not being a service associated with another procedure on the aorta (Anaes.)(Assist.)	$1,124.30

Item	Service	Fee ($)
33512 Note T8.27	Aorto-iliac endarterectomy (1 or both iliac arteries), including closure by suture not being a service associated with a service to which item 33515 applies (Anaes.)(Assist.)	$1,249.25
33515 Note T8.27	Aorto-femoral endarterectomy (1 or both femoral arteries) or bilateral ilio-femoral endarterectomy, including closure by suture, not being a service associated with a service to which item 33512 applies (Anaes.)(Assist.)	$1,374.20
33518 Note T8.27	Iliac endarterectomy, including closure by suture, not being a service associated with another procedure on the iliac artery (Anaes.)(Assist.)	$1,005.30
33521 Note T8.27	Ilio-femoral endarterectomy (1 side), including closure by suture (Anaes.)(Assist.)	$1,088.50
33524 Note T8.27	Renal artery, endarterectomy of (Anaes.)(Assist.)	$1,284.85
33527 Note T8.27	Renal arteries (both), endarterectomy of (Anaes.)(Assist.)	$1,492.90
33530 Note T8.27	Coeliac or superior mesenteric artery, endarterectomy of (Anaes.)(Assist.)	$1,284.85
33533 Note T8.27	Coeliac and superior mesenteric artery, endarterectomy of (Anaes.)(Assist.)	$1,492.90
33536 Note T8.27	Inferior mesenteric artery, endarterectomy of, not being a service associated with a service to which another item in this Sub-group applies (Anaes.)(Assist.)	$1,064.80
33539 Note T8.27	Artery of extremities, endarterectomy of, including closure by suture (Anaes.)(Assist.)	$767.30
33542 Note T8.27	Extended deep femoral endarterectomy where the endarterectomy is at least 7cms long (Anaes.)(Assist.)	$1,094.45
33545 Note T8.27	Artery, vein or bypass graft, patch grafting to by vein or synthetic material where patch is less than 3cm long (Anaes.)(Assist.)	$216.50
33548 Note T8.27	Artery, vein or bypass graft, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Anaes.)(Assist.)	$440.30
33551 Note T8.27	Vein, harvesting of from leg or arm for patch when not performed through same incision as operation (Anaes.)(Assist.)	$216.50
33554	Endarterectomy, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (Anaes.)(Assist.)	$215.45
33800	Embolus, removal of, from artery of neck (Anaes.)(Assist.)	$933.85
33803 Note T8.27	Embolectomy or thrombectomy, by abdominal approach, of an artery or bypass graft of trunk (Anaes.)(Assist.)	$892.25
33806 Note T8.27	Embolectomy or thrombectomy, from an artery or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery (Anaes.)(Assist.)	$642.45
33810	Inferior vena cava or iliac vein, closed thrombectomy by catheter via the femoral vein (Anaes.)(Assist.)	$468.65

Item	Service	Fee ($)
33811	Inferior vena cava or iliac vein, open removal of thrombus or tumour (Anaes.)(Assist.)	$1,395.05
33812	Thrombus, removal of, from femoral or other similar large vein (Anaes.)(Assist.)	$737.60
33815 Note T8.27	Major artery or vein of extremity, repair of wound of, with restoration of continuity, by lateral suture (Anaes.)(Assist.)	$678.10
33818	Major artery or vein of extremity, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.)(Assist.)	$791.15
33821	Major artery or vein of extremity, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.)(Assist.)	$904.15
33824	Major artery or vein of neck, repair of wound of, with restoration of continuity, by lateral suture (Anaes.)(Assist.)	$862.45
33827	Major artery or vein of neck, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.)(Assist.)	$1,011.15
33830	Major artery or vein of neck, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.)(Assist.)	$1,159.85
33833 Note T8.27	Major artery or vein of abdomen, repair of wound of, with restoration of continuity by lateral suture (Anaes.)(Assist.)	$1,052.90
33836	Major artery or vein of abdomen, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.)(Assist.)	$1,255.05
33839	Major artery or vein of abdomen, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.)(Assist.)	$1,469.20
33842	Artery of neck, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes.)(Assist.)	$725.70
33845	Laparotomy for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes.)(Assist.)	$505.60
33848	Extremity, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Anaes.)(Assist.)	$505.60
34100	Major artery of neck, elective ligation or exploration of, not being a service associated with any other vascular procedure (Anaes.)(Assist.)	$559.15
34103	Great artery or great vein (including subclavian, axillary, iliac, femoral or popliteal), ligation of, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes.)(Assist.)	$327.10
34106	Artery or vein (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes.)(Assist.)	$230.80

Item	Service	Fee ($)
34109	Temporal artery, biopsy of (Anaes.)(Assist.)	$267.60
34112	Arterio-venous fistula of an extremity, dissection and ligation (Anaes.)(Assist.)	$678.10
34115	Arterio-venous fistula of the neck, dissection and ligation (Anaes.)(Assist.)	$767.30
34118	Arterio-venous fistula of the abdomen, dissection and ligation (Anaes.)(Assist.)	$1,094.45
34121	Arterio-venous fistula of an extremity, dissection and repair of, with restoration of continuity (Anaes.)(Assist.)	$874.35
34124	Arterio-venous fistula of the neck, dissection and repair of, with restoration of continuity (Anaes.)(Assist.)	$957.65
34127	Arterio-venous fistula of the abdomen, dissection and repair of, with restoration of continuity (Anaes.)(Assist.)	$1,255.05
34130	Surgically created arterio-venous fistula of an extremity, closure of (Anaes.)(Assist.)	$392.65
34133	Scalenotomy (Anaes.)(Assist.)	$440.30
34136	First rib, resection of portion of (Anaes.)(Assist.)	$707.75
34139	Cervical rib, removal of, or other operation for removal of thoracic outlet compression, not being a service to which another item in this Sub-group applies (Anaes.)(Assist.)	$707.75
34142 Note T8.27	Coeliac artery, decompression of, for coeliac artery compression syndrome, as an independent procedure (Anaes.)(Assist.)	$874.35
34145	Popliteal artery, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Anaes.)(Assist.)	$636.50
34148	Carotid associated tumour, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is 4cm or less in maximum diameter (Anaes.)(Assist.)	$1,136.15
34151	Carotid associated tumour, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is greater than 4cm in maximum diameter (Anaes.)(Assist.)	$1,552.50
34154	Recurrent carotid associated tumour, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes.)(Assist.)	$1,849.95
34157	Neck, excision of infected bypass graft, including closure of vessel or vessels (Anaes.)(Assist.)	$939.85
34160	Aorto-duodenal fistula, repair of, by suture of aorta and repair of duodenum (Anaes.)(Assist.)	$1,760.75
34163	Aorto-duodenal fistula, repair of, by insertion of aortic graft and repair of duodenum (Anaes.)(Assist.)	$2,260.35

Item	Service	Fee ($)
34166	Aorto-duodenal fistula, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo bifemoral grafting (Anaes.)(Assist.)	$2,260.35
34169	Infected bypass graft from trunk, excision of, including closure of arteries (Anaes.)(Assist.)	$1,255.05
34172	Infected axillo-femoral or femoro-femoral graft, excision of, including closure of arteries (Anaes.)(Assist.)	$1,023.10
34175	Infected bypass graft from extremities, excision of including closure of arteries (Anaes.)(Assist.)	$939.85
34500	Arteriovenous shunt, external, insertion of (Anaes.)(Assist.)	$243.90
34503	Arteriovenous anastomosis of upper or lower limb, in conjunction with another venous or arterial operation (Anaes.)(Assist.)	$327.10
34506	Arteriovenous shunt, external, removal of (Anaes.)(Assist.)	$166.55
34509	Arteriovenous anastomosis of upper or lower limb, not in conjunction with another venous or arterial operation (Anaes.)(Assist.)	$773.25
34512	Arteriovenous access device, insertion of (Anaes.)(Assist.)	$850.65
34515	Arteriovenous access device, thrombectomy of (Anaes.)(Assist.)	$606.70
34518 Note T8.27	Stenosis of arteriovenous fistula or prosthetic arteriovenous access device, correction of (Anaes.)(Assist.)	$1,017.10
34521 Note T8.7	Intra-abdominal artery or vein, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Anaes.)(Assist.)	$624.85
34524 Note T8.7	Arterial cannulation for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Anaes.)(Assist.)	$327.10
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.)	$436.30
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.)	$215.45
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.)	$161.60
34533	Isolated limb perfusion, including cannulation of artery and vein at commencement of procedure, regional perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy at conclusion of procedure (excluding aftercare) (Anaes.)(Assist.)	$981.40
34800	Inferior vena cava, plication, ligation, or application of caval clip (Anaes.)(Assist.)	$642.45

Item	Service	Fee ($)
34803	Inferior vena cava, reconstruction of or bypass by vein or synthetic material (Anaes.)(Assist.)	$1,415.70
34806	Cross leg bypass grafting, saphenous to iliac or femoral vein (Anaes.)(Assist.)	$767.30
34809	Saphenous vein anastomosis to femoral or popliteal vein for femoral vein bypass (Anaes.)(Assist.)	$767.30
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.)(Assist.)	$927.95
34815 Note T8.27	Vein stenosis, patch angioplasty for, (excluding vein graft stenosis) - using vein or synthetic material (Anaes.)(Assist.)	$767.30
34818	Venous valve, plication or repair to restore valve competency (Anaes.)(Assist.)	$844.65
34821	Vein transplant to restore valvular function (Anaes.)(Assist.)	$1,148.05
34824	External stent, application of, to restore venous valve competency to superficial vein - 1 stent (Anaes.)(Assist.)	$392.65
34827	External stents, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (Anaes.)(Assist.)	$475.85
34830	External stent, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.)(Assist.)	$559.15
34833	External stents, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Anaes.)(Assist.)	$725.70
35000	Lumbar sympathectomy (Anaes.)(Assist.)	$559.15
35003	Cervical or upper thoracic sympathectomy by any surgical approach (Anaes.)(Assist.)	$725.70
35006	Cervical or upper thoracic sympathectomy, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes.)(Assist.)	$910.10
35009	Lumbar sympathectomy, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Anaes.)(Assist.)	$707.75
35012	Sacral or pre-sacral sympathectomy (Anaes.)(Assist.)	$559.15
35100	Ischaemic limb, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, when debridement includes muscle, tendon or bone (Anaes.)(Assist.)	$291.55
35103	Ischaemic limb, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.)	$185.55
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.)	$135.65

Item	Service	Fee ($)
35202	Major arteries or veins in the neck, abdomen or extremities, access to, as part of re-operation after prior surgery on these vessels (Anaes.)(Assist.)	$646.40
35300	Transluminal balloon angioplasty of 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.)(Assist.)	$407.70
35303	Transluminal balloon angioplasty of aortic arch branches, aortic visceral branches, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.)(Assist.)	$522.70
35304	Transluminal balloon angioplasty of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.)(Assist.)	$407.70
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.)(Assist.)	$522.70
35306	Transluminal stent insertion including associated balloon dilatation for 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.)(Assist.)	$482.45
35309	Transluminal stent insertion including associated balloon dilatation for visceral arteries or veins, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.)(Assist.)	$603.05
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.)(Assist.)	$603.05
35312	Peripheral arterial atherectomy including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.)(Assist.)	$683.45
35315	Peripheral laser angioplasty including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.)(Assist.)	$683.45
35317 Note T8.28	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.)(Assist.)	$281.45
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.)(Assist.)	$504.50

Item	Service	Fee ($)
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.)(Assist.)	$677.70
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.)(Assist.)	$643.25
35324	Angioscopy not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.)(Assist.)	$241.15
35327	Angioscopy combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.)(Assist.)	$323.20
35330	Insertion of inferior vena caval filter, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.)(Assist.)	$407.70
	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.)	$64.25
35503	Intrauterine contraceptive device, introduction of, not being a service associated with a service to which another item in this Group applies (Anaes.)	$42.35
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.)	$42.45
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.)	$138.05
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.)(Assist.)	$203.25
35509	Hymenectomy (Anaes.)	$70.85
35512	Bartholin's cyst, excision of (Anaes.)	$141.85
35513	Bartholin's cyst, excision of (Anaes.)	$175.40
35516	Bartholin's cyst or gland, marsupialisation of (Anaes.)	$92.05
35517	Bartholin's cyst or gland, marsupialisation of (Anaes.)	$115.45

Item	Service	Fee ($)
35518 Note T4.7	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.)	$164.35
35520	Bartholin's abscess, incision of (Anaes.)	$46.10
35523	Urethra or urethral caruncle, cauterisation of (Anaes.)	$46.10
35526	Urethral caruncle, excision of (Anaes.)	$92.05
35527	Urethral caruncle, excision of (Anaes.)	$115.45
35530	Clitoris, amputation of, where medically indicated (Anaes.)(Assist.)	$213.40
35533	Vulvoplasty or labioplasty, where medically indicated, not being a service associated with a service to which item 35536 applies (Anaes.)	$276.75
35536	Vulva, wide local excision of suspected malignancy or hemivulvectomy, 1 or both procedures (Anaes.)(Assist.)	$275.60
35539	Colposcopically directed CO? 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.)	$215.90
35542	Colposcopically directed CO? laser therapy for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 2 or more anatomical sites (Anaes.)(Assist.)	$252.80
35545	Colposcopically directed CO? laser therapy for condylomata, unsuccessfully treated by other methods (Anaes.)	$145.30
35548	Vulvectomy, radical, for malignancy (Anaes.)(Assist.)	$659.80
35551	Pelvic lymph glands, excision of (radical) (Anaes.)(Assist.)	$540.95
35554	Vagina, dilatation of, as an independent procedure including any associated consultation (Anaes.)	$34.40
35557	Vagina, removal of simple tumour (including Gartner duct cyst) (Anaes.)	$169.65
35560	Vagina, partial or complete removal of (Anaes.)(Assist.)	$540.95
35561	Vaginectomy, radical, for proven invasive malignancy - 1 surgeon (Anaes.)(Assist.)	$1,091.25
35562	Vaginectomy, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (Anaes.)(Assist.)	$895.95
35564	Vaginectomy, radical, for proven invasive malignancy, conjoint surgery - perineal surgeon(Assist.)	$413.60
35565	Vaginal reconstruction for congenital absence, gynatresia or urogenital sinus (Anaes.)(Assist.)	$540.95

Item	Service	Fee ($)
35566	Vaginal septum, excision of, for correction of double vagina (Anaes.)(Assist.)	$314.25
35567	Vaginal repair including 1 or more of anterior, posterior or enterocele repair, with sacrospinous colpopexy (Anaes.)(Assist.)	$555.30
35569	Plastic repair to enlarge vaginal orifice (Anaes.)	$127.20
35572	Colpotomy, not being a service to which another item in this Group applies (Anaes.)	$97.95
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.)(Assist.)	$336.20
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.)(Assist.)	$424.00
35584	Manchester (DonaldFothergill) operation or le fort operation for genital prolapse (Anaes.)(Assist.)	$533.55
35587	Urethrocele, operation for (Anaes.)	$138.90
35590	Operation involving abdominal approach for repair of enterocele or suspension of vaginal vault or enterocele and suspension of vaginal vault (Anaes.)(Assist.)	$424.00
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 had been performed surgery reflected by a procedure to which item 35576, 35580, 35584, 35590, 35657, 35673, 35750 or 35753 applies (Anaes.)(Assist.)	$424.00
35596	Fistula between genital and urinary or alimentary tracts, repair of, not being a service to which item 37029, 37333 or 37336 applies (Anaes.)(Assist.)	$540.95
35599	Stress incontinence, sling operation for (Anaes.)(Assist.)	$533.55
35600	Stress incontinence, vaginal procedure for (Anaes.)(Assist.)	$414.20
35602	Stress incontinence, combined synchronous abdominovaginal operation for; abdominal procedure (including aftercare) (Anaes.)(Assist.)	$533.55
35605	Stress incontinence, combined synchronous abdominovaginal operation for; vaginal procedure (including aftercare)(Assist.)	$289.45
35608	Cervix, cauterisation (other than by chemical means), ionisation, diathermy or biopsy of, with or without dilatation of cervix (Anaes.)	$50.60
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.)	$50.60
35612	Cervix, residual stump, removal of, by abdominal approach (Anaes.)(Assist.)	$400.20
35613	Cervix, residual stump, removal of, by vaginal approach (Anaes.)(Assist.)	$320.25

Item	Service	Fee ($)
35614 Note T8.29	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.)	$50.50
35615	Vulva, biopsy of, when performed in conjunction with a service to which item 35614 applies	$42.45
35616	Endometrium, endoscopic examination of and ablation of, by microwave, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage (Anaes.)	$355.60
35617	Cervix, cone biopsy, amputation or repair of, not being a service to which item 35584 applies (Anaes.)	$137.35
35618	Cervix, cone biopsy, amputation or repair of, not being a service to which item 35583 or 35584 applies (Anaes.)	$172.45
35620 Note T8.31	Endometrial biopsy where malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (Anaes.)	$42.15
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.)	$476.60
35623	Hysteroscopic resection of myoma, or myoma and uterine septum resection (where both are performed), followed by endometrial ablation by laser or diathermy (Anaes.)	$648.00
35626 Note T8.30	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	$65.50
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.)	$84.80
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.)	$144.80
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.)	$172.45
35634	Hysteroscopic resection of uterine septum followed by endometrial ablation by laser or diathermy (Anaes.)	$542.40
35635	Hysteroscopy involving resection of the uterine septum (Anaes.)	$236.90
35636	Hysteroscopy, involving resection of myoma, or resection of myoma and uterine septum (where both are performed) (Anaes.)	$342.55

Item	Service	Fee ($)
35637 Note T1.3	Laparoscopy, involving puncture of cysts, diathermy of endometriosis, ventrosuspension, division of adhesions or similar procedure - 1 or more procedures with or without biopsy - not being a service associated with any other laparoscopic procedure or hysterectomy (Anaes.)(Assist.)	$321.65
35638	Complicated operative laparoscopy, including use of laser when required, for 1 or more of the following procedures; oophorectomy, ovarian cystectomy, myomectomy, salpingectomy or salpingostomy, ablation of moderate or severe endometriosis requiring more than 1 hours operating time, or division of utero-sacral ligaments for significant dysmenorrhoea - not being a service associated with any other intraperitoneal or retroperitoneal procedure except item 30393 (Anaes.)(Assist.)	$562.85
35639 Note T8.31	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 dayhospital facility, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes.)	$106.75
35640 Note T8.31	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 dayhospital facility, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes.)	$144.80
35641	Endometriosis level 4 or 5, laparoscopic resection of, involving any two of the following procedures, resection of the pelvic side wall including dissection of endometriosis or scar tissue from the ureter, resection of the Pouch of Douglas, resection of an ovarian endometrioma greater than 2 cms in diameter, dissection of bowel from uterus from the level of the endocervical junction or above: where the operating time exceeds 90 minutes (Anaes.)(Assist.)	$982.95
35643	Evacuation of the contents of the gravid uterus by curettage or suction curettage not being a service to which item 35639 or 35640 applies, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes.)	$172.45
35644 Note T8.32	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.)	$161.05
35645 Note T8.32	Cervix, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in association 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 35649 applies (Anaes.)	$252.15
35646 Note T8.32	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.)	$161.05

Item	Service	Fee ($)
35647 Note T8.32	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.)	$161.05
35648 Note T8.32	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.)	$252.15
35649	Hysterotomy or uterine myomectomy, abdominal (Anaes.)(Assist.)	$424.00
35653	Hysterectomy, abdominal, sub total or total, with or without removal of uterine adnexae (Anaes.)(Assist.)	$533.65
35657 Note T8.33	Hysterectomy, vaginal, with or without uterine curettage, not being a service to which item 35673 applies (Anaes.)(Assist.)	$533.65
35658 Note T8.34	Uterus (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal removal at hysterectomy (Anaes.)(Assist.)	$329.05
35661	Hysterectomy, abdominal, requiring extensive retroperitoneal dissection with or without exposure of 1 or both ureters, for the management of severe endometriosis, pelvic inflammatory disease or benign pelvic tumours, with or without conservation of ovaries (Anaes.)(Assist.)	$689.20
35664	Radical hysterectomy with radical excision of pelvic lymph glands (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.)(Assist.)	$1,148.65
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.)(Assist.)	$976.25
35670	Hysterectomy, abdominal, with radical excision of pelvic lymph glands, with or without removal of uterine adnexae (Anaes.)(Assist.)	$803.90
35673	Hysterectomy, vaginal, (with or without uterine curettage) with salpingectomy, oophorectomy or excision of ovarian cyst, 1 or more, 1 or both sides (Anaes.)(Assist.)	$599.40
35674 Note T4.7	Ultrasound guided needling and injection of ectopic pregnancy	$164.35
35676	Ectopic pregnancy, removal of (Anaes.)(Assist.)	$336.20
35677	Ectopic pregnancy, removal of (Anaes.)(Assist.)	$424.00
35678	Ectopic pregnancy, laparoscopic removal of (Anaes.)(Assist.)	$511.15
35680	Bicornuate uterus, plastic reconstruction for (Anaes.)(Assist.)	$460.40

Item	Service	Fee ($)
35683	Uterus, suspension or fixation of, as an independent procedure (Anaes.)(Assist.)	$277.85
35684	Uterus, suspension or fixation of, as an independent procedure (Anaes.)(Assist.)	$372.75
35687 Note T8.33	Sterilisation by transection or resection of fallopian tubes, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method (Anaes.)(Assist.)	$257.25
35688 Note T8.33	Sterilisation by transection or resection of fallopian tubes, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method (Anaes.)(Assist.)	$314.25
35691	Sterilisation by interruption of fallopian tubes when performed in conjunction with Caesarean section (Anaes.)	$125.55
35694	Tuboplasty (salpingostomy, salpingolysis or tubal implantation into uterus), unilateral or bilateral, 1 or more procedures (Anaes.)(Assist.)	$504.40
35697	Microsurgical tuboplasty (salpingostomy, salpingolysis or tubal implantation into uterus), unilateral or bilateral, 1 or more procedures (Anaes.)(Assist.)	$748.45
35700	Fallopian tubes, unilateral microsurgical anastomosis of, using operating microscope, for other than reversal of previous sterilisation (Anaes.)(Assist.)	$577.50
35703	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.)	$53.35
35706	Rubin test for patency of fallopian tubes (Anaes.)	$53.35
35709	Fallopian tubes, hydrotubation of, as a repetitive postoperative procedure (Anaes.)	$34.40
35710	Falloposcopy, unilateral or bilateral, including hysteroscopy and tubal catheterization (Anaes.)(Assist.)	$366.50
35712	Laparotomy, involving oophorectomy, salpingectomy, salpingooophorectomy, removal of ovarian, parovarian, fimbrial or broad ligament cyst - 1 such procedure, not being a service associated with hysterectomy (Anaes.)(Assist.)	$286.50
35713	Laparotomy, involving oophorectomy, salpingectomy, salpingooophorectomy, removal of ovarian, parovarian, fimbrial or broad ligament cyst 1 such procedure, not being a service associated with hysterectomy (Anaes.)(Assist.)	$358.20
35716	Laparotomy, involving oophorectomy, salpingectomy, salpingooophorectomy, removal of ovarian, parovarian, fimbrial or broad ligament cyst - 2 or more such procedures, unilateral or bilateral, not being a service associated with hysterectomy (Anaes.)(Assist.)	$343.55
35717	Laparotomy, involving oophorectomy, salpingectomy, salpingooophorectomy, removal of ovarian, parovarian, fimbrial or broad ligament cyst 2 or more such procedures, unilateral or bilateral, not being a service associated with hysterectomy (Anaes.)(Assist.)	$431.30

Item	Service	Fee ($)
35720 Note T8.38	Radical or debulking operation for advanced gynaecological malignancy, with or without omentectomy (Anaes.)(Assist.)	$533.55
35723	Retroperitoneal lymph node biopsies from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (Anaes.)(Assist.)	$382.10
35726	Infracolic omentectomy with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (Anaes.)(Assist.)	$382.10
35729	Ovarian transposition out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (Anaes.)	$172.30
35750	Laparoscopically assisted hysterectomy, including any associated laparoscopy (Anaes.)(Assist.)	$620.65
35753	Laparoscopically assisted hysterectomy with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst or treatment of moderate endometriosis, one or both sides, including any associated laparoscopy (Anaes.)(Assist.)	$686.30
35754	Laparoscopically assisted hysterectomy which requires dissection of endometriosis, or other pathology, from the ureter, one or both sides, including any associated laparoscopy, including when performed with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst, or treatment of endometriosis, not being a service to which item 35641 applies (Anaes.)(Assist.)	$863.60
35756	Laparoscopically assisted hysterectomy, when procedure is completed by open hysterectomy, including any associated laparoscopy (Anaes.)(Assist.)	$620.65
35759	Procedure for the control of post operative haemorrhage following gynaecological surgery, under general anaesthesia, utilising a vaginal or abdominal and vaginal approach where no other procedure is performed (Anaes.)(Assist.)	$445.55
	Subgroup 5 - Urological	
36500	Adrenal gland, excision of partial or total (Anaes.)(Assist.)	$731.35
36502	Pelvic lymphadenectomy, open or laparoscopic, or both, unilateral or bilateral (Anaes.)(Assist.)	$540.95
36503	Renal transplant, not being a service to which item 36506 or 36509 applies (Anaes.)(Assist.)	$1,100.40
36506	Renal transplant, performed by vascular surgeon and urologist operating together vascular anastomosis, including aftercare (Anaes.)(Assist.)	$731.35
36509	Renal transplant, performed by vascular surgeon and urologist operating together ureterovesical anastomosis, including aftercare(Assist.)	$619.35
36516	Nephrectomy, complete (Anaes.)(Assist.)	$731.35
36519	Nephrectomy, complete, complicated by previous surgery on the same kidney (Anaes.)(Assist.)	$1,021.30

Item	Service	Fee ($)
36522	Nephrectomy, partial (Anaes.)(Assist.)	$876.40
36525	Nephrectomy, partial, complicated by previous surgery on the same kidney (Anaes.)(Assist.)	$1,245.40
36528	nephrectomy, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10 cms in diameter (Anaes.)(Assist.)	$1,021.30
36529	Nephrectomy, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10 cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney (Anaes.)(Assist.)	$1,260.40
36531	Nephroureterectomy, complete, including associated bladder repair and any associated endoscopic procedure (Anaes.)(Assist.)	$915.85
36532	Nephro-ureterectomy, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures (Anaes.)(Assist.)	$1,314.55
36533	Nephro-ureterectomy, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, complicated by previous open or laparoscopic surgery on the same kidney or ureter (Anaes.)(Assist.)	$1,553.60
36537	Kidney or perinephric area, exploration of, with or without drainage of, by open exposure, not being a service to which another item in this Sub-group applies (Anaes.)(Assist.)	$546.95
36540	Nephrolithotomy or pyelolithotomy, or both, through the same skin incision, for 1 or 2 stones (Anaes.)(Assist.)	$876.40
36543	Nephrolithotomy or pyelolithotomy, or both, extended, for staghorn stone or 3 or more stones, including 1 or more of the following: nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (Anaes.)(Assist.)	$1,021.30
36546	Extracorporeal shock wave lithotripsy (ESWL) to urinary tract and posttreatment care for 3 days, including pretreatment consultations, unilateral (Anaes.)	$546.95
36549	Ureterolithotomy (Anaes.)(Assist.)	$658.95
36552 Note T8.2	Nephrostomy or pyelostomy, open, as an independent procedure (Anaes.)(Assist.)	$586.50
36558	Renal cyst or cysts, excision or unroofing of (Anaes.)(Assist.)	$514.00
36561	Renal biopsy (closed) (Anaes.)	$136.45
36564	Pyeloplasty, by open exposure (Anaes.)(Assist.)	$731.35
36567	Pyeloplasty in a kidney that is congenitally abnormal in addition to the presence of PUJ obstruction, or in a solitary kidney, by open exposure (Anaes.)(Assist.)	$803.90

Item	Service	Fee ($)
36570	Pyeloplasty, complicated by previous surgery on the same kidney, by open exposure (Anaes.)(Assist.)	$1,021.30
36573	Divided ureter, repair of (Anaes.)(Assist.)	$731.35
36576	Kidney, exposure and exploration of, including repair or nephrectomy, for trauma, not being a service associated with any other procedure performed on the kidney, renal pelvis or renal pedicle (Anaes.)(Assist.)	$915.85
36579	Ureterectomy, complete or partial, with or without associated bladder repair, not being a service associated with a service to which item 37000 applies (Anaes.)(Assist.)	$586.50
36585	Ureter, transplantation of, into skin (Anaes.)(Assist.)	$586.50
36588	Ureter, reimplantation into bladder (Anaes.)(Assist.)	$731.35
36591	Ureter, reimplantation into bladder with psoas hitch or Boari flap or both (Anaes.)(Assist.)	$876.40
36594	Ureter, transplantation of, into intestine (Anaes.)(Assist.)	$731.35
36597	Ureter, transplantation of, into another ureter (Anaes.)(Assist.)	$731.35
36600	Ureter, transplantation of, into isolated intestinal segment, unilateral (Anaes.)(Assist.)	$876.40
36603	Ureters, transplantation of, into isolated intestinal segment, bilateral (Anaes.)(Assist.)	$1,021.30
36604	Ureteric stent, passage of through percutaneous nephrostomy tube, using interventional imaging techniques (Anaes.)	$211.70
36606	Intestinal urinary reservoir, continent, formation of, including formation of nonreturn valves and implantation of ureters (1 or both) into reservoir (Anaes.)(Assist.)	$1,831.80
36609	Intestinal urinary conduit or ureterostomy, revision of (Anaes.)(Assist.)	$586.50
36612	Ureter, exploration of, with or without drainage of, as an independent procedure (Anaes.)(Assist.)	$514.00
36615	Ureterolysis, with or without repositioning of the ureter, for obstruction of the ureter, evident either radiologically or by proximal ureteric dilatation at operation, secondary to retroperitoneal fibrosis, or similar condition (Anaes.)(Assist.)	$586.50
36618	Reduction ureteroplasty (Anaes.)(Assist.)	$514.00
36621	Closure of cutaneous ureterostomy (Anaes.)(Assist.)	$367.40
36624	Nephrostomy, percutaneous, using interventional imaging techniques (Anaes.)(Assist.)	$441.45

Item	Service	Fee ($)
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.)	$546.95
36630	Nephroscopy, being a service to which item 36627 applies, where, after a substantial portion of the procedure has been performed, it is necessary to discontinue the operation due to bleeding (Anaes.)(Assist.)	$270.20
36633	Nephroscopy, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, not being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Anaes.)(Assist.)	$586.50
36636	Nephroscopy, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Anaes.)(Assist.)	$316.35
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.)	$658.95
36642	Nephroscopy, being a service to which item 36639 applies, where, after a substantial portion of the procedure has been performed, it is necessary to discontinue the operation due to bleeding (Anaes.)(Assist.)	$329.45
36645	Nephroscopy, percutaneous, with removal or destruction of a stone greater than 3cm in any dimension, or for 3 or more stones (Anaes.)(Assist.)	$843.40
36648	Nephroscopy, being a service to which item 36645 applies, where, after a substantial portion of the procedure has been performed, it is necessary to discontinue the operation (Anaes.)(Assist.)	$751.20
36649	Nephrostomy drainage tube, exchange of - but not including imaging (Anaes.)(Assist.)	$211.70
36652 Note T8.36	Pyeloscopy, retrograde, of one collecting system, with or without any one or more of, cystoscopy, ureteric meatotomy, ureteric dilatation, not being a service associated with a service to which item 36803, 36812 or 36824 applies (Anaes.)(Assist.)	$514.00
36654 Note T8.36	Pyeloscopy, retrograde, of one collecting system, being a service to which item 36652 applies, plus 1 or more of extraction of stone from the renal pelvis or calyces, or biopsy or diathermy of the renal pelvis or calyces, not being a service associated with a service to which item 36656 applies to a procedure performed in the same collecting system(Assist.)	$658.95
36656 Note T8.36	Pyeloscopy, retrograde, of one collecting system, being a service to which item 36652 applies, plus extraction of 2 or more stones in the renal pelvis or calyces or destruction of stone with ultrasound, electrohydraulic or kinetic lithotripsy, or laser in the renal pelvis or calyces, with or without extraction of fragments, not being a service associated with a service to which item 36654 applies to a procedure performed in the same collecting system (Anaes.)(Assist.)	$843.40
36800	Bladder, catheterisation of, where no other procedure is performed (Anaes.)	$21.85

Item	Service	Fee ($)
36803 Note T8.36	Ureteroscopy, of one ureter, with or without any one or more of; cystoscopy, ureteric meatotomy or ureteric dilatation, not being a service associated with a service to which item 36652, 36654, 36656, 36806, 36809, 36812, 36824, 36848 or 36857 applies (Anaes.)(Assist.)	$368.90
36806 Note T8.36	Ureteroscopy, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus one or more of extraction of stone from the ureter, or biopsy or diathermy of the ureter, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36809, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Anaes.)(Assist.)	$514.00
36809 Note T8.36	Ureteroscopy, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus destruction of stone in the ureter with ultrasound, electrohydraulic or kinetic lithotripsy, or laser, with or without extraction of fragments, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36806, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Anaes.)(Assist.)	$658.95
36811	Cystoscopy with insertion of urethral prosthesis (Anaes.)	$255.80
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.)	$131.80
36815 Note T8.12	Cystoscopy, with or without urethroscopy, for the treatment of penile warts or urethral warts, not being a service associated with a service to which item 30189 applies (Anaes.)	$188.20
36818	Cystoscopy, with ureteric catheterisation including fluoroscopic imaging of the upper urinary tract, unilateral or bilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes.)(Assist.)	$218.75
36821	Cystoscopy with 1 or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or of renal pelvis, unilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes.)(Assist.)	$255.65
36824	Cystoscopy with ureteric catheterisation, unilateral or bilateral, not being a service associated with a service to which item 36818 or 36821 applies (Anaes.)	$168.65
36825	Cystoscopy, with endoscopic incision of pelviureteric junction or ureteric stricture, including removal or replacement of ureteric stent, not being a service associated with a service to which item 36818, 36821, 36824, 36830 or 36833 applies (Anaes.)(Assist.)	$459.80
36827	Cystoscopy, with controlled hydrodilatation of the bladder (Anaes.)	$181.85
36830	Cystoscopy, with ureteric meatotomy (Anaes.)	$160.85
36833	Cystoscopy with removal of ureteric stent or other foreign body (Anaes.)(Assist.)	$218.75

Item	Service	Fee ($)
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.)	$181.85
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.)	$255.65
36842	Cystoscopy, with lavage of blood clots from bladder including any associated diathermy of prostate or bladder and not being a service associated with a service to which item 36812, 36827 to 36863, 37203 or 37206 apply (Anaes.)(Assist.)	$257.25
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.)	$546.95
36848	Cystoscopy with resection of ureterocele (Anaes.)	$181.85
36851	Cystoscopy with injection into bladder wall (Anaes.)	$181.85
36854	Cystoscopy with endoscopic incision or resection of external sphincter, bladder neck or both (Anaes.)	$368.90
36857	Endoscopic manipulation or extraction of ureteric calculus (Anaes.)	$289.85
36860	Endoscopic examination of intestinal conduit or reservoir (Anaes.)	$131.80
36863	Litholapaxy, with or without cystoscopy (Anaes.)(Assist.)	$368.90
37000	Bladder, partial excision of (Anaes.)(Assist.)	$586.50
37004	Bladder, repair of rupture (Anaes.)(Assist.)	$514.00
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.)	$329.45
37011	Suprapubic stab cystotomy, not being a service associated with a service to which items 37200 to 37221 apply (Anaes.)	$73.75
37014	Bladder, total excision of (Anaes.)(Assist.)	$843.40
37020	Bladder diverticulum, excision or obliteration of (Anaes.)(Assist.)	$586.50
37023	Vesical fistula, cutaneous, operation for (Anaes.)	$329.45
37026	Cutaneous vesicostomy, establishment of (Anaes.)(Assist.)	$329.45
37029	Vesicovaginal fistula, closure of by abdominal approach (Anaes.)(Assist.)	$731.35
37038	Vesicointestinal fistula, closure of, excluding bowel resection (Anaes.)(Assist.)	$547.25
37041	Bladder aspiration, by needle	$36.90

Item	Service	Fee ($)
37042	Bladder stress incontinence, sling procedure for, using autologous fascial sling, including harvesting of sling, not being a service to which item 35599 applies (Anaes.)(Assist.)	$720.90
37043	Bladder stress incontinence, Stamey or similar type needle colposuspension, not being a service to which item 35599 applies (Anaes.)(Assist.)	$533.55
37044	Bladder stress incontinence, suprapubic procedure for, e.g. Burch colposuspension, not being a service to which item 35599 applies (Anaes.)(Assist.)	$547.25
37045	Mitrofanoff continent valve, formation of (Anaes.)(Assist.)	$1,130.15
37047	Bladder enlargement using intestine (Anaes.)(Assist.)	$1,317.85
37050	Bladder exstrophy closure, not involving sphincter reconstruction (Anaes.)(Assist.)	$586.50
37053	Bladder transection and re-anastomosis to trigone (Anaes.)(Assist.)	$677.70
37200	Prostatectomy, open (Anaes.)(Assist.)	$803.90
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.)	$824.30
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.)	$441.45
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.)	$685.40
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 item 37203 or 37207, which had to be discontinued for medical reasons (Anaes.)	$329.05
37209	Prostate, and/or seminal vesicle/ampulla of vas, unilateral or bilateral, total excision of, not being a service associated with a service to which item number 37210 or 37211 applies (Anaes.)(Assist.)	$1,021.30
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.)(Assist.)	$1,260.40
37211	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, with pelvic lymphadenectomy, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Anaes.)(Assist.)	$1,530.80

Item	Service	Fee ($)
37212	Prostate, open perineal biopsy or open drainage of abscess (Anaes.)(Assist.)	$218.75
37215	Prostate, biopsy of, endoscopic, with or without cystoscopy (Anaes.)(Assist.)	$329.45
37218	Prostate, needle biopsy of, or injection into (Anaes.)	$109.40
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.)(Assist.)	$222.15
37220 Note T8.37	Prostate, radioactive seed implantation of, urological component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages T1, T2a or T2b, with a Gleason score of less than or equal to 6 and a prostate specific antigen (psa) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed by a urologist at an approved site in association with a radiation oncologist, and be associated with a service to which item 55603 applies.	$826.00
37221	Prostatic abscess, endoscopic drainage of (Anaes.)(Assist.)	$368.90
37223	Prostatic coil, insertion of, under ultrasound control (Anaes.)	$163.10
37300	Urethral sounds, passage of, as an independent procedure (Anaes.)	$36.90
37303	Urethral stricture, dilatation of (Anaes.)	$58.60
37306	Urethra, repair of rupture of distal section (Anaes.)(Assist.)	$514.00
37309	Urethra, repair of rupture of prostatic or membranous segment (Anaes.)(Assist.)	$731.35
37315	Urethroscopy, as an independent procedure (Anaes.)	$109.40
37318	Urethroscopy, with any 1 or more of - biopsy, diathermy, visual laser destruction of stone or removal of foreign body or stone (Anaes.)(Assist.)	$218.75
37321	Urethral meatotomy, external (Anaes.)	$73.75
37324	Urethrotomy or urethrostomy, internal or external (Anaes.)	$181.85
37327	Urethrotomy, optical, for urethral stricture (Anaes.)(Assist.)	$255.65
37330	Urethrectomy, partial or complete, for removal of tumour (Anaes.)(Assist.)	$514.00
37333	Urethrovaginal fistula, closure of (Anaes.)(Assist.)	$441.45
37336	Urethrorectal fistula, closure of (Anaes.)(Assist.)	$586.50
37339	Periurethral or transurethral injection of materials for the treatment of urinary incontinence, including cystoscopy and urethroscopy (Anaes.)	$189.75
37340	Urethral sling, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, vaginal approach, not being a service associated with a service to which item number 37341 applies (Anaes.)(Assist.)	$336.20

Item	Service	Fee ($)
37341	Urethral sling, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, suprapubic or combined suprapubic/vaginal approach, not being a service associated with a service to which item number 37340 applies (Anaes.)(Assist.)	$720.90
37342	Urethroplasty single stage operation (Anaes.)(Assist.)	$658.95
37343	Urethroplasty, single stage operation, transpubic approach via separate incisions above and below the symphysis pubis, excluding laparotomy, symphysectomy and suprapubic cystotomy, with or without re-routing of the urethra around the crura (Anaes.)(Assist.)	$1,100.40
37345	Urethroplasty 2 stage operation first stage (Anaes.)(Assist.)	$546.95
37348	Urethroplasty 2 stage operation second stage (Anaes.)(Assist.)	$546.95
37351	Urethroplasty, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$218.75
37354	Hypospadias, meatotomy and hemicircumcision (Anaes.)(Assist.)	$255.65
37369	Urethra, excision of prolapse of (Anaes.)	$147.55
37372	Urethral diverticulum, excision of (Anaes.)(Assist.)	$368.90
37375	Urethral sphincter, reconstruction by bladder tubularisation technique or similar procedure (Anaes.)(Assist.)	$915.85
37381	Artificial urinary sphincter, insertion of cuff, perineal approach (Anaes.)(Assist.)	$586.50
37384	Artificial urinary sphincter, insertion of cuff, abdominal approach (Anaes.)(Assist.)	$915.85
37387	Artificial urinary sphincter, insertion of pressure regulating balloon and pump (Anaes.)(Assist.)	$255.65
37390	Artificial urinary sphincter, revision or removal of, with or without replacement (Anaes.)(Assist.)	$731.35
37393	Priapism, decompression by glanular stab caverno-sospongiosum shunt or penile aspiration with or without lavage (Anaes.)	$181.85
37396	Priapism, shunt operation for, not being a service to which item 37393 applies (Anaes.)(Assist.)	$586.50
37402	Penis, partial amputation of (Anaes.)(Assist.)	$368.90
37405	Penis, complete or radical amputation of (Anaes.)(Assist.)	$731.35
37408	Penis, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.)(Assist.)	$368.90
37411	Penis, repair of avulsion (Anaes.)(Assist.)	$731.35

Item	Service	Fee ($)
37415	Penis, injection of, for the investigation and treatment of impotence - 2 services only in a period of 36 consecutive months	$36.90
37417	Penis, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting (Anaes.)(Assist.)	$441.45
37418	Penis, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting, involving mobilization of the urethra (Anaes.)(Assist.)	$586.50
37420	Penis, surgery to inhibit rapid penile drainage causing impotence, by ligation of veins deep to Buck's fascia including 1 or more deep cavernosal veins, with or without pharmacological erection test (Anaes.)(Assist.)	$289.85
37423	Penis, lengthening by translocation of corpora (Anaes.)(Assist.)	$731.35
37426	Penis, artificial erection device, insertion of, into 1 or both corpora (Anaes.)(Assist.)	$770.90
37429	Penis, artificial erection device, insertion of pump and pressure regulating reservoir (Anaes.)(Assist.)	$255.65
37432	Penis, artificial erection device, complete or partial revision or removal of components, with or without replacement (Anaes.)(Assist.)	$731.35
37435	Penis, frenuloplasty as an independent procedure (Anaes.)	$73.75
37438	Scrotum, partial excision of (Anaes.)(Assist.)	$218.75
37444	Ureterolithotomy complicated by previous surgery at the same site of the same ureter (Anaes.)(Assist.)	$790.75
37601	Spermatocele or epididymal cyst, excision of, 1 or more of, on 1 side (Anaes.)	$218.75
37604	Exploration of scrotal contents, with or without fixation and with or without biopsy, unilateral (Anaes.)	$218.75
37607	Retroperitoneal lymph node dissection, unilateral, not being a service associated with a service to which item 36528 applies (Anaes.)(Assist.)	$731.35
37610	Retroperitoneal lymph node dissection, unilateral, not being a service associated with a service to which item 36528 applies, following previous similar retroperitoneal dissection, retroperitoneal irradiation or chemotherapy (Anaes.)(Assist.)	$1,100.40
37613	Epididymectomy (Anaes.)	$218.75
37616	Vasovasostomy or vasoepididymostomy, unilateral, using the operating microscope, for other than reversal of previous elective sterilisation (Anaes.)(Assist.)	$546.95
37619	Vasovasostomy or vasoepididymostomy, unilateral, for other than reversal of previous elective sterilisation (Anaes.)(Assist.)	$218.75
37622 Note T8.33	Vasotomy or vasectomy, unilateral or bilateral (Anaes.)	$152.90

Item	Service	Fee ($)
37623 Note T8.33	Vasotomy or vasectomy, unilateral or bilateral (Anaes.)	$181.85
37800	Patent urachus, excision of (Anaes.)(Assist.)	$412.30
37803	Undescended testis, orchidopexy for, not being a service to which item 37806 applies (Anaes.)(Assist.)	$412.30
37806	Undescended testis in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for (Anaes.)(Assist.)	$476.40
37809	Undescended testis, revision orchidopexy for (Anaes.)(Assist.)	$476.40
37812	Impalpable testis, exploration of groin for, not being a service associated with a service to which items 37803 to 37809 apply (Anaes.)(Assist.)	$439.85
37815	Hypospadias, examination under anaesthesia with erection test (Anaes.)	$73.30
37818	Hypospadias, glanuloplasty incorporating meatal advancement (Anaes.)(Assist.)	$388.75
37821	Hypospadias, distal, 1 stage repair (Anaes.)(Assist.)	$658.95
37824	Hypospadias, proximal, 1 stage repair (Anaes.)(Assist.)	$916.25
37827	Hypospadias, staged repair, first stage (Anaes.)(Assist.)	$422.10
37830	Hypospadias, staged repair, second stage (Anaes.)(Assist.)	$546.95
37833	Hypospadias, repair of post operative urethral fistula (Anaes.)(Assist.)	$261.00
37836	Epispadias, staged repair, first stage (Anaes.)(Assist.)	$549.75
37839	Epispadias, staged repair, second stage (Anaes.)(Assist.)	$623.00
37842	Exstrophy of bladder or epispadias, secondary repair with bladder neck tightening, with or without ureteric reimplantation (Anaes.)(Assist.)	$1,209.50
37845	Ambiguous genitalia with urogenital sinus, reduction clitoroplasty, with or without endoscopy (Anaes.)(Assist.)	$549.75
37848	Ambiguous genitalia with urogenital sinus, reduction clitoroplasty, with endoscopy and vaginoplasty (Anaes.)(Assist.)	$989.50
37851	Congenital adrenal hyperplasia, mixed gonadal dysgenesis or similar condition, vaginoplasty for, with or without endoscopy (Anaes.)(Assist.)	$733.05
37854	Urethral valve, destruction of, including cystoscopy and urethroscopy (Anaes.)(Assist.)	$289.85
	Subgroup 6 - Cardio-Thoracic	
38200	Right heart catheterisation, including fluoroscopy, oximetry, dye dilution curves, cardiac output measurement by any method, shunt detection and exercise stress test (Anaes.)	$352.35

Item	Service	Fee ($)
38203	Left heart catheterisation by percutaneous arterial puncture, arteriotomy or percutaneous left ventri cular puncture including fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection and exercise stress test (Anaes.)	$420.45
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.)	$508.30
38209 Note T8.39	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.)	$652.65
38212 Note T8.39	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 or testing not being a service associated with a service to which item 38209 or 38213 applies (Anaes.)	$1,085.60
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.)	$323.20
38215 Note T8.35	Selective coronary angiography placement of catheters and injection of opaque material (Anaes.)	$350.90
38218 Note T8.35	Selective coronary angiography, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography (Anaes.)	$526.30
38220 Note T8.35	Placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts) (Anaes.)	$175.45
38222 Note T8.35	Placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts) (Anaes.)	$350.90
38256	Temporary transvenous pacemaking electrode, insertion of (Anaes.)	$211.35
38270	Balloon valvuloplasty or septostomy, including cardiac catheterisations before and after balloon dilatation (Anaes.)(Assist.)	$721.60
38275	Myocardial biopsy, by cardiac catheterisation (Anaes.)	$235.90
38278	Single chamber permanent transvenous electrode, insertion, removal or replacement of (Anaes.)	$505.20
38281 Note T8.39	Permanent pacemaker, insertion, removal or replacement of (Anaes.)	$202.05
38284 Note T8.39	Dual chamber permanent transvenous electrodes, insertion, removal or replacement of (Anaes.)	$662.40

Item	Service	Fee ($)
38287	Ablation of arrhythmia circuit or focus or isolation procedure involving 1 atrial chamber (Anaes.)(Assist.)	$1,659.80
38290	Ablation of arrhythmia circuits or foci, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.)(Assist.)	$2,113.50
38293	Ventricular arrhythmia with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.)(Assist.)	$2,268.60
38400	Thoracic cavity, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38403 applies	$30.50
38403	Thoracic cavity, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample	$60.80
38406 Note T8.7	Pericardium, paracentesis of (excluding aftercare) (Anaes.)	$105.65
38409 Note T8.7	Intercostal drain, insertion of, not involving resection of rib (excluding aftercare) (Anaes.)	$105.65
38410	Intercostal drain, insertion of, with pleurodesis and not involving resection of rib (excluding aftercare) (Anaes.)	$130.20
38412	Percutaneous needle biopsy of lung (Anaes.)	$165.45
38415	Empyema, radical operation for, involving resection of rib (Anaes.)(Assist.)	$315.85
38418	Thoracotomy, exploratory, with or without biopsy (Anaes.)(Assist.)	$758.10
38421	Thoracotomy, with pulmonary decortication (Anaes.)(Assist.)	$1,211.80
38424	Thoracotomy, with pleurectomy or pleurodesis, or enucleation of hydatid cysts (Anaes.)(Assist.)	$758.10
38427	Thoracoplasty (complete) - 3 or more ribs (Anaes.)(Assist.)	$936.05
38430	Thoracoplasty (in stages) each stage (Anaes.)(Assist.)	$482.45
38436	Thoracoscopy, with or without division of pleural adhesions, including insertion of intercostal catheter, with or without biopsy (Anaes.)	$197.55
38438	Pneumonectomy or lobectomy or segmentectomy not being a service associated with a service to which Item 38418 applies (Anaes.)(Assist.)	$1,211.80
38440	Lung, wedge resection of (Anaes.)(Assist.)	$907.45
38441	Radical lobectomy or pneumonectomy including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (Anaes.)(Assist.)	$1,435.75
38446	Thoracotomy or sternotomy, for removal of thymus or mediastinal tumour (Anaes.)(Assist.)	$936.05

Item	Service	Fee ($)
38447	Pericardiectomy via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Anaes.)(Assist.)	$1,211.80
38448	Mediastinum, cervical exploration of, with or without biopsy (Anaes.)(Assist.)	$287.15
38449	Pericardiectomy via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (Anaes.)(Assist.)	$1,695.30
38450	Pericardium, transthoracic drainage of (Anaes.)(Assist.)	$677.65
38452	Pericardium, sub-xyphoid drainage of (Anaes.)(Assist.)	$453.75
38453	Tracheal excision and repair without cardiopulmonary bypass (Anaes.)(Assist.)	$1,361.15
38455	Tracheal excision and repair of, with cardiopulmonary bypass (Anaes.)(Assist.)	$1,841.20
38456	Intrathoracic operation on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than 1 of those organs, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$1,211.80
38457	Pectus excavatum or pectus carinatum, repair or radical correction of (Anaes.)(Assist.)	$1,131.35
38458	Pectus excavatum, repair of, with implantation of subcutaneous prosthesis (Anaes.)(Assist.)	$603.05
38460	Sternal wires or wires, removal of (Anaes.)	$217.85
38462	Sternotomy wound, debridement of, not involving reopening of the mediastinum (Anaes.)	$258.15
38464	Sternotomy wound, debridement of, involving curettage of infected bone with or without removal of wires but not involving reopening of the mediastinum (Anaes.)	$280.65
38466	Sternum, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (Anaes.)(Assist.)	$757.85
38468	Sternum and mediastinum, reoperation for infection of, involving muscle advancement flaps or greater omentum (Anaes.)(Assist.)	$1,167.70
38469	Sternum and mediastinum, reoperation for infection of, involving muscle advancement flaps and greater omentum (Anaes.)(Assist.)	$1,361.15
38470	Permanent myocardial electrode, insertion of, by thoracotomy or sternotomy (Anaes.)(Assist.)	$758.10
38473	Permanent pacemaker electrode, insertion by sub-xyphoid approach (Anaes.)(Assist.)	$453.75
38475	Valve annuloplasty without insertion of ring, not being a service associated with a service to which item 38480 or 38481 applies (Anaes.)(Assist.)	$658.00
38477	Valve annuloplasty with insertion of ring not being a service to which item 38478 applies (Anaes.)(Assist.)	$1,584.70

Item	Service	Fee ($)
38478	Valve annuloplasty with insertion of ring performed in conjunction with item 38480 or 38481 (Anaes.)(Assist.)	$767.65
38480	Valve repair, 1 leaflet (Anaes.)(Assist.)	$1,584.70
38481	Valve repair, 2 or more leaflets (Anaes.)(Assist.)	$1,804.00
38483	Aortic valve leaflet or leaflets, decalcification of, not being a service to which item 38475, 38477, 38480, 38481, 38488 or 38489 applies (Anaes.)(Assist.)	$1,361.15
38485	Mitral annulus, reconstruction of, after decalcification, when performed in association with valve surgery (Anaes.)(Assist.)	$646.40
38487	Mitral valve, open valvotomy of (Anaes.)(Assist.)	$1,361.15
38488	Valve replacement with bioprosthesis or mechanical prosthesis (Anaes.)(Assist.)	$1,510.50
38489	Valve replacement with allograft (subcoronary or cylindrical implant), or unstented xenograft (Anaes.)(Assist.)	$1,796.35
38490	Sub-valvular structures, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (Anaes.)(Assist.)	$438.60
38493	Operative management of acute infective endocarditis, in association with heart valve surgery (Anaes.)(Assist.)	$1,548.50
38496 Note T8.40	Artery harvesting (other than internal mammary), for coronary artery bypass (Anaes.)(Assist.)	$493.50
38497 Note T8.40	Coronary artery bypass using saphenous vein graft or grafts only, including harvesting of vein graft material where performed (Anaes.)(Assist.)	$1,619.60
38500 Note T8.40	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.)(Assist.)	$1,740.15
38503 Note T8.40	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.)(Assist.)	$1,889.45
38505	Coronary endarterectomy, by open operation, including repair with 1 or more patch grafts, each vessel (Anaes.)(Assist.)	$219.30
38506	Left ventricular aneurysm, plication of (Anaes.)(Assist.)	$1,286.40
38507	Left ventricular aneurysm resection with primary repair (Anaes.)(Assist.)	$1,510.20
38508	Left ventricular aneurysm resection with patch reconstruction of the left ventricle (Anaes.)(Assist.)	$1,889.45
38509	Ischaemic ventricular septal rupture, repair of (Anaes.)(Assist.)	$1,889.45

Item	Service	Fee ($)
38512	Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only (Anaes.)(Assist.)	$1,659.80
38515	Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation (Anaes.)(Assist.)	$2,113.50
38518	Ventricular arrhythmia with mapping and muscle ablation, with or without aneurysmeotomy (Anaes.)(Assist.)	$2,268.60
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.)(Assist.)	$832.70
38524	Automatic defibrillator generator, insertion or replacement of - not being a service associated with a service to which item 38213 applies (Anaes.)(Assist.)	$227.65
38550	Ascending thoracic aorta, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.)(Assist.)	$1,697.65
38553	Ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.)(Assist.)	$2,151.30
38556	Ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.)(Assist.)	$2,455.75
38559	Aortic arch and ascending thoracic aorta, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.)(Assist.)	$2,002.05
38562	Aortic arch and ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.)(Assist.)	$2,455.75
38565	Aortic arch and ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.)(Assist.)	$2,754.40
38568	Descending thoracic aorta, repair or replacement of, without shunt or cardiopulmonary bypass (Anaes.)(Assist.)	$1,473.60
38571	Descending thoracic aorta, repair or replacement of, using shunt or cardiopulmonary bypass (Anaes.)(Assist.)	$1,622.95
38572	Operative management of acute rupture or dissection, in conjunction with procedures on the thoracic aorta (Anaes.)(Assist.)	$1,571.75
38577	Cannulation for, and supervision and monitoring of, the administration of retrograde cerebral perfusion during deep hypothermic arrest(Assist.)	$438.60
38588	Cannulation of the coronary sinus for, and supervision of, the retrograde administration of blood or crystalloid for cardioplegia, including pressure monitoring(Assist.)	$329.05

Item	Service	Fee ($)
38600	Central cannulation for cardiopulmonary bypass excluding post-operative management, not being a service associated with a service to which another item in this Subgroup applies (Anaes.)(Assist.)	$1,211.80
38603	Peripheral cannulation for cardiopulmonary bypass excluding post-operative management (Anaes.)(Assist.)	$758.10
38606	Intra-aortic balloon pump, percutaneous insertion of (Anaes.)	$304.45
38609	Intra-aortic balloon pump, insertion of, by arteriotomy (Anaes.)(Assist.)	$379.00
38612	Intra-aortic balloon pump, removal of, with closure of artery by direct suture (Anaes.)(Assist.)	$424.90
38613	Intra-aortic balloon pump, removal of, with closure of artery by patch graft (Anaes.)(Assist.)	$533.25
38615	Left or right ventricular assist device, insertion of (Anaes.)(Assist.)	$1,211.80
38618	Left and right ventricular assist device, insertion of (Anaes.)(Assist.)	$1,510.50
38621	Left or right ventricular assist device, removal of, as an independent procedure (Anaes.)(Assist.)	$603.05
38624	Left and right ventricular assist device, removal of, as an independent procedure (Anaes.)(Assist.)	$677.65
38627	Extra-corporeal membrane oxygenation, bypass or ventricular assist device cannulae, adjustment and re-positioning of, by open operation, in patients supported by these devices (Anaes.)(Assist.)	$529.65
38637	Patent diseased coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of (Anaes.)(Assist.)	$438.60
38640 Note T8.41	Re-operation via median sternotomy, for any procedure, including any divisions of adhesions where the time taken to divide the adhesions is 45 minutes or less (Anaes.)(Assist.)	$758.10
38643 Note T8.41	Thoracotomy or sternotomy involving division of adhesions where the time taken to divide the adhesions exceeds 45 minutes (Anaes.)(Assist.)	$844.25
38647 Note T8.41	Thoracotomy or sternotomy involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (Anaes.)(Assist.)	$1,688.45
38650	Myomectomy or myotomy for hypertrophic obstructive cardiomyopathy (Anaes.)(Assist.)	$1,510.50
38653	Open heart surgery, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$1,510.50
38656 Note T8.41	Thoracotomy or median sternotomy for post-operative bleeding (Anaes.)(Assist.)	$758.10
38670	Cardiac tumour, excision of, involving the wall of the artrium or inter-atrial septum, without patch or conduit reconstruction (Anaes.)(Assist.)	$1,510.20

Item	Service	Fee ($)
38673	Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Anaes.)(Assist.)	$1,699.80
38677	Cardiac tumour arising from ventricular myocardium, partial thickness excision of (Anaes.)(Assist.)	$1,590.15
38680	Cardiac tumour arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Anaes.)(Assist.)	$1,886.20
38700	Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.)(Assist.)	$844.25
38703	Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.)(Assist.)	$1,521.95
38706	Aorta, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.)(Assist.)	$1,441.50
38709	Aorta, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.)(Assist.)	$1,688.45
38712	Aortic interruption, repair of, for congenital heart disease (Anaes.)(Assist.)	$2,027.40
38715	Main pulmonary artery, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.)(Assist.)	$1,349.65
38718	Main pulmonary artery, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.)(Assist.)	$1,688.45
38721	Vena cava, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.)(Assist.)	$1,183.10
38724	Vena cava, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.)(Assist.)	$1,688.45
38727	Intrathoracic vessels, anastomosis or repair of, without cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.)(Assist.)	$1,183.10
38730	Intrathoracic vessels, anastomosis or repair of, with cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.)(Assist.)	$1,688.45
38733	Systemic pulmonary or cavo-pulmonary shunt, creation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.)(Assist.)	$1,183.10
38736	Systemic pulmonary or cavo-pulmonary shunt, creation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.)(Assist.)	$1,688.45
38739	Atrial septectomy, with or without cardiopulmonary bypass, for congenital heart disease (Anaes.)(Assist.)	$1,521.95

Item	Service	Fee ($)
38742	Atrial septal defect, closure by direct suture or patch, for congenital heart disease (Anaes.)(Assist.)	$1,521.95
38745	Intra-atrial baffle, insertion of, for congenital heart disease (Anaes.)(Assist.)	$1,688.45
38748	Ventricular septectomy, for congenital heart disease (Anaes.)(Assist.)	$1,688.45
38751	Ventricular septal defect, closure by direct suture or patch, for congenital heart disease (Anaes.)(Assist.)	$1,688.45
38754	Intraventricular baffle or conduit, insertion of, for congenital heart disease (Anaes.)(Assist.)	$2,113.50
38757	Extracardiac conduit, insertion of, for congenital heart disease (Anaes.)(Assist.)	$1,688.45
38760	Extracardiac conduit, replacement of, for congenital heart disease (Anaes.)(Assist.)	$1,688.45
38763	Ventricular myectomy, for relief of ventricular obstruction, right or left, for congenital heart disease (Anaes.)(Assist.)	$1,688.45
38766	Ventricular augmentation, right or left, for congenital heart disease (Anaes.)(Assist.)	$1,688.45
	Subgroup 7 - Neurosurgical	
39000	Lumbar puncture (Anaes.)	$59.55
39003	Cisternal puncture (Anaes.)	$67.75
39006	Ventricular puncture (not including burr-hole) (Anaes.)	$126.10
39009	Subdural haemorrhage, tap for, each tap (Anaes.)	$46.95
39012	Burr-hole, single, preparatory to ventricular puncture or for inspection purpose - not being a service to which another item applies (Anaes.)	$187.95
39013 Note T8.7	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.)	$86.40
39015 Note T8.7	Ventricular reservoir, external ventricular drain or intracranial pressure monitoring device, insertion of - including burr-hole (excluding after-care) (Anaes.)(Assist.)	$297.40
39018	Cerebrospinal fluid reservoir, insertion of (Anaes.)(Assist.)	$297.40
39100 Note T8.7	Injection of primary branch of trigeminal nerve with alcohol, cortisone, phenol, or similar substance (Anaes.)	$187.95
39106	Neurectomy, intracranial, for trigeminal neuralgia (Anaes.)(Assist.)	$939.85
39109	Trigeminal gangliotomy by radiofrequency, balloon or glycerol (Anaes.)	$350.95
39112	Cranial nerve, intracranial decompression of, using microsurgical techniques (Anaes.)(Assist.)	$1,219.40

Item	Service	Fee ($)
39115 Note T8.7	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.)	$59.55
39118 Note T8.7	Percutaneous neurotomy for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.)(Assist.)	$235.55
39121 Note T8.7	Percutaneous cordotomy (Anaes.)(Assist.)	$499.70
39124	Cordotomy or myelotomy, laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.)(Assist.)	$1,278.90
39125	Spinal catheter, insertion of - for an automated infusion device (Anaes.)(Assist.)	$235.75
39126	Automated subcutaneous infusion device, insertion of (Anaes.)(Assist.)	$286.25
39127 Note T8.7	Subcutaneous reservoir and spinal catheter for pain, insertion of (Anaes.)	$374.70
39128	Automated subcutaneous infusion device and spinal catheter, insertion of (Anaes.)(Assist.)	$522.00
39130 Note T8.7	Percutaneous epidural electrode, insertion of 1 or more of - for spinal stimulation (Anaes.)	$482.75
39131	Percutaneous epidural electrodes, management, adjustment, electronic programming and trial of stimulation of, by a medical practitioner - each day	$101.10
39133 Note T8.7	Epidural stimulator or intrathecal infusion device, revision of (Anaes.)	$126.10
39134	Spinal neurostimulator receiver or pulse generator, subcutaneous placement of (Anaes.)(Assist.)	$269.40
39136 Note T8.7	Percutaneous epidural implant for management of pain, removal of (Anaes.)	$126.10
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.)(Assist.)	$850.65
39140	Epidural catheter, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.)	$231.65
39300	Cutaneous nerve (including digital nerve), primary repair of, using microsurgical techniques (Anaes.)(Assist.)	$279.55
39303	Cutaneous nerve (including digital nerve), secondary repair of, using microsurgical techniques (Anaes.)(Assist.)	$368.70
39306	Nerve trunk, primary repair of, using microsurgical techniques (Anaes.)(Assist.)	$535.40
39309	Nerve trunk, secondary repair of, using microsurgical techniques (Anaes.)(Assist.)	$565.00

Item	Service	Fee ($)
39312	Nerve trunk, internal (interfascicular), neurolysis of, using microsurgical techniques (Anaes.)(Assist.)	$315.20
39315	Nerve trunk, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.)(Assist.)	$814.85
39318	Cutaneous nerve (including digital nerve), nerve graft to, using microsurgical techniques (Anaes.)(Assist.)	$505.60
39321	Nerve, transposition of (Anaes.)(Assist.)	$374.70
39323	Percutaneous neurotomy by cryoneurotomy or radiofrequency lesion generator, not being a service to which another item applies (Anaes.)(Assist.)	$218.90
39324 Note T8.7	Neurectomy, neurotomy or removal of tumour from superficial peripheral nerve, by open operation (Anaes.)(Assist.)	$218.90
39327 Note T8.7	Neurectomy, neurotomy or removal of tumour from deep peripheral nerve, by open operation (Anaes.)(Assist.)	$374.70
39330 Note T8.3	Neurolysis by open operation without transposition, not being a service associated with a service to which item 39312 applies (Anaes.)(Assist.)	$218.90
39331	Carpal tunnel release (division of transverse carpal ligament), by any method (Anaes.)	$218.90
39333	Brachial plexus, exploration of, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$315.20
39500	Vestibular nerve, section of, via posterior fossa (Anaes.)(Assist.)	$1,005.30
39503	Facio-hypoglossal nerve or facio-accessory nerve, anastomosis of (Anaes.)(Assist.)	$755.40
39600	Intracranial haemorrhage, burr-hole craniotomy for - including burr-holes (Anaes.)(Assist.)	$374.70
39603	Intracranial haemorrhage, osteoplastic craniotomy or extensive craniectomy and removal of haematoma (Anaes.)(Assist.)	$945.75
39606	Fractured skull, depressed or comminuted, operation for (Anaes.)(Assist.)	$630.50
39609	Fractured skull, compound, without dural penetration, operation for (Anaes.)(Assist.)	$755.40
39612	Fractured skull, compound, depressed or complicated, with dural penetration and brain laceration, operation for (Anaes.)(Assist.)	$886.35
39615	Fractured skull with rhinorrhoea or otorrhoea, cranioplasty and repair of (Anaes.)(Assist.)	$945.75
39640 Note T8.42	Tumour involving anterior cranial fossa, removal of, involving craniotomy, radical excision of the skull base, and dural repair (Anaes.)(Assist.)	$2,398.05

Item	Service	Fee ($)
39642 Note T8.42	Tumour involving anterior cranial fossa, removal of, involving frontal craniotomy with lateral rhinotomy for clearance of paranasal sinus extension, (intracranial procedure) (Anaes.)(Assist.)	$2,521.10
39646 Note T8.42	Tumour involving anterior cranial fossa, removal of, involving frontal craniotomy with lateral rhinotomy and radical clearance of paranasal sinus and orbital fossa extensions, with intracranial decompression of the optic nerve, (intracranial procedure) (Anaes.)(Assist.)	$2,890.00
39650 Note T8.42	Tumour involving middle cranial fossa and infra-temporal fossa, removal of, craniotomy and radical or sub-total radical excision, with division and reconstruction of zygomatic arch, (intracranial procedure) (Anaes.)(Assist.)	$2,090.60
39653 Note T8.42	Petro-clival and clival tumour, removal of, by supra and infratentorial approaches for radical or sub-total radical excision (intracranial procedure), not being a service to which item 39654 or 39656 applies (Anaes.)(Assist.)	$3,720.10
39654 Note T8.42	Petro-clival and clival tumour, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure), conjoint surgery, principal surgeon (Anaes.)(Assist.)	$2,705.55
39656 Note T8.42	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.)	$2,029.15
39658 Note T8.42	Tumour involving the clivus, radical or sub-total radical excision of, involving transoral or transmaxillary approach (Anaes.)(Assist.)	$2,398.05
39660 Note T8.42	Tumour or vascular lesion of cavernous sinus, radical excision of, involving craniotomy with or without intracranial carotid artery exposure (Anaes.)(Assist.)	$2,398.05
39662 Note T8.42	Tumour or vascular lesion of foramen magnum, radical excision of, via transcondylar or far lateral suboccipital approach (Anaes.)(Assist.)	$2,398.05
39700	Skull tumour, benign or malignant, excision of, excluding cranioplasty (Anaes.)(Assist.)	$440.30
39703	Intracranial tumour, cyst or other brain tissue, burr-hole and biopsy of, or drainage of, or both (Anaes.)(Assist.)	$410.45
39706	Intracranial tumour, biopsy or decompression of via osteoplastic flap or biopsy and decompression of via osteoplastic flap (Anaes.)(Assist.)	$880.25
39709	Craniotomy for removal of glioma, metastatic carcinoma or any other tumour in cerebrum, cerebellum or brain stem - not being a service to which another item in this Sub-group applies (Anaes.)(Assist.)	$1,255.05
39712	Craniotomy for removal of meningioma, pinealoma, cranio-pharyngioma, intraventricular tumour or any other intracranial tumour, not being a service to which another item in this Sub-group applies (Anaes.)(Assist.)	$2,266.25
39715	Pituitary tumour, removal of, by transcranial or transphenoidal approach (Anaes.)(Assist.)	$1,570.35

Item	Service	Fee ($)
39718	Arachnoidal cyst, craniotomy for (Anaes.)(Assist.)	$690.00
39721	Craniotomy, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling, etc (Anaes.)(Assist.)	$630.50
39800	Aneurysm, clipping or reinforcement of sac (Anaes.)(Assist.)	$2,260.35
39803	Intracranial arteriovenous malformation, excision of (Anaes.)(Assist.)	$2,260.35
39806	Aneurysm, or arteriovenous malformation, intracranial proximal artery clipping of (Anaes.)(Assist.)	$1,017.10
39812	Intracranial aneurysm or arteriovenous fistula, ligation of cervical vessel or vessels (Anaes.)(Assist.)	$499.70
39815	Carotid-cavernous fistula, obliteration of - combined cervical and intracranial procedure (Anaes.)(Assist.)	$1,445.35
39818	Extracranial to intracranial bypass using superficial temporal artery (Anaes.)(Assist.)	$1,445.35
39821	Extracranial to intracranial bypass using saphenous vein graft (Anaes.)(Assist.)	$1,716.30
39900	Intracranial infection, drainage of, via burr-hole - including burr-hole (Anaes.)(Assist.)	$410.45
39903	Intracranial abscess, excision of (Anaes.)(Assist.)	$1,255.05
39906	Osteomyelitis of skull or removal of infected bone flap, craniectomy for (Anaes.)(Assist.)	$630.50
40000	Ventriculo-cisternostomy (Torkildsen's operation) (Anaes.)(Assist.)	$725.70
40003	Cranial or cisternal shunt diversion, insertion of (Anaes.)(Assist.)	$725.70
40006	Lumbar shunt diversion, insertion of (Anaes.)(Assist.)	$571.00
40009	Cranial, cisternal or lumbar shunt, revision or removal of (Anaes.)(Assist.)	$416.35
40012	Third ventriculostomy (open or endoscopic) with or without endoscopic septum pellucidotomy (Anaes.)(Assist.)	$814.85
40015	Subtemporal decompression (Anaes.)(Assist.)	$505.20
40018	Lumbar cerebrospinal fluid drain, insertion of (Anaes.)	$126.10
40100	Meningocele, excision and closure of (Anaes.)(Assist.)	$547.25
40103	Myelomeningocele, excision and closure of, including skin flaps or Z plasty where performed (Anaes.)(Assist.)	$803.00
40106	Arnold-Chiari malformation, decompression of (Anaes.)(Assist.)	$814.85
40109	Encephalocoele, excision and closure of (Anaes.)(Assist.)	$880.25

Item	Service	Fee ($)
40112	Tethered cord, release of, including lipomeningocele or diastematomyelia (Anaes.)(Assist.)	$1,130.15
40115	Craniostenosis, operation for - single suture (Anaes.)(Assist.)	$571.00
40118	Craniostenosis, operation for - more than 1 suture (Anaes.)(Assist.)	$755.40
40300	Intervertebral disc or discs, laminectomy for removal of (Anaes.)(Assist.)	$755.40
40301	Intervertebral disc or discs, microsurgical discectomy of (Anaes.)(Assist.)	$757.85
40303	Recurrent disc lesion or spinal stenosis, or both, laminectomy for - 1 level (Anaes.)(Assist.)	$862.45
40306	Spinal stenosis, laminectomy for, involving more than 1 vertebral interspace (disc level) (Anaes.)(Assist.)	$1,136.15
40309	Extradural tumour or abscess, laminectomy for (Anaes.)(Assist.)	$862.45
40312	Intradural lesion, laminectomy for, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$1,159.85
40315	Craniocervical junction lesion, transoral approach for (Anaes.)(Assist.)	$1,255.05
40316	Odontoid screw fixation (Anaes.)(Assist.)	$1,645.00
40318	Intramedullary tumour or arteriovenous malformation, laminectomy and radical excision of (Anaes.)(Assist.)	$1,570.35
40321	Posterior spinal fusion, not being a service to which items 40324 and 40327 apply (Anaes.)(Assist.)	$862.45
40324	Laminectomy followed by posterior fusion, performed by neurosurgeon and orthopaedic surgeon operating together - laminectomy, including aftercare (Anaes.)(Assist.)	$505.60
40327	Laminectomy followed by posterior fusion, performed by neurosurgeon and orthopaedic surgeon operating together - posterior fusion, including aftercare(Assist.)	$505.60
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.)(Assist.)	$755.40
40331	Cervical decompression of spinal cord with or without involvement of nerve roots, without fusion, 1 level, by any approach, not being a service to which item 40330 applies (Anaes.)(Assist.)	$755.40
40332	Cervical decompression of spinal cord with or without involvement of nerve roots, including anterior fusion, 1 level, not being a service to which item 40330 applies (Anaes.)(Assist.)	$1,232.65
40333	Cervical discectomy (anterior), without fusion (Anaes.)(Assist.)	$630.50

Item	Service	Fee ($)
40334	Cervical decompression of spinal cord with or without involvement of nerve roots, without fusion, more than 1 level, by any approach, not being a service to which item 40330 applies (Anaes.)(Assist.)	$833.55
40335	Cervical decompression of spinal cord with or without involvement of nerve roots, including anterior fusion, more than 1 level, by any approach, not being a service to which item 40330 applies (Anaes.)(Assist.)	$1,530.95
40336 Note T8.43	Intradiscal injection of chymopapain (discase) - 1 disc (Anaes.)(Assist.)	$249.90
40339	Hydromyelia, plugging of obex for, with or without duroplasty (Anaes.)(Assist.)	$1,255.05
40342	Hydromyelia, craniotomy and laminectomy for, with cavity packing and CSF shunt (Anaes.)(Assist.)	$1,159.85
40345	Thoracic decompression of spinal cord with or without involvement of nerve roots, via pedicle or costotransversectomy (Anaes.)(Assist.)	$1,079.80
40348	Thoracic decompression of spinal cord via thoracotomy with vertebrectomy, not including stabilisation procedure (Anaes.)(Assist.)	$1,370.85
40351	Thoraco-lumbar or high lumbar anterior decompression of spinal cord, not including stabilisation procedure (Anaes.)(Assist.)	$1,370.85
40600	Cranioplasty, reconstructive (Anaes.)(Assist.)	$755.40
40700	Corpus callosum, anterior section of, for epilepsy (Anaes.)(Assist.)	$1,380.05
40703	Corticectomy, topectomy or partial lobectomy for epilepsy (Anaes.)(Assist.)	$1,159.85
40706	Hemispherectomy for intractable epilepsy (Anaes.)(Assist.)	$1,695.20
40709	Burr-hole placement of intracranial depth or surface electrodes (Anaes.)(Assist.)	$410.45
40712	Intracranial electrode placement via craniotomy (Anaes.)(Assist.)	$826.75
40800	Stereotactic anatomical localisation, as an independent procedure (Anaes.)(Assist.)	$505.20
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.)(Assist.)	$1,380.90
40803	Intracranial stereotactic procedure by any method, not being a service to which item 40800 or 40801 applies (Anaes.)(Assist.)	$945.75
40903	Neuroendoscopy, for inspection of an intraventricular lesion, with or without biopsy including burr hole (Anaes.)(Assist.)	$438.60
	Subgroup 8 - Ear, Nose And Throat	
41500 Note T8.44	Ear, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.)	$65.25

Item	Service	Fee ($)
41503	Ear, removal of foreign body in, involving incision of external auditory canal (Anaes.)	$188.95
41506	Aural polyp, removal of (Anaes.)	$113.95
41509	External auditory meatus, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (Anaes.)	$128.95
41512	Meatoplasty involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes.)(Assist.)	$463.45
41515 Note T8.45	Meatoplasty involving removal of cartilage or bone or both cartilage and bone, being a service associated with a service to which item 41530, 41548, 41560 or 41563 applies (Anaes.)(Assist.)	$304.15
41518	External auditory meatus, removal of exostoses in (Anaes.)(Assist.)	$734.65
41521	Correction of auditory canal stenosis, including meatoplasty, with or without grafting (Anaes.)(Assist.)	$782.20
41524 Note T8.46	Reconstruction of external auditory canal, being a service associated with a service to which items 41557, 41560 and 41563 apply (Anaes.)(Assist.)	$225.95
41527	Myringoplasty, transcanal approach (Rosen incision) (Anaes.)(Assist.)	$464.85
41530 Note T8.45	Myringoplasty, postaural or endaural approach with or without mastoid inspection (Anaes.)	$757.20
41533	Atticotomy without reconstruction of the bony defect, with or without myringoplasty (Anaes.)(Assist.)	$905.20
41536	Atticotomy with reconstruction of the bony defect with or without myringoplasty (Anaes.)(Assist.)	$1,013.85
41539	Ossicular chain reconstruction (Anaes.)(Assist.)	$862.15
41542	Ossicular chain reconstruction and myringoplasty (Anaes.)(Assist.)	$944.70
41545	Mastoidectomy (cortical) (Anaes.)(Assist.)	$412.30
41548 Note T8.45	Obliteration of the mastoid cavity (Anaes.)(Assist.)	$547.25
41551	Mastoidectomy, intact wall technique, with myringoplasty (Anaes.)(Assist.)	$1,260.10
41554	Mastoidectomy, intact wall technique, with myringoplasty and ossicular chain reconstruction (Anaes.)(Assist.)	$1,484.65
41557 Note T8.45 Note T8.46	Mastoidectomy (radical or modified radical) (Anaes.)(Assist.)	$862.15
41560 Note T8.45 Note T8.46	Mastoidectomy (radical or modified radical) and myringoplasty (Anaes.)	$944.70
41563 Note T8.45 Note T8.46	Mastoidectomy (radical or modified radical), myringoplasty and ossicular chain reconstruction (Anaes.)(Assist.)	$1,169.45

Item	Service	Fee ($)
41564	Mastoidectomy (radical or modified radical), obliteration of the mastoid cavity, blind sac closure of external auditory canal and obliteration of eustachian tube (Anaes.)(Assist.)	$1,512.30
41566	Revision of mastoidectomy (radical, modified radical or intact wall), including myringoplasty (Anaes.)(Assist.)	$862.15
41569	Decompression of facial nerve in its mastoid portion (Anaes.)(Assist.)	$944.70
41572	Labyrinthotomy or destruction of labyrinth (Anaes.)(Assist.)	$817.15
41575	Cerebellopontine angle tumour, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach transmastoid, translabyrinthine or retromastoid procedure (including aftercare) (Anaes.)(Assist.)	$1,926.70
41576	Cerebello - pontine angle tumour, removal of, by transmastoid, translabyrinthine or retromastoid appoach - intracranial procedure (including aftercare) not being a service to which item 41578 or 41579 applies (Anaes.)(Assist.)	$2,890.00
41578	Cerebello pontine angle tumour, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes.)(Assist.)	$1,926.70
41579	Cerebello-pontine angle tumour, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co-surgeon(Assist.)	$1,444.95
41581	Tumour involving infra-temporal fossa, removal of, involving craniotomy and radical excision of (Anaes.)(Assist.)	$2,216.00
41584	Partial temporal bone resection for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes.)(Assist.)	$1,520.80
41587	Total temporal bone resection for removal of tumour (Anaes.)(Assist.)	$2,071.20
41590	Endolymphatic sac, transmastoid decompression with or without drainage of (Anaes.)(Assist.)	$944.70
41593	Translabyrinthine vestibular nerve section (Anaes.)(Assist.)	$1,231.20
41596	Retrolabyrinthine vestibular nerve section or cochlear nerve section, or both (Anaes.)(Assist.)	$1,376.00
41599	Internal auditory meatus, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes.)(Assist.)	$1,376.00
41602	Fenestration operation each ear (Anaes.)(Assist.)	$944.70
41605	Venous graft to fenestration cavity (Anaes.)(Assist.)	$464.85
41608	Stapedectomy (Anaes.)(Assist.)	$862.15
41611	Stapes mobilisation (Anaes.)(Assist.)	$554.70

Item	Service	Fee ($)
41614	Round window surgery including repair of cochleotomy (Anaes.)(Assist.)	$862.15
41615	Oval window surgery, including repair of fistula, not being a service associated with a service to which any other item in this Group applies (Anaes.)(Assist.)	$862.15
41617	Cochlear implant, insertion of, including mastoidectomy (Anaes.)(Assist.)	$1,499.10
41620	Glomus tumour, transtympanic removal of (Anaes.)(Assist.)	$652.20
41623	Glomus tumour, transmastoid removal of, including mastoidectomy (Anaes.)(Assist.)	$944.70
41626 Note T8.7	Abscess or inflammation of middle ear, operation for (excluding aftercare) (Anaes.)	$113.95
41629	Middle ear, exploration of (Anaes.)(Assist.)	$412.30
41632	Middle ear, insertion of tube for drainage of (including myringotomy) (Anaes.)	$188.95
41635	Clearance of middle ear for granuloma, cholesteatoma and polyp, 1 or more, with or without myringoplasty (Anaes.)(Assist.)	$905.20
41638	Clearance of middle ear for granuloma, cholesteatoma and polyp, 1 or more, with or without myringoplasty with ossicular chain reconstruction (Anaes.)(Assist.)	$1,129.80
41641	Perforation of tympanum, cauterisation or diathermy of (Anaes.)	$37.55
41644	Excision of rim of eardrum perforation, not being a service associated with myringoplasty (Anaes.)	$112.95
41647	Ear toilet requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (Anaes.)	$86.95
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.)	$86.95
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.)	$56.95
41656 Note T8.7	Nasal haemorrhage, posterior, arrest of, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.)	$97.10
41659	Nose, removal of foreign body in, other than by simple probing (Anaes.)	$61.40
41662 Note T8.47	Nasal polyp or polypi (simple), removal of	$65.25
41665 Note T8.47	Nasal polyp or polypi (requiring admission to hospital), removal of (Anaes.)	$136.45
41668 Note T8.47	Nasal polyp or polypi (requiring admission to hospital), removal of (Anaes.)	$173.95

Item	Service	Fee ($)
41671 Note T8.73	Nasal septum, septoplasty, submucous resection or closure of septal perforation (Anaes.)	$382.25
41672	Nasal septum, reconstruction of (Anaes.)(Assist.)	$476.95
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.)	$79.45
41677	Nasal haemorrhage, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.)	$71.15
41680	Cryotherapy to nose in the treatment of nasal haemorrhage (Anaes.)	$128.95
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.)	$92.65
41686	Dislocation of turbinate or turbinates, 1 or both sides, not being a service associated with a service to which another item in this Group applies (Anaes.)	$56.95
41689	Turbinectomy or turbinectomies, partial or total, unilateral (Anaes.)	$107.95
41692	Turbinates, submucous resection of, unilateral (Anaes.)	$140.85
41695	Nasal turbinates, cryotherapy to (Anaes.)	$79.05
41698	Maxillary antrum, proof puncture and lavage of (Anaes.)	$25.70
41701	Maxillary antrum, proof puncture and lavage of under general anaesthesia (requiring admission to hospital), not being a service associated with a service to which another item in this Group applies (Anaes.)	$72.80
41704	Maxillary antrum, lavage of each attendance at which the procedure is performed, including any associated consultation (Anaes.)	$28.75
41707	Maxillary artery, transantral ligation of (Anaes.)(Assist.)	$354.80
41710	Antrostomy (radical) (Anaes.)(Assist.)	$412.30
41713	Antrostomy (radical) with transantral ethmoidectomy or transantral vidian neurectomy (Anaes.)(Assist.)	$479.75
41716	Antrum, intranasal operation on or removal of foreign body from (Anaes.)(Assist.)	$233.90
41719	Antrum, drainage of, through tooth socket (Anaes.)	$92.95
41722	Oroantral fistula, plastic closure of (Anaes.)(Assist.)	$464.85
41725	Ethmoidal artery or arteries, transorbital ligation of (unilateral) (Anaes.)(Assist.)	$354.80

Item	Service	Fee ($)
41728	Lateral rhinotomy with removal of tumour (Anaes.)(Assist.)	$709.75
41729	Dermoid of nose, excision of, with intranasal extension (Anaes.)(Assist.)	$449.80
41731	Frontonasal ethmoidectomy by external approach with or without sphenoidectomy (Anaes.)(Assist.)	$614.75
41734	Radical frontoethmoidectomy with osteoplastic flap (Anaes.)(Assist.)	$802.15
41737	Frontal sinus, or ethmoidal sinuses on the one side, intranasal operation on (Anaes.)(Assist.)	$382.25
41740	Frontal sinus, catheterisation of (Anaes.)	$46.50
41743	Frontal sinus, trephine of (Anaes.)(Assist.)	$266.90
41746	Frontal sinus, radical obliteration of (Anaes.)(Assist.)	$614.75
41749	Ethmoidal sinuses, external operation on (Anaes.)(Assist.)	$479.75
41752	Sphenoidal sinus, intranasal operation on (Anaes.)(Assist.)	$233.90
41755	Eustachian tube, catheterisation of (Anaes.)	$36.80
41758	Division of pharyngeal adhesions (Anaes.)	$92.95
41761	Post nasal space, direct examination of, with or without biopsy (Anaes.)	$97.10
41764	Nasendoscopy or sinoscopy or fibreoptic examination of nasopharynx and larynx, 1 or more of these procedures (Anaes.)	$97.10
41767	Nasopharyngeal angiofibroma, transpalatal removal (Anaes.)(Assist.)	$582.95
41770	Pharyngeal pouch, removal of, with or without cricopharyngeal myotomy (Anaes.)(Assist.)	$554.70
41773	Pharyngeal pouch, endoscopic resection of (Dohlman's operation) (Anaes.)(Assist.)	$464.85
41776	Cricopharyngeal myotomy with or without inversion of pharyngeal pouch (Anaes.)(Assist.)	$463.45
41779	Pharyngotomy (lateral), with or without total excision of tongue (Anaes.)(Assist.)	$554.70
41782	Partial pharyngectomy via pharyngotomy (Anaes.)(Assist.)	$753.10
41785	Partial pharyngectomy via pharyngotomy with partial or total glossectomy (Anaes.)(Assist.)	$934.30
41786	Uvulopalatopharyngoplasty, with or without tonsillectomy, by any means (Anaes.)(Assist.)	$582.95

Item	Service	Fee ($)
41787	Uvulectomy and partial palatectomy with laser incision of the palate, with or without tonsillectomy, 1 or more stages, including any revision procedures within 12 months (Anaes.)(Assist.)	$449.80
41788	Tonsils or tonsils and adenoids, removal of, in a person aged less than 12 years (Anaes.)	$173.95
41789	Tonsils or tonsils and adenoids, removal of, in a person aged less than 12 years (Anaes.)	$233.90
41792	Tonsils or tonsils and adenoids, removal of, in a person 12 years of age or over (Anaes.)	$218.90
41793	Tonsils or tonsils and adenoids, removal of, in a person 12 years of age or over (Anaes.)	$293.85
41796	Tonsils or tonsils and adenoids, arrest of haemorrhage requiring general anaesthesia, following removal of (Anaes.)	$89.95
41797	Tonsils or tonsils and adenoids, arrest of haemorrhage requiring general anaesthesia, following removal of (Anaes.)	$113.95
41800	Adenoids, removal of (Anaes.)	$92.95
41801	Adenoids, removal of (Anaes.)	$128.95
41804	Lingual tonsil or lateral pharyngeal bands, removal of (Anaes.)	$71.15
41807	Peritonsillar abscess (quinsy), incision of (Anaes.)	$55.50
41810	Uvulotomy or uvulectomy (Anaes.)	$28.20
41813	Vallecular or pharyngeal cysts, removal of (Anaes.)(Assist.)	$281.90
41816	Oesophagoscopy (with rigid oesophagoscope) (Anaes.)	$146.90
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.)	$276.05
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.)	$331.25
41822	Oesophagoscopy (with rigid oesophagoscope) with biopsy (Anaes.)	$188.95
41825	Oesophagoscopy (with rigid oesophagoscope) with removal of foreign body (Anaes.)(Assist.)	$281.90
41828	Oesophageal stricture, dilatation of, without oesophagoscopy (Anaes.)	$41.30
41831	Oesophagus, endoscopic pneumatic dilatation of (Anaes.)(Assist.)	$282.40

Item	Service	Fee ($)
41832	Oesophagus, balloon dilatation of, using interventional imaging techniques (Anaes.)	$180.70
41834	Laryngectomy (total) (Anaes.)(Assist.)	$1,019.60
41837	Vertical hemilaryngectomy including tracheostomy (Anaes.)(Assist.)	$977.70
41840	Supraglottic laryngectomy including tracheostomy (Anaes.)(Assist.)	$1,202.20
41843	Laryngopharyngectomy or primary restoration of alimentary continuity after laryngopharyngectomy using stomach or bowel (Anaes.)(Assist.)	$1,057.10
41846 Note T8.2 Note T8.48	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.)	$146.90
41849	Larynx, direct examination of, with biopsy (Anaes.)(Assist.)	$215.85
41852	Larynx, direct examination of, with removal of tumour (Anaes.)(Assist.)	$233.90
41855	Microlaryngoscopy (Anaes.)(Assist.)	$227.95
41858 Note T8.49	Microlaryngoscopy with removal of juvenile papillomata (Anaes.)(Assist.)	$390.95
41861 Note T8.49	Microlaryngoscopy with removal of papillomata by laser surgery (Anaes.)(Assist.)	$477.95
41864	Microlaryngoscopy with removal of tumour (Anaes.)(Assist.)	$322.40
41867	Microlaryngoscopy with arytenoidectomy (Anaes.)(Assist.)	$485.15
41868	Laryngeal web, division of, using microlarygoscopic techniques (Anaes.)	$307.45
41869	Botulinum toxin injection into vocal cords, including associated consultation	$211.20
41870	Injection of vocal cord by teflon, fat, collagen or gelfoam (Anaes.)(Assist.)	$359.80
41873	Larynx, fractured, operation for (Anaes.)(Assist.)	$464.85
41876	Larynx, external operation on, or laryngofissure, with or without cordectomy (Anaes.)(Assist.)	$464.85
41879	Laryngoplasty or tracheoplasty, including tracheostomy (Anaes.)(Assist.)	$753.10
41880	Tracheostomy by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (Anaes.)	$201.00
41881	Tracheostomy by open exposure of the trachea, including separation of the strap muscles or division of the thyroid isthmus, where performed (Anaes.)(Assist.)	$317.75
41884	Cricothyrostomy by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.)	$72.00

Item	Service	Fee ($)
41885	Trache-oesophageal fistula, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes.)(Assist.)	$227.70
41886	Trachea, removal of foreign body in (Anaes.)	$140.85
41889	Bronchoscopy, as an independent procedure (Anaes.)	$140.85
41892	Bronchoscopy with 1 or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.)	$185.95
41895	Bronchus, removal of foreign body in (Anaes.)(Assist.)	$290.90
41898	Fibreoptic bronchoscopy with 1 or more transbronchial lung biopsies, with or without bronchial or bronchoalveolar lavage, with or without the use of interventional imaging (Anaes.)(Assist.)	$203.25
41901	Endoscopic laser resection of endobronchial tumours for relief of obstruction including any associated endoscopic procedures (Anaes.)(Assist.)	$477.95
41904	Bronchoscopy with dilatation of tracheal stricture (Anaes.)	$194.95
41905	Trachea or bronchus, dilatation of stricture and endoscopic insertion of stent (Anaes.)(Assist.)	$358.65
41907	Nasal septum button, insertion of (Anaes.)	$97.10
41910	Duct of major salivary gland, transposition of (Anaes.)(Assist.)	$308.70
	Subgroup 9 - Ophthalmology	
42503	Ophthalmological examination under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.)	$81.00
42506	Eye, enucleation of, with or without sphere implant (Anaes.)(Assist.)	$380.70
42509	Eye, enucleation of, with insertion of integrated implant (Anaes.)(Assist.)	$481.75
42510	Eye, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.)(Assist.)	$555.30
42512	Globe, evisceration of (Anaes.)(Assist.)	$380.70
42515	Globe, evisceration of, and insertion of intrascleral ball or cartilage (Anaes.)(Assist.)	$481.75
42518	Anophthalmic orbit, insertion of cartilage or artificial implant as a delayed procedure, or removal of implant from socket; or placement of a motility intergrating peg by drilling into existing orbital implant (Anaes.)(Assist.)	$279.55
42521	Anophthalmic socket, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Anaes.)(Assist.)	$951.75
42524	Orbit, skin graft to, as a delayed procedure (Anaes.)	$161.85
42527	Contracted socket, reconstruction including mucous membrane grafting and stent mould (Anaes.)(Assist.)	$321.10

Item	Service	Fee ($)
42530	Orbit, exploration with or without biopsy, requiring removal of bone (Anaes.)(Assist.)	$499.70
42533	Orbit, exploration of, with drainage or biopsy not requiring removal of bone (Anaes.)(Assist.)	$321.10
42536	Orbit, exenteration of, with or without skin graft and with or without temporalis muscle transplant (Anaes.)(Assist.)	$660.25
42539	Orbit, exploration of, with removal of tumour or foreign body, requiring removal of bone (Anaes.)(Assist.)	$939.85
42542	Orbit, exploration of anterior aspect with removal of tumour or foreign body (Anaes.)(Assist.)	$398.60
42543	Orbit, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes.)(Assist.)	$699.10
42545	Orbit, decompression of, for dysthyroid eye disease, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, 1 eye (Anaes.)(Assist.)	$1,011.15
42548	Optic nerve meninges, incision of (Anaes.)(Assist.)	$600.75
42551 Note T8.51	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.)(Assist.)	$499.70
42554 Note T8.51	Eyeball, perforating wound of, with incarceration or prolapse of uveal tissue repair (Anaes.)(Assist.)	$582.95
42557 Note T8.51	Eyeball, perforating wound of, with incarceration of lens or vitreous repair (Anaes.)(Assist.)	$814.85
42560 Note T8.51	Intraocular foreign body, magnetic removal from anterior segment (Anaes.)(Assist.)	$321.10
42563 Note T8.51	Intraocular foreign body, nonmagnetic removal from anterior segment (Anaes.)(Assist.)	$410.45
42566 Note T8.51	Intraocular foreign body, magnetic removal from posterior segment (Anaes.)(Assist.)	$582.95
42569 Note T8.51	Intraocular foreign body, nonmagnetic removal from posterior segment (Anaes.)(Assist.)	$814.85
42572	Orbital abscess or cyst, drainage of (Anaes.)	$92.75
42573	Dermoid, periorbital, excision of (Anaes.)	$179.95
42574	Dermoid, orbital, excision of (Anaes.)(Assist.)	$382.25
42575	Tarsal cyst, extirpation of (Anaes.)	$65.45
42578	Tarsal cartilage, excision of (Anaes.)(Assist.)	$368.70

Item	Service	Fee ($)
42581	Ectropion or entropion, tarsal cauterisation of (Anaes.)	$92.75
42584	Tarsorrhaphy (Anaes.)(Assist.)	$218.90
42587	Trichiasis, treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.)	$41.05
42590	Canthoplasty, medial or lateral (Anaes.)(Assist.)	$267.60
42593	Lacrimal gland, excision of palpebral lobe (Anaes.)	$161.85
42596	Lacrimal sac, excision of, or operation on (Anaes.)(Assist.)	$398.60
42599	Lacrimal canalicular system, establishment of patency by closed operation using silicone tubes or similar, 1 eye (Anaes.)(Assist.)	$499.70
42602	Lacrimal canalicular system, establishment of patency by open operation, 1 eye (Anaes.)(Assist.)	$499.70
42605	Lacrimal canaliculus, immediate repair of (Anaes.)(Assist.)	$368.70
42608	Lacrimal drainage by insertion of glass tube, as an independent procedure (Anaes.)(Assist.)	$237.90
42610	Nasolacrimal tube (unilateral), removal or replacement of, or lacrimal passages, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (Anaes.)	$76.10
42611	Nasolacrimal tube (bilateral), removal or replacement of, or lacrimal passages, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (Anaes.)	$114.20
42614 Note T8.7	Nasolacrimal tube (unilateral), removal or replacement of, or lacrimal passages, probing to establish patency of the lacrimal passage and/or site of obstruction, unilateral, including lavage, not being a service associated with a service to which item 42610 applies (excluding aftercare)	$38.15
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)	$57.10
42617	Punctum snip operation (Anaes.)	$108.30
42620	Punctum, occlusion of, by use of a plug (Anaes.)	$41.70
42621	Punctum, temporary occlusion of, by use of electrical cautery (Anaes.)	$41.70
42622	Punctum, permanent occlusion of, by use of electrical cautery (Anaes.)	$65.45
42623	Dacryocystorhinostomy (Anaes.)(Assist.)	$553.25
42626	Dacryocystorhinostomy where a previous dacryocystorhinostomy has been performed (Anaes.)(Assist.)	$892.25

Item	Service	Fee ($)
42629	Conjunctivorhinostomy including dacryocystorhinostomy and fashioning of conjunctival flaps (Anaes.)(Assist.)	$672.15
42632	Conjunctival peritomy or repair of corneal laceration by conjunctival flap (Anaes.)	$92.75
42635	Corneal perforations, sealing of, with tissue adhesive (Anaes.)(Assist.)	$237.90
42638	Conjunctival graft over cornea (Anaes.)(Assist.)	$297.40
42641	Autoconjunctival transplant, or mucous membrane graft (Anaes.)(Assist.)	$386.60
42644 Note T8.7	Cornea or sclera, removal of imbedded foreign body from (excluding aftercare) (Anaes.)	$57.05
42647	Corneal scars, removal of, by partial keratectomy, not being a service associated with a service to which item 42686 applies (Anaes.)	$161.85
42650 Note T8.7	Cornea, epithelial debridement for corneal ulcer or corneal erosion (excluding aftercare) (Anaes.)	$57.05
42651	Cornea, epithelial debridement for eliminating band keratopathy (Anaes.)	$127.15
42653	Cornea, transplantation of, full thickness (Anaes.)(Assist.)	$1,058.75
42656	Cornea, transplantation of, where there have been 2 previous graft operations (Anaes.)(Assist.)	$1,320.50
42659	Cornea, transplantation of, superficial or lamellar (Anaes.)(Assist.)	$713.75
42662	Sclera, transplantation of, full thickness, including collection of donor material (Anaes.)(Assist.)	$713.75
42665	Sclera, transplantation of, superficial or lamellar, including collection of donor material (Anaes.)(Assist.)	$475.85
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	$112.25
42668	Corneal sutures, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.)	$59.55
42671 Note T8.50	Refractive keratoplasty with penetrating incisions (excluding radial keratotomy) following corneal grafting or intraocular operation including any measurements and calculations associated with the procedure (Anaes.)(Assist.)	$713.75
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.)	$356.90
42676	Conjunctiva, biopsy of, as an independent procedure	$91.55

Item	Service	Fee ($)
42677	Conjunctiva, cautery of, including treatment of pannus each attendance at which treatment is given including any associated consultation (Anaes.)	$48.20
42680	Conjunctiva, cryotherapy to, for melanotic lesions or similar using CO^2 or N^20 (Anaes.)	$237.90
42683	Conjunctival cysts, removal of, requiring admission to hospital or approved day-hospital facility (Anaes.)	$95.15
42686	Pterygium, removal of (Anaes.)	$216.50
42689	Pinguecula, removal of, not being a service associated with the fitting of contact lenses (Anaes.)	$92.75
42692	Limbic tumour, removal of, excluding Pterygium (Anaes.)(Assist.)	$218.90
42695	Limbic tumour, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.)(Assist.)	$356.90
42698 Note T8.51	Lens extraction, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.)	$556.75
42701 Note T8.51	Artificial lens, insertion of, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.)	$310.45
42702 Note T8.51	Lens extraction and insertion of artificial lens, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.)	$712.00
42703 Note T8.51	Artificial lens, insertion of, into the posterior chamber and suture to the iris and sclera (Anaes.)(Assist.)	$452.50
42704 Note T8.51	Artificial lens, removal or repositioning of by open operation not being a service associated with a service to which item 42701 applies (Anaes.)	$368.70
42707 Note T8.51	Artificial lens, removal of and replacement with a different lens (Anaes.)	$630.50
42710	Artificial lens, removal of, and replacement with a lens inserted into the posterior chamber and sutured to the iris or sclera (Anaes.)(Assist.)	$713.75
42713	Intraocular lenses, repositioning of, by the use of a McCannell suture or similar (Anaes.)(Assist.)	$297.40
42716 Note T8.51	Cataract, juvenile, removal of, including subsequent needlings (Anaes.)(Assist.)	$945.75
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.)(Assist.)	$410.45

Item	Service	Fee ($)
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.)(Assist.)	$449.00
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.)(Assist.)	$1,058.75
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.)	$178.50
42731 Note T8.51	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.)(Assist.)	$1,201.45
42734 Note T8.51	Capsulotomy, other than by laser (Anaes.)(Assist.)	$237.90
42737	Needling of posterior capsule (Anaes.)(Assist.)	$237.90
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.)(Assist.)	$237.90
42743 Note T8.51	Anterior chamber, irrigation of blood from, as an independent procedure (Anaes.)(Assist.)	$499.70
42746 Note T8.51	Glaucoma, filtering operation for (Anaes.)(Assist.)	$755.40
42749	Glaucoma, filtering operation for, where previous filtering operation has been performed (Anaes.)(Assist.)	$945.75
42752	Glaucoma, insertion of Molteno valve for, 1 or more stages (Anaes.)(Assist.)	$1,058.75
42755	Glaucoma, removal of Molteno valve (Anaes.)	$130.90
42758	Goniotomy (Anaes.)(Assist.)	$553.25
42761 Note T8.51	Division of anterior or posterior synechiae, as an independent procedure, other than by laser (Anaes.)(Assist.)	$410.45
42764 Note T8.51	Iridectomy (including excision of tumour of iris) or iridotomy, as an independent procedure, other than by laser (Anaes.)(Assist.)	$410.45
42767 Note T8.51	Tumour, involving ciliary body or ciliary body and iris, excision of (Anaes.)(Assist.)	$862.45
42770 Note T8.52	Cyclodestructive procedures for the treatment of intractable glaucoma, treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.)(Assist.)	$233.20

Item	Service	Fee ($)
42771 Note T8.52	Cyclodestructive procedures for the treatment of intractable glaucoma, treatment to one eye - where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which 42770 applies) is indicated in a 2 year period (Anaes.)(Assist.)	$229.55
42773	Detached retina, diathermy or cryotherapy for, not being a service associated with a service to which item 42776 applies (Anaes.)(Assist.)	$713.75
42776	Detached retina, buckling or resection operation for (Anaes.)(Assist.)	$1,058.75
42779	Detached retina, revision operation for (Anaes.)(Assist.)	$1,320.50
42782 Note T8.53	Laser trabeculoplasty - each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.)(Assist.)	$356.90
42783 Note T8.53	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.)(Assist.)	$356.90
42785 Note T8.54	Laser iridotomy - each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.)(Assist.)	$279.55
42786 Note T8.54	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.)(Assist.)	$279.55
42788 Note T8.55	Laser capsulotomy - each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.)(Assist.)	$279.55
42789 Note T8.55	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.)(Assist.)	$279.55
42791 Note T8.56	Laser vitreolysis or corticolysis of lens material or fibrinolysis - each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.)(Assist.)	$279.55
42792 Note T8.56	Laser vitreolysis or corticolysis of lens material or fibrinolysis - each treatment to 1 eye - where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42791 applies) is indicated in a 2 year period (Anaes.)(Assist.)	$279.55
42794 Note T8.57	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.)	$53.50
42797 Note T8.58	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.)	$53.50
42806	Iris tumour, laser photocoagulation of (Anaes.)(Assist.)	$279.55
42807	Photomydriasis, laser	$281.45
42808	Photoiridosyneresis, laser	$281.45
42809	Retina, photocoagulation of (Anaes.)(Assist.)	$356.90

Item	Service	Fee ($)
42810	Phototherapeutic keratectomy, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.)	$449.05
42812	Detached retina, removal of encircling silicone band from (Anaes.)	$130.90
42815	Posterior chamber, removal of silicone oil from (Anaes.)(Assist.)	$499.70
42818	Retina, cryotherapy to, as an independent procedure, with external probe (Anaes.)	$463.85
42821	Retrobulbar transillumination, as an independent procedure (Anaes.)	$71.35
42824	Retrobulbar injection of alcohol or other drug, as an independent procedure	$55.30
42827	Botulinus toxin, injection of, for blepharospasm, including all such injections on any 1 day (Anaes.)	$35.65
42830	Botulinus toxin, injection of, for strabismus including all such injections on any 1 day and associated electromyography (Anaes.)	$123.75
42833	Squint, operation for, on 1 or both eyes, the operation involving a total of 1 or 2 muscles (Anaes.)(Assist.)	$463.85
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.)(Assist.)	$576.95
42839	Squint, operation for, on 1 or both eyes, the operation involving a total of 3 or more muscles (Anaes.)(Assist.)	$553.25
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.)(Assist.)	$690.00
42845 Note T8.59	Readjustment of adjustable sutures, 1 or both eyes, as an independent procedure following an operation for correction of squint (Anaes.)	$149.80
42848	Squint, muscle transplant for (Hummelsheim type, or similar operation) (Anaes.)(Assist.)	$553.25
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.)(Assist.)	$690.00
42854	Ruptured medial palpebral ligament or ruptured extraocular muscle, repair of (Anaes.)(Assist.)	$321.10
42857 Note T8.51	Resuturing of wound following intraocular procedures with or without excision of prolapsed iris (Anaes.)(Assist.)	$321.10
42860	Eyelid (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Anaes.)(Assist.)	$713.75
42863	Eyelid, recession of (Anaes.)(Assist.)	$612.65

Item	Service	Fee ($)
42866	Entropion or tarsal ectropion, repair of, by tightening, shortening or repair of inferior retractors by open operation across the entire width of the eyelid (Anaes.)(Assist.)	$594.80
42869	Eyelid closure in facial nerve paralysis, insertion of foreign implant for (Anaes.)(Assist.)	$434.25
42872	Eyebrow, elevation of, for paretic states (Anaes.)	$190.35
	Subgroup 10 - Operations For Osteomyelitis	
43500	Operation on phalanx (for acute osteomyelitis) (Anaes.)	$97.60
43503	Operation on sternum, clavicle, rib, ulna, radius, carpus, tibia, fibula, tarsus, skull, mandible or maxilla (other than alveolar margins) (for acute osteomyelitis) 1 bone (Anaes.)	$161.95
43506	Operation on humerus or femur (for acute osteomyelitis) 1 bone (Anaes.)(Assist.)	$281.90
43509	Operation on spine or pelvic bones (for acute osteomyelitis) 1 bone (Anaes.)(Assist.)	$281.90
43512	Operation on scapula, sternum, clavicle, rib, ulna, radius, metacarpus, carpus, phalanx, tibia, fibula, metatarsus, tarsus, mandible or maxilla (other than alveolar margins) (for chronic osteomyelitis) 1 bone or any combination of adjoining bones (Anaes.)(Assist.)	$281.90
43515	Operation on humerus or femur (for chronic osteomyelitis) 1 bone (Anaes.)(Assist.)	$281.90
43518	Operation on spine or pelvic bones (for chronic osteomyelitis) 1 bone (Anaes.)(Assist.)	$464.85
43521	Operation on skull (for chronic osteomyelitis) (Anaes.)(Assist.)	$367.40
43524	Operation on any combination of adjoining bones, being bones referred to in item 43515, 43518 or 43521 (for chronic osteomyelitis) (Anaes.)(Assist.)	$464.85
	Subgroup 11 - Paediatric	
43801	Intestinal malrotation with or without volvulus, laparotomy for, not involving bowel resection (Anaes.)(Assist.)	$757.20
43804	Intestinal malrotation with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Anaes.)(Assist.)	$806.25
43807	Duodenal atresia or stenosis, duodenoduodenostomy or duodenojejunostomy for (Anaes.)(Assist.)	$879.60
43810	Jejunal atresia, bowel resection and anastomosis for, with or without tapering (Anaes.)(Assist.)	$1,026.25
43813	Meconium ileus, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intestinal perforation with or without meconium peritonitis (Anaes.)(Assist.)	$1,026.25

Item	Service	Fee ($)
43816	Ileal atresia, colonic atresia or meconium ileus not being a service associated with a service to which item 43813 applies, laparotomy for (Anaes.)(Assist.)	$952.90
43819	Hirschsprung's disease, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes.)(Assist.)	$769.65
43822	Anorectal malformation, laparotomy and colostomy for (Anaes.)(Assist.)	$769.65
43825	Neonatal alimentary obstruction, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes.)(Assist.)	$879.60
43828	Acute neonatal necrotising enterocolitis, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes.)(Assist.)	$971.75
43831	Acute neonatal necrotising enterocolitis where no definitive procedure is possible, laparotomy for (Anaes.)(Assist.)	$757.20
43834	Bowel resection for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Anaes.)(Assist.)	$879.60
43837	Congenital diaphragmatic hernia, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Anaes.)(Assist.)	$1,099.45
43840	Congenital diaphragmatic hernia, repair by thoracic or abdominal approach, diagnosed after the first day of life and before 20 days of age (Anaes.)(Assist.)	$952.90
43843	Oesophageal atresia (with or without repair of tracheo-oesophageal fistula), complete correction of, not being a service to which item 43846 applies (Anaes.)(Assist.)	$1,465.95
43846	Oesophageal atresia (with or without repair of tracheo-oesophageal fistula), complete correction of, in infant of birth weight less than 1500 grams (Anaes.)(Assist.)	$1,575.85
43849	Oesophageal atresia, gastrostomy for (Anaes.)(Assist.)	$403.10
43852	Oesophageal atresia, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.)(Assist.)	$1,282.70
43855	Oesophageal atresia, delayed primary anastomosis for (Anaes.)(Assist.)	$1,356.05
43858	Oesophageal atresia, cervical oesophagostomy for (Anaes.)(Assist.)	$476.40
43861	Congenital cystadenomatoid malformation or congenital lobar emphysema, thoracotomy and lung resection for (Anaes.)(Assist.)	$1,319.40
43864	Gastroschisis, operation for (Anaes.)(Assist.)	$989.50
43867	Gastroschisis, secondary operation for, with removal of silo and closure of abdominal wall (Anaes.)(Assist.)	$549.75
43870	Exomphalos containing small bowel only, operation for (Anaes.)(Assist.)	$769.65
43873	Exomphalos containing small bowel and other viscera, operation for (Anaes.)(Assist.)	$1,026.25

Item	Service	Fee ($)
43876	Sacrococcygeal teratoma, excision of, by posterior approach (Anaes.)(Assist.)	$879.60
43879	Sacrococcygeal teratoma, excision of, by combined posterior and abdominal approach (Anaes.)(Assist.)	$1,026.25
43882	Cloacal exstrophy, operation for (Anaes.)(Assist.)	$1,319.40
43900	Tracheo-oesophageal fistula without atresia, division and repair of (Anaes.)(Assist.)	$879.60
43903	Oesophageal atresia or corrosive oesophageal stricture, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes.)(Assist.)	$1,465.95
43906	Oesophagus, resection of congenital, anastomic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Anaes.)(Assist.)	$1,282.70
43909	Tracheomalacia, aortopexy for (Anaes.)(Assist.)	$1,282.70
43912	Thoracotomy and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Anaes.)(Assist.)	$1,211.80
43915	Eventration, plication of diaphragm for (Anaes.)(Assist.)	$916.25
43930	Hypertrophic pyloric stenosis, pyloromyotomy for (Anaes.)(Assist.)	$352.35
43933	Idiopathic intussusception, laparotomy and manipulative reduction of (Anaes.)(Assist.)	$412.40
43936	Intussusception, laparotomy and resection with anastomosis (Anaes.)(Assist.)	$769.65
43939	Ventral hernia following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.)(Assist.)	$586.40
43942	Abdominal wall vitello intestinal remnant, excision of (Anaes.)	$183.30
43945	Patent vitello intestinal duct, excision of (Anaes.)(Assist.)	$769.65
43948	Umbilical granuloma, excision of, under general anaesthesia (Anaes.)	$110.00
43951	Gastro-oesophageal reflux with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Anaes.)(Assist.)	$689.20
43954	Gastro-oesophageal reflux with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes.)(Assist.)	$843.00
43957	Gastro-oesophageal reflux, laparotomy and fundoplication for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Anaes.)(Assist.)	$916.25
43960	Anorectal malformation, perineal anoplasty of (Anaes.)(Assist.)	$322.40
43963	Anorectal malformation, posterior sagittal anorectoplasty of (Anaes.)(Assist.)	$1,282.70
43966	Anorectal malformation, posterior sagittal anorectoplasty of, with laparotomy (Anaes.)(Assist.)	$1,465.95

Item	Service	Fee ($)
43969	Persistent cloaca, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Anaes.)(Assist.)	$2,015.75
43972	Choledochal cyst, resection of, with 1 duct anastomosis (Anaes.)(Assist.)	$1,465.95
43975	Choledochal cyst, resection of, with 2 duct anastomoses (Anaes.)(Assist.)	$1,722.55
43978	Biliary atresia, portoenterostomy for (Anaes.)(Assist.)	$1,465.95
43981	Nephroblastoma, neuroblastoma or other malignant tumour, laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.)(Assist.)	$403.10
43984	Nephroblastoma, radical nephrectomy for (Anaes.)(Assist.)	$1,026.25
43987	Neuroblastoma, radical excision of (Anaes.)(Assist.)	$1,136.20
43990	Hirschsprung's disease, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends to sigmoid colon (Anaes.)(Assist.)	$1,392.70
43993	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.)(Assist.)	$1,502.65
43996	Hirschsprung's disease, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolonic anastomosis (Anaes.)(Assist.)	$1,685.90
43999	Hirschsprung's disease, anal sphincterotomy as an independent procedure for (Anaes.)(Assist.)	$210.85
44102	Rectum, examination of, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.)(Assist.)	$203.25
44105	Rectal prolapse, submucosal or perirectal injection for, under general anaesthesia (Anaes.)	$35.70
44108	Inguinal hernia repair at age less than 3 months (Anaes.)(Assist.)	$388.75
44111	Obstructed or strangulated inguinal hernia, repair of, at age less than 3 months, including orchidopexy when performed (Anaes.)(Assist.)	$455.30
44114	Inguinal hernia repair at age less than 3 months when orchidopexy also required (Anaes.)(Assist.)	$455.30
44130	Lymphadenectomy, for atypical mycobacterial infection or other granulomatous disease (Anaes.)(Assist.)	$366.50
44133	Torticollis, open division of sternomastoid muscle for (Anaes.)(Assist.)	$290.90
44136	Ingrown toe nail, operation for, under general anaesthesia (Anaes.)	$134.05

Subgroup 12 - Amputations

Item	Service	Fee ($)
44325	Hand, midcarpal or transmetacarpal, amputation of (Anaes.)(Assist.)	$233.90
44328	Hand, forearm or through arm, amputation of (Anaes.)(Assist.)	$281.90
44331	Amputation at shoulder (Anaes.)(Assist.)	$464.85
44334	Interscapulothoracic amputation (Anaes.)(Assist.)	$944.70
44338	1 digit of foot, amputation of (Anaes.)	$113.95
44342	2 digits of 1 foot, amputation of (Anaes.)	$173.95
44346	3 digits of 1 foot, amputation of (Anaes.)(Assist.)	$200.90
44350	4 digits of 1 foot, amputation of (Anaes.)(Assist.)	$227.95
44354	5 digits of 1 foot, amputation of (Anaes.)(Assist.)	$260.90
44358	Toe, including metatarsal or part of metatarsal each toe, amputation of (Anaes.)	$145.45
44359	One or more toes of one foot, amputation of, including if performed, excision of 1 or more metatarsal bones of the foot, performed for diabetic or other microvascular disease, excluding aftercare (Anaes.)(Assist.)	$208.75
44361	Foot at ankle (Syme, Pirogoff types), amputation of (Anaes.)(Assist.)	$281.90
44364	Foot, midtarsal or transmetatarsal, amputation of (Anaes.)(Assist.)	$233.90
44367list43972_45503	Amputation through thigh, at knee or below knee (Anaes.)(Assist.)	$412.80
44370	Amputation at hip (Anaes.)(Assist.)	$569.70
44373	Hindquarter, amputation of (Anaes.)(Assist.)	$1,169.45
44376	Amputation stump, reamputation of, to provide adequate skin and muscle cover(Assist.)	Derived Fee
	Subgroup 13 - Plastic And Reconstructive Surgery	
45000	Single stage local muscle flap repair, on eyelid, nose, lip, neck, hand, thumb, finger or genitals (Anaes.)	$428.25
45003	Single stage local myocutaneous flap repair to 1 defect, simple and small (Anaes.)	$475.85
45006	Single stage large myocutaneous flap repair to 1 defect, (pectoralis major, latissimus dorsi, or similar large muscle) (Anaes.)(Assist.)	$820.85
45009	Single stage local muscle flap repair to 1 defect, simple and small (Anaes.)(Assist.)	$299.85
45012 Note T8.67	Single stage large muscle flap repair to 1 defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle) (Anaes.)(Assist.)	$502.25
45015	Muscle or myocutaneous flap, delay of (Anaes.)	$237.90

Item	Service	Fee ($)
45018	Dermis, dermofat or fascia graft (excluding transfer of fat by injection) (Anaes.)(Assist.)	$374.70
45019 Note T8.60	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.)	$313.75
45020 Note T8.60	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.)	$313.75
45021 Note T8.61	Abrasive therapy for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.)	$140.35
45024 Note T8.61	Abrasive therapy for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.)	$315.20
45025 Note T8.61	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.)	$140.35
45026 Note T8.61	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.)	$315.20
45027	Angioma, cauterisation of or injection into, where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.)	$95.15
45030 Note T8.64	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.)	$102.25
45033 Note T8.64	Angioma (haemangioma or lymphangioma or both), large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes.)	$190.35
45035	Angioma (haemangioma or lymphangioma or both) large and deep, involving muscles or nerves, excision of (Anaes.)(Assist.)	$555.30
45036 Note T8.64	Angioma (haemangioma or lymphangioma or both) of neck, deep, excision of (Anaes.)(Assist.)	$892.25
45039 Note T8.64	Arteriovenous malformation (3 cms or less) of superficial tissue, excision of (Anaes.)	$190.35
45042 Note T8.64	Arteriovenous malformation, (greater than 3 cms), excision of (Anaes.)(Assist.)	$243.90

Item	Service	Fee ($)
45045 Note T8.64	Arteriovenous malformation on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.)	$243.90
45048	Lymphoedematous tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (Anaes.)(Assist.)	$612.65
45051 Note T8.62	Contour reconstruction for pathological deformity, insertion of foreign implant (non biological but excluding injection of liquid or semisolid material) by open operation (Anaes.)(Assist.)	$374.80
45054 Note T8.63	Limb or chest, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Anaes.)(Assist.)	$194.60
45200 Note T8.64	Single stage local flap, where indicated to repair 1 defect, simple and small, excluding flap for male pattern baldness (Anaes.)	$224.95
45203 Note T8.64	Single stage local flap, where indicated to repair 1 defect, complicated or large, excluding flap for male pattern baldness (Anaes.)(Assist.)	$321.10
45206 Note T8.64	Single stage local flap where indicated to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals (Anaes.)	$303.40
45209	Direct flap repair (cross arm, abdominal or similar), first stage (Anaes.)(Assist.)	$374.80
45212	Direct flap repair (cross arm, abdominal or similar), second stage (Anaes.)	$185.95
45215	Direct flap repair, cross leg, first stage (Anaes.)(Assist.)	$802.15
45218	Direct flap repair, cross leg, second stage (Anaes.)(Assist.)	$359.80
45221	Direct flap repair, small (cross finger or similar), first stage (Anaes.)	$206.85
45224	Direct flap repair, small (cross finger or similar), second stage (Anaes.)	$92.95
45227	Indirect flap or tubed pedicle, formation of (Anaes.)(Assist.)	$352.35
45230	Direct or indirect flap or tubed pedicle, delay of (Anaes.)	$176.10
45233	Indirect flap or tubed pedicle, preparation of intermediate or final site and attachment to the site (Anaes.)(Assist.)	$374.80
45236	Indirect flap or tubed pedicle, spreading of pedicle, as a separate procedure (Anaes.)	$293.85
45239	Direct, indirect or local flap, revision of (Anaes.)	$206.85
45400	Free grafting (split skin) of a granulating area, small (Anaes.)	$161.95
45403	Free grafting (split skin) of a granulating area, extensive (Anaes.)(Assist.)	$322.40
45406 Note T8.65	Free grafting (split skin) to burns, including excision of burnt tissue - involving not more than 3% of total body surface (Anaes.)(Assist.)	$356.90
45409 Note T8.65	Free grafting (split skin) to burns, including excision of burnt tissue - involving 3% or more but less than 6% of total body surface (Anaes.)(Assist.)	$475.85

Item	Service	Fee ($)
45412 Note T8.65	Free grafting (split skin) to burns, including excision of burnt tissue - involving 6% or more but less than 9% of total body surface (Anaes.)(Assist.)	$654.35
45415 Note T8.65	Free grafting (split skin) to burns, including excision of burnt tissue - involving 9% or more but less than 12% of total body surface (Anaes.)(Assist.)	$713.75
45418 Note T8.65	Free grafting (split skin) to burns, including excision of burnt tissue - involving 12% or more but less than 15 per cent of total body surface (Anaes.)(Assist.)	$773.25
45439	Free grafting (split skin) to 1 defect, including elective dissection, small (Anaes.)	$224.95
45442	Free grafting (split skin) to 1 defect, including elective dissection, extensive (Anaes.)(Assist.)	$463.85
45445	Free grafting (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of and removal of mould) (Anaes.)(Assist.)	$440.30
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.)	$297.40
45451	Free grafting (full thickness) to 1 defect, excluding grafts for male pattern baldness (Anaes.)(Assist.)	$374.80
45460	Free grafting (split skin) to burns, including excision of burnt tissue - involving 15 percent or more but less than 20 percent of total body surface - one surgeon (Anaes.)(Assist.)	$991.40
45461	Free grafting (split skin) to burns, including excision of burnt tissue - involving 15 percent or more but less than 20 percent of total body surface - conjoint surgery, principal surgeon (Anaes.)(Assist.)	$706.55
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.)	$533.25
45464	Free grafting (split skin) to burns, including excision of burnt tissue - involving 20 percent or more but less than 30 percent of total body surface - one surgeon (Anaes.)(Assist.)	$1,513.25
45465	Free grafting (split skin) to burns, including excision of burnt tissue - involving 20 percent or more but less than 30 percent of total body surface - conjoint surgery, principal surgeon (Anaes.)(Assist.)	$1,078.10
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.)	$813.00
45468	Free grafting (split skin) to burns, including excision of burnt tissue - involving 30 percent or more but less than 40 percent of total body surface - conjoint surgery, principal surgeon (Anaes.)(Assist.)	$1,449.60

Item	Service	Fee ($)
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.)	$1,093.65
45471	Free grafting (split skin) to burns, including excision of burnt tissue - involving 40 percent or more but less than 50 percent of total body surface - conjoint surgery, principal surgeon (Anaes.)(Assist.)	$1,822.15
45472	Free grafting (split skin) to burns, including excision of burnt tissue - involving 40 percent or more but less than 50 percent of total body surface - conjoint surgery, co-surgeon(Assist.)	$1,374.45
45474	Free grafting (split skin) to burns, including excision of burnt tissue - involving 50 percent or more but less than 60 percent of total body surface - conjoint surgery, principal surgeon (Anaes.)(Assist.)	$2,193.70
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.)	$1,655.15
45477	Free grafting (split skin) to burns, including excision of burnt tissue - involving 60 percent or more but less than 70 percent of total body surface - conjoint surgery, principal surgeon (Anaes.)(Assist.)	$2,565.20
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.)	$1,934.85
45480	Free grafting (split skin) to burns, including excision of burnt tissue - involving 70 percent or more but less than 80 percent of total body surface - conjoint surgery, principal surgeon (Anaes.)(Assist.)	$2,936.70
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.)	$2,215.60
45483	Free grafting (split skin) to burns, including excision of burnt tissue - involving 80 percent or more of total body surface - conjoint surgery, principal surgeon (Anaes.)(Assist.)	$3,345.85
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.)	$2,524.50
45485	Free grafting (split skin) to burns, including excision of burnt tissue - upper eyelid, nose, lip, ear or palm of the hand (Anaes.)(Assist.)	$417.40
45486	Free grafting (split skin) to burns, including excision of burnt tissue - forehead, cheek, anterior aspect of the neck, chin, plantar aspect of the foot, heel or genitalia (Anaes.)(Assist.)	$356.90
45487	Free grafting (split skin) to burns, including excision of burnt tissue - whole of toe (Anaes.)(Assist.)	$321.10
45488	Free grafting (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the hand (Anaes.)(Assist.)	$356.90

Item	Service	Fee ($)
45489	Free grafting (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the hand (Anaes.)(Assist.)	$535.40
45490	Free grafting (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the hand (Anaes.)(Assist.)	$713.85
45491	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the hand (Anaes.)(Assist.)	$892.25
45492	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the hand (Anaes.)(Assist.)	$1,070.75
45493	Free grafting (split skin) to burns, including excision of burnt tissue - portion of digit of hand (Anaes.)(Assist.)	$321.10
45494	Free grafting (split skin) to burns, including excision of burnt tissue - whole of face (excluding ears) (Anaes.)(Assist.)	$1,296.20
45496	Flap, free tissue transfer using microvascular techniques - revision of, by open operation (Anaes.)	$329.05
45497	Flap, free tissue transfer using microvascular techniques - complete revision of, by liposuction (Anaes.)	$257.05
45498	Flap, free tissue transfer using microvascular techniques - staged revision of, by liposuction - first stage (Anaes.)	$206.85
45499	Flap, free tissue transfer using microvascular techniques - staged revision of, by liposuction - second stage (Anaes.)	$154.25
45500	Microvascular repair using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.)(Assist.)	$862.45
45501	Microvascular anastomosis of artery using microsurgical techniques, for re-implantation of limb or digit (Anaes.)(Assist.)	$1,403.85
45502	Microvascular anastomosis of vein using microsurgical techniques, for re-implantation of limb or digit (Anaes.)(Assist.)	$1,403.85
45503	Micro-arterial or micro-venous graft using microsurgical techniques (Anaes.)(Assist.)	$1,606.05
45504	Microvascular anastomosis of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.)(Assist.)	$1,403.85
45505	Microvascular anastomosis of vein using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.)(Assist.)	$1,403.85
45506 Note T8.64	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.)	$173.95

Item	Service	Fee ($)
45512 Note T8.64	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.)	$233.90
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.)	$147.50
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.)	$178.50
45519	Extensive burn scars of skin (more than 1 percent of body surface area), excision of, for correction of scar contracture (Anaes.)(Assist.)	$339.35
45520 Note T8.64	Reduction mammaplasty (unilateral) with surgical repositioning of nipple (Anaes.)(Assist.)	$712.25
45522 Note T8.64	Reduction mammaplasty (unilateral) without surgical repositioning of nipple (Anaes.)(Assist.)	$499.70
45524 Note T8.64 Note T8.66	Mammaplasty, augmentation, for significant breast asymmetry where the augmentation is limited to 1 breast (Anaes.)(Assist.)	$586.65
45527 Note T8.16 Note T8.66 Note T8.67	Mammaplasty, augmentation, (unilateral), following mastectomy (Anaes.)(Assist.)	$586.65
45528 Note T8.66	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 of the breast (Anaes.)(Assist.)	$879.90
45530 Note T8.67	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.)(Assist.)	$869.60
45533	Breast reconstruction using breast sharing technique (first stage) including breast reduction, transfer of complex skin and breast tissue flap, split skin graft to pedicle of flap or other similar procedure (Anaes.)(Assist.)	$984.85
45536	Breast reconstruction using breast sharing technique (second stage) including division of pedicle, insetting of breast flap, with closure of donor site or other similar procedure (Anaes.)(Assist.)	$362.15
45539	Breast reconstruction (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.)(Assist.)	$847.35
45542	Breast reconstruction (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (Anaes.)(Assist.)	$485.15

Item	Service	Fee ($)
45545 Note T8.67 Note T8.69	Nipple or areola or both, reconstruction of, by any surgical technique (Anaes.)(Assist.)	$492.45
45546 Note T8.69	Nipple or areola or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple	$156.55
45548	Breast prosthesis, removal of, as an independent procedure (Anaes.)	$218.90
45551	Breast prosthesis, removal of, with complete excision of fibrous capsule (Anaes.)(Assist.)	$350.95
45552	Breast prosthesis, removal of, with complete excision of fibrous capsule and replacement of prosthesis (Anaes.)(Assist.)	$505.20
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.)(Assist.)	$553.25
45555list45504_45782	Silicone breast prosthesis, removal of and replacement with prosthesis other than silicone gel prosthesis (Anaes.)(Assist.)	$505.20
45556 Note T8.68	Breast ptosis, correction of (unilateral), to match the position of the contralateral breast (Anaes.)(Assist.)	$605.90
45557 Note T8.68	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.)(Assist.)	$605.90
45558 Note T8.68	Breast ptosis, correction of (bilateral), 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.)(Assist.)	$908.85
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.)	$374.70
45562	Free transfer of tissue involving raising of tissue on vascular or neurovascular pedicle, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.)(Assist.)	$869.60
45563 Note T8.64	Neurovascular island flap, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.)(Assist.)	$869.60
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.)(Assist.)	$2,014.10

Item	Service	Fee ($)
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.)	$1,510.65
45566	Tissue expansion not being a service to which item 45539 or 45542 applies - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.)(Assist.)	$847.35
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.)	$230.80
45575	Facial nerve paralysis, free fascia graft for (Anaes.)(Assist.)	$569.70
45578	Facial nerve paralysis, muscle transfer for (Anaes.)(Assist.)	$659.80
45581	Facial nerve palsy, excision of tissue for (Anaes.)	$218.90
45584 Note T8.11 Note T8.70	Liposuction (suction assisted lipolysis) to 1 regional area (thigh, buttock, or similar), for treatment of post-traumatic pseudolipoma (Anaes.)	$499.70
45585 Note T8.11 Note T8.70	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.)	$499.70
45587 Note T8.64 Note T8.71	Meloplasty for correction of facial asymmetry due to soft tissue abnormality where the meloplasty is limited to 1 side of the face (Anaes.)(Assist.)	$704.70
45588 Note T8.71	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.)(Assist.)	$1,057.05
45590	Orbital cavity, reconstruction of a wall or floor, with or without foreign implant (Anaes.)(Assist.)	$382.25
45593	Orbital cavity, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.)(Assist.)	$449.00
45596	Maxilla, total resection of (Anaes.)(Assist.)	$712.25
45597	Maxilla, total resection of both maxillae (Anaes.)(Assist.)	$953.40
45599	Mandible, total resection of both sides, including condylectomies where performed (Anaes.)(Assist.)	$740.85
45602	Mandible, including lower border, or maxilla, sub-total resection of (Anaes.)(Assist.)	$553.25

Item	Service	Fee ($)
45605	Mandible or maxilla, segmental resection of, for tumours or cysts (Anaes.)(Assist.)	$464.85
45608	Mandible, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Anaes.)(Assist.)	$654.35
45611	Mandible, condylectomy (Anaes.)(Assist.)	$374.80
45614	Eyelid, whole thickness reconstruction of, other than by direct suture only (Anaes.)(Assist.)	$464.85
45617 Note T8.72	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.)	$185.95
45620 Note T8.72	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.)	$257.85
45623	Ptosis of eyelid (unilateral), correction of (Anaes.)(Assist.)	$572.00
45624	Ptosis of eyelid, correction of, where previous ptosis surgery has been performed on that side (Anaes.)(Assist.)	$741.50
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.)	$148.35
45626 Note T8.64	Ectropion or entropion, correction of (unilateral) (Anaes.)	$257.85
45629	Symblepharon, grafting for (Anaes.)(Assist.)	$374.80
45632 Note T8.64	Rhinoplasty, correction of lateral or alar cartilages (Anaes.)	$404.90
45635 Note T8.64	Rhinoplasty, correction of bony vault only (Anaes.)	$464.85
45638 Note T8.64 Note T8.73	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.)	$802.15
45639 Note T8.64 Note T8.73	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.)	$802.15
45641 Note T8.64	Rhinoplasty involving nasal or septal cartilage graft, or nasal bone graft, or nasal bone and nasal cartilage graft (Anaes.)	$856.55
45644 Note T8.64	Rhinoplasty involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft (Anaes.)(Assist.)	$1,012.05
45645	Choanal atresia, repair of by puncture and dilatation (Anaes.)	$176.90

Item	Service	Fee ($)
45646	Choanal atresia, correction by open operation with bone removal (Anaes.)(Assist.)	$712.25
45647	Face, contour restoration of 1 region, using autogenous bone or cartilage graft (not being a service to which item 45644 applies) (Anaes.)(Assist.)	$1,012.05
45650	Rhinoplasty, secondary revision of (Anaes.)	$116.95
45652	Rhinophyma, carbon dioxide laser or erbium laser excision-ablation of (Anaes.)	$281.90
45653	Rhinophyma, shaving of (Anaes.)	$281.90
45656	Composite graft (chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.)(Assist.)	$397.30
45659 Note T8.64	Lop ear, bat ear or similar deformity, correction of (Anaes.)	$412.30
45660	External ear, complex total reconstruction of, using multiple costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - performed by a specialist in the practice of his or her specialty (Anaes.)(Assist.)	$2,277.10
45661	External ear, complex total reconstruction of, elevation of costal cartilage framework using cartilage previously stored in abdominal wall, including the use of local skin and fascia flaps and full thickness skin graft to cover cartilage (second stage) - performed by a specialist in the practice of his or her specialty (Anaes.)(Assist.)	$1,012.05
45662 Note T8.64	Congenital atresia, reconstruction of external auditory canal (Anaes.)(Assist.)	$554.70
45665	Lip, eyelid or ear, full thickness wedge excision of, with repair by direct sutures (Anaes.)	$257.85
45668	Vermilionectomy, by surgical excision (Anaes.)	$257.85
45669 Note T8.74	Vermilionectomy, using carbon dioxide laser or erbium laser excision-ablation (Anaes.)	$257.85
45671	Lip or eyelid reconstruction using full thickness flap (Abbe or similar), first stage (Anaes.)(Assist.)	$659.80
45674	Lip or eyelid reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.)	$191.90
45675	Macrocheilia or macroglossia, operation for (Anaes.)(Assist.)	$382.25
45676	Macrostomia, operation for (Anaes.)(Assist.)	$455.05
45677 Note T8.64	Cleft lip, unilateral primary repair, 1 stage, without anterior palate repair (Anaes.)(Assist.)	$428.25
45680 Note T8.64	Cleft lip, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.)(Assist.)	$535.40

Item	Service	Fee ($)
45683 Note T8.64	Cleft lip, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.)(Assist.)	$594.80
45686 Note T8.64	Cleft lip, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.)(Assist.)	$701.95
45689 Note T8.64	Cleft lip, lip adhesion procedure, unilateral or bilateral (Anaes.)(Assist.)	$207.00
45692 Note T8.64	Cleft lip, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.)	$237.90
45695 Note T8.64	Cleft lip, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.)(Assist.)	$386.60
45698 Note T8.64	Cleft lip, primary columella lengthening procedure, bilateral (Anaes.)	$362.85
45701 Note T8.64	Cleft lip reconstruction using full thickness flap (Abbe or similar), first stage (Anaes.)(Assist.)	$654.35
45704 Note T8.64	Cleft lip reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.)	$237.90
45707 Note T8.64	Cleft palate, primary repair (Anaes.)(Assist.)	$618.55
45710 Note T8.64	Cleft palate, secondary repair, closure of fistula using local flaps (Anaes.)	$386.60
45713 Note T8.64	Cleft palate, secondary repair, lengthening procedure (Anaes.)(Assist.)	$440.30
45714	Oro-nasal fistula, plastic closure of, including services to which item 45200, 45203 or 45239 applies (Anaes.)(Assist.)	$618.55
45716	Velo-pharyngeal incompetence, pharyngeal flap for, or pharyngoplasty for (Anaes.)	$618.55
45720 Note T8.75	Mandible or maxilla, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.)(Assist.)	$764.75
45723 Note T8.75	Mandible or maxilla, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.)(Assist.)	$862.45
45726 Note T8.75	Mandible or maxilla, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.)(Assist.)	$974.60
45729 Note T8.75	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.)(Assist.)	$1,094.45

Item	Service	Fee ($)
45731 Note T8.75	Mandible or maxilla, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.)(Assist.)	$1,109.50
45732 Note T8.75	Mandible or maxilla, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.)(Assist.)	$1,249.15
45735 Note T8.75	Mandible and maxilla, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.)(Assist.)	$1,274.35
45738 Note T8.75	Mandible and maxilla, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.)(Assist.)	$1,433.55
45741 Note T8.75	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.)(Assist.)	$1,401.90
45744 Note T8.75	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.)(Assist.)	$1,576.20
45747 Note T8.75	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty (when performed) and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.)(Assist.)	$1,529.40
45752 Note T8.75	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.)(Assist.)	$1,713.10
45753	Midfacial osteotomies - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.)(Assist.)	$1,723.35
45754	Midfacial osteotomies - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.)(Assist.)	$2,065.75
45755	Temporomandibular meniscectomy (Anaes.)(Assist.)	$290.90
45758	Temporo-mandibular joint, arthroplasty (Anaes.)(Assist.)	$520.55

Item	Service	Fee ($)
45761 Note T8.76	Genioplasty, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.)(Assist.)	$592.20
45767	Hypertelorism, correction of, intracranial (Anaes.)(Assist.)	$1,986.70
45770	Hypertelorism, correction of, subcranial (Anaes.)(Assist.)	$1,521.80
45773	Treacher Collins Syndrome, periorbital correction of, with rib and iliac bone grafts (Anaes.)(Assist.)	$1,386.95
45776	Orbital dystopia (unilateral), correction of, with total repositioning of 1 orbit, intracranial (Anaes.)(Assist.)	$1,386.95
45779	Orbital dystopia (unilateral), correction of, with total repositioning of 1 orbit, extracranial (Anaes.)(Assist.)	$1,019.60
45782	Frontoorbital advancement, unilateral (Anaes.)(Assist.)	$779.70
45785	Cranial vault reconstruction for oxycephaly, brachycephaly, turricephaly or similar condition (bilateral fronto-orbital advancement) (Anaes.)(Assist.)	$1,319.45
45788	Glenoid fossa, zygomatic arch and temporal bone, reconstruction of, (Obwegeser technique) (Anaes.)(Assist.)	$1,304.40
45791	Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.)(Assist.)	$704.70
45794	Osseo-integration procedure - extra-oral, implantation of titanium fixture (Anaes.)	$398.60
45797	Osseo-integration procedure, fixation of transcutaneous abutment (Anaes.)	$147.50
	Subgroup 14 - Hand Surgery	
46300	Inter-phalangeal joint or metacarpophalangeal joint, arthrodesis of (Anaes.)(Assist.)	$267.65
46303	Carpometacarpal joint, arthrodesis of (Anaes.)(Assist.)	$297.50
46306	Inter-phalangeal joint or metacarpophalangeal joint - interposition arthroplasty of and including tendon transfers or realignment on the 1 ray (Anaes.)(Assist.)	$416.45
46307	Interphalangeal joint or metacarpophalangeal joint - volar plate arthroplasty for traumatic deformity including tendon transfers or realignment on the 1 ray (Anaes.)(Assist.)	$416.45
46309	Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 1 joint (Anaes.)(Assist.)	$416.45
46312	Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 2 joints (Anaes.)(Assist.)	$535.50

Item	Service	Fee ($)
46315	Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 3 joints (Anaes.)(Assist.)	$713.90
46318	Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 4 joints (Anaes.)(Assist.)	$892.45
46321	Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 5 or more joints (Anaes.)(Assist.)	$1,070.95
46324	Carpal bone replacement arthroplasty including associated tendon transfer or realignment when performed (Anaes.)(Assist.)	$638.65
46325	Carpal bone replacement or resection arthroplasty using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed (Anaes.)(Assist.)	$666.40
46327	Inter-phalangeal joint or metacarpophalangeal joint, arthrotomy of (Anaes.)	$160.75
46330	Inter-phalangeal joint or metacarpophalangeal joint, arthrotomy of, with ligamentous or capsular repair (Anaes.)(Assist.)	$273.75
46333	Inter-phalangeal joint or metacarpophalangeal joint, ligamentous repair of, using free tissue graft or implant (Anaes.)(Assist.)	$446.20
46336	Inter-phalangeal joint or metacarpophalangeal joint, synovectomy, capsulectomy or debridement of, not being a service associated with any other procedure related to that joint (Anaes.)(Assist.)	$208.30
46339	Extensor tendons or flexor tendons of hand or wrist, synovectomy of (Anaes.)(Assist.)	$368.80
46342	Distal radioulnar joint or carpometacarpal joint or joints, synovectomy of (Anaes.)(Assist.)	$368.80
46345	Distal radioulnar joint, reconstruction or stabilisation of, including fusion, or ligamentous arthroplasty and excision of distal ulna, when performed (Anaes.)(Assist.)	$446.20
46348	Digit, synovectomy of flexor tendon or tendons - 1 digit (Anaes.)	$193.35
46351	Digit, synovectomy of flexor tendon or tendons - 2 digits (Anaes.)(Assist.)	$288.55
46354	Digit, synovectomy of flexor tendon or tendons - 3 digits (Anaes.)(Assist.)	$386.70
46357	Digit, synovectomy of flexor tendon or tendons - 4 digits (Anaes.)(Assist.)	$481.90
46360	Digit, synovectomy of flexor tendon or tendons - 5 digits (Anaes.)(Assist.)	$580.05
46363	Tendon sheath of hand or wrist, open operation on, for stenosing tenovaginitis (Anaes.)	$166.60
46366	Dupuytren's contracture, subcutaneous fasciotomy for - each band (Anaes.)	$101.15

Item	Service	Fee ($)
46369	Dupuytren's contracture, palmar fasciectomy for - 1 hand (Anaes.)	$166.60
46372	Dupuytren's contracture, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand (Anaes.)(Assist.)	$338.50
46375	Dupuytren's contracture, fasciectomy for, from 2 rays, including dissection of nerves - 1 hand (Anaes.)(Assist.)	$401.60
46378	Dupuytren's contracture, fasciectomy for, from 3 or more rays, including dissection of nerves - 1 hand (Anaes.)(Assist.)	$535.50
46381	Inter-phalangeal joint, joint capsule release when performed in conjunction with operation for Dupuytren's contracture - each procedure (Anaes.)(Assist.)	$237.95
46384	Z plasty (or similar local flap procedure) when performed in conjunction with operation for Dupuytren's contracture - 1 such procedure (Anaes.)(Assist.)	$237.95
46387	Dupuytren's contracture, fasciectomy for, from 1 ray, including dissection of nerves - operation for recurrence in that ray (Anaes.)(Assist.)	$490.85
46390	Dupuytren's contracture, fasciectomy for, from 2 rays, including dissection of nerves - operation for recurrence in those rays (Anaes.)(Assist.)	$654.50
46393	Dupuytren's contracture, fasciectomy for, from 3 or more rays, including dissection of nerves - operation for recurrence in those rays (Anaes.)(Assist.)	$758.55
46396	Phalanx or metacarpal of the hand, osteotomy or osteectomy of (Anaes.)(Assist.)	$260.70
46399	Phalanx or metacarpal of the hand, osteotomy of, with internal fixation (Anaes.)(Assist.)	$409.60
46402	Phalanx or metacarpal, bone grafting of, for pseudarthrosis (non-union), including obtaining of graft material (Anaes.)(Assist.)	$409.60
46405	Phalanx or metacarpal, bone grafting of, for pseudarthrosis (non-union), involving internal fixation and including obtaining of graft material (Anaes.)(Assist.)	$499.80
46408	Tendon, reconstruction of, by tendon graft (Anaes.)(Assist.)	$547.35
46411	Flexor tendon pulley, reconstruction of, by graft (Anaes.)(Assist.)	$321.20
46414	Artificial tendon prosthesis, insertion of in preparation for tendon grafting (Anaes.)(Assist.)	$416.35
46417	Tendon transfer for restoration of hand function, each transfer (Anaes.)(Assist.)	$386.70
46420	Extensor tendon of hand or wrist, primary repair of, each tendon (Anaes.)	$161.85
46423	Extensor tendon of hand or wrist, secondary repair of, each tendon (Anaes.)(Assist.)	$258.80
46426	Flexor tendon of hand or wrist, primary repair of, proximal to A1 pulley, each tendon (Anaes.)(Assist.)	$267.65

Item	Service	Fee ($)
46429	Flexor tendon of hand or wrist, secondary repair of, proximal to A1 pulley, each tendon (Anaes.)(Assist.)	$327.20
46432	Flexor tendon of hand, primary repair of, distal to A1 pulley, each tendon (Anaes.)(Assist.)	$357.00
46435	Flexor tendon of hand, secondary repair of, distal to A1 pulley, each tendon (Anaes.)(Assist.)	$416.45
46438	Mallet finger, closed pin fixation of (Anaes.)	$107.10
46441	Mallet finger, open repair of, including pin fixation when performed (Anaes.)(Assist.)	$258.80
46442	Mallet finger with intra-articular fracture involving more than one-third of base of terminal phalanx - open reduction (Anaes.)(Assist.)	$222.15
46444	Boutonniere deformity without joint contracture, reconstruction of (Anaes.)(Assist.)	$386.70
46447	Boutonniere deformity with joint contracture, reconstruction of (Anaes.)(Assist.)	$481.90
46450	Extensor tendon, tenolysis of, following tendon injury, repair or graft (Anaes.)	$178.50
46453	Flexor tendon, tenolysis of, following tendon injury, repair or graft (Anaes.)(Assist.)	$297.50
46456	Finger, percutaneous tenotomy of (Anaes.)	$77.30
46459	Operation for osteomyelitis on distal phalanx (Anaes.)	$148.80
46462	Operation for osteomyelitis on middle or proximal phalanx, metacarpal or carpus (Anaes.)(Assist.)	$237.95
46464	Amputation of a supernumerary complete digit (Anaes.)	$178.50
46465	Amputation of single digit, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.)	$178.50
46468	Amputation of 2 digits, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.)(Assist.)	$312.35
46471	Amputation of 3 digits, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.)(Assist.)	$446.20
46474	Amputation of 4 digits, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.)(Assist.)	$580.05
46477	Amputation of 5 digits, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.)(Assist.)	$713.90
46480	Amputation of single digit, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover, including metacarpal (Anaes.)(Assist.)	$297.50

Item	Service	Fee ($)
46483	Revision of amputation stump to provide adequate soft tissue cover (Anaes.)(Assist.)	$237.95
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.)	$178.50
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.)(Assist.)	$208.30
46492	Contracture of digits of hand, flexor or extensor, correction of, involving tissues deeper than skin and subcutaneous tissue (Anaes.)(Assist.)	$285.60
46494	Ganglion of hand, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.)	$173.95
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.)	$160.75
46498	Ganglion of flexor tendon sheath, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.)	$173.95
46500	Ganglion of dorsal wrist joint, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.)(Assist.)	$208.30
46501	Ganglion of volar wrist joint, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.)(Assist.)	$260.35
46502	Recurrent ganglion of dorsal wrist joint, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.)(Assist.)	$239.55
46503	Recurrent ganglion of volar wrist joint, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.)(Assist.)	$299.30
46504	Neurovascular island flap, for pulp innervation (Anaes.)(Assist.)	$874.55
46507	Digit or ray, transposition or transfer of, on vascular pedicle, complete procedure (Anaes.)(Assist.)	$1,017.30
46510	Macrodactyly, surgical reduction of enlarged elements - each digit (Anaes.)(Assist.)	$277.65
46513	Digital nail of finger or thumb, removal of, not being a service to which item 46516 applies (Anaes.)	$44.70
46516	Digital nail of finger or thumb, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes.)	$89.30
46519	Middle palmar, thenar or hypothenar spaces of hand, drainage of (excluding aftercare) (Anaes.)	$111.75

Item	Service	Fee ($)
46522	Flexor tendon sheath of finger or thumb - open operation and drainage for infection (Anaes.)(Assist.)	$333.15
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.)	$44.70
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.)	$134.05
46531	Ingrowing nail of finger or thumb, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.)	$67.30
46534	Nail plate injury or deformity, radical excision of nail germinal matrix (Anaes.)	$186.25
	THERAPEUTIC PROCEDURES	
	GROUP T8 - SURGICAL OPERATIONS	
	Subgroup 15 - Orthopaedic	
47000	Mandible, treatment of dislocation of, by closed reduction (Anaes.)	$55.90
47003	Clavicle, treatment of dislocation of, by closed reduction (Anaes.)	$67.00
47006	Clavicle, treatment of dislocation of, by open reduction (Anaes.)	$134.70
47009	Shoulder, treatment of dislocation of, requiring general anaesthesia, not being a service to which item 47012 applies (Anaes.)	$134.05
47012	Shoulder, treatment of dislocation of, requiring general anaesthesia, open reduction (Anaes.)(Assist.)	$268.10
47015	Shoulder, treatment of dislocation of, not requiring general anaesthesia	$67.00
47018	Elbow, treatment of dislocation of, by closed reduction (Anaes.)	$156.30
47021	Elbow, treatment of dislocation of, by open reduction (Anaes.)(Assist.)	$208.55
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.)	$156.30
47027	Radioulnar joint, distal or proximal, treatment of dislocation of, by open reduction, not being a service associated with fracture or dislocation in the same region (Anaes.)(Assist.)	$208.55
47030	Carpus, or carpus on radius and ulna, or carpometacarpal joint, treatment of dislocation of, by closed reduction (Anaes.)	$156.30
47033	Carpus, or carpus on radius and ulna, or carpometacarpal joint, treatment of dislocation of, by open reduction (Anaes.)(Assist.)	$208.55
47036	Interphalangeal joint, treatment of dislocation of, by closed reduction (Anaes.)	$67.00

Item	Service	Fee ($)
47039	Interphalangeal joint, treatment of dislocation of, by open reduction (Anaes.)	$89.30
47042	Metacarpophalangeal joint, treatment of dislocation of, by closed reduction (Anaes.)	$89.30
47045	Metacarpophalangeal joint, treatment of dislocation of, by open reduction (Anaes.)	$119.20
47048	Hip, treatment of dislocation of, by closed reduction (Anaes.)	$256.95
47051	Hip, treatment of dislocation of, by open reduction (Anaes.)(Assist.)	$342.50
47054	Knee, treatment of dislocation of, by closed reduction (Anaes.)(Assist.)	$256.95
47057	Patella, treatment of dislocation of, by closed reduction (Anaes.)	$100.50
47060	Patella, treatment of dislocation of, by open reduction (Anaes.)	$134.05
47063	Ankle or tarsus, treatment of dislocation of, by closed reduction (Anaes.)	$201.05
47066	Ankle or tarsus, treatment of dislocation of, by open reduction (Anaes.)(Assist.)	$268.10
47069	Toe, treatment of dislocation of, by closed reduction (Anaes.)	$55.90
47072	Toe, treatment of dislocation of, by open reduction (Anaes.)	$74.35
47300	Distal phalanx of finger or thumb, treatment of fracture of, by closed reduction, including percutaneous fixation where used (Anaes.)	$67.00
47303	Distal phalanx of finger or thumb, treatment of intra-articular fracture of, by closed reduction (Anaes.)	$78.20
47306	Distal phalanx of finger or thumb, treatment of fracture of, by open reduction (Anaes.)	$89.30
47309	Distal phalanx of finger or thumb, treatment of intra-articular fracture of, by open reduction (Anaes.)	$111.75
47312	Middle phalanx of finger, treatment of fracture of, by closed reduction (Anaes.)	$100.50
47315	Middle phalanx of finger, treatment of intra-articular fracture of, by closed reduction (Anaes.)	$115.40
47318	Middle phalanx of finger, treatment of fracture of, by open reduction (Anaes.)	$134.05
47321	Middle phalanx of finger, treatment of intra-articular fracture of, by open reduction (Anaes.)	$167.50
47324	Proximal phalanx of finger or thumb, treatment of fracture of, by closed reduction (Anaes.)	$134.05
47327	Proximal phalanx of finger or thumb, treatment of intra-articular fracture of, by closed reduction (Anaes.)	$156.30

Item	Service	Fee ($)
47330	Proximal phalanx of finger or thumb, treatment of fracture of, by open reduction (Anaes.)	$178.75
47333	Proximal phalanx of finger or thumb, treatment of intra-articular fracture of, by open reduction (Anaes.)(Assist.)	$223.30
47336	Metacarpal, treatment of fracture of, by closed reduction (Anaes.)	$134.05
47339	Metacarpal, treatment of intra-articular fracture of, by closed reduction (Anaes.)	$156.30
47342	Metacarpal, treatment of fracture of, by open reduction (Anaes.)	$178.75
47345	Metacarpal, treatment of intra-articular fracture of, by open reduction (Anaes.)(Assist.)	$223.30
47348	Carpus (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies (Anaes.)	$74.35
47351	Carpus (excluding scaphoid), treatment of fracture of, by open reduction (Anaes.)	$186.25
47354	Carpal scaphoid, treatment of fracture of, not being a service to which item 47357 applies (Anaes.)	$134.05
47357	Carpal scaphoid, treatment of fracture of, by open reduction (Anaes.)(Assist.)	$297.90
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.)	$104.30
47363	Radius or ulna, distal end of, treatment of fracture of, by closed reduction (Anaes.)	$156.30
47366	Radius or ulna, distal end of, treatment of fracture of, by open reduction (Anaes.)(Assist.)	$208.55
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.)	$134.05
47372	Radius, distal end of, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.)	$223.30
47375	Radius, distal end of, treatment of Colles', Smith's or Barton's fracture, by open reduction (Anaes.)(Assist.)	$297.90
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.)	$134.05
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.)	$201.05
47384	Radius or ulna, shaft of, treatment of fracture of, by open reduction (Anaes.)(Assist.)	$268.10

Item	Service	Fee ($)
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.)(Assist.)	$230.85
47386	Radius or ulna, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by open reduction or internal fixation (Anaes.)(Assist.)	$372.30
47387	Radius and ulna, shafts of, treatment of fracture of, by cast immobilisation, not being a service to which item 47390 or 47393 applies (Anaes.)(Assist.)	$215.90
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.)	$323.95
47393	Radius and ulna, shafts of, treatment of fracture of, by open reduction (Anaes.)(Assist.)	$431.90
47396	Olecranon, treatment of fracture of, not being a service to which item 47399 applies (Anaes.)	$148.95
47399	Olecranon, treatment of fracture of, by open reduction (Anaes.)(Assist.)	$297.90
47402	Olecranon, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (Anaes.)(Assist.)	$223.30
47405	Radius, treatment of fracture of head or neck of, closed management of (Anaes.)	$148.95
47408	Radius, treatment of fracture of head or neck of, open management of, including internal fixation and excision where performed (Anaes.)(Assist.)	$297.90
47411	Humerus, treatment of fracture of tuberosity of, not being a service to which item 47417 applies (Anaes.)	$89.30
47414	Humerus, treatment of fracture of tuberosity of, by open reduction (Anaes.)	$178.75
47417	Humerus, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed reduction (Anaes.)(Assist.)	$208.55
47420	Humerus, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by open reduction (Anaes.)(Assist.)	$409.60
47423	Humerus, proximal, treatment of fracture of, not being a service to which item 47426, 47429 or 47432 applies (Anaes.)	$171.20
47426	Humerus, proximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.)	$256.95
47429	Humerus, proximal, treatment of fracture of, by open reduction (Anaes.)(Assist.)	$342.50
47432	Humerus, proximal, treatment of intra-articular fracture of, by open reduction (Anaes.)(Assist.)	$428.20

Item	Service	Fee ($)
47435	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.)(Assist.)	$327.65
47438	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (Anaes.)(Assist.)	$521.35
47441	Humerus, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (Anaes.)(Assist.)	$651.60
47444	Humerus, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies (Anaes.)	$178.75
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.)	$268.10
47450	Humerus, shaft of, treatment of fracture of, by internal or external (Anaes.)(Assist.)	$357.45
47451	Humerus, shaft of, treatment of fracture of, by intramedullary fixation (Anaes.)(Assist.)	$430.95
47453	Humerus, distal, (supracondylar or condylar), treatment of fracture of, not being a service to which item 47456 or 47459 applies (Anaes.)(Assist.)	$208.55
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.)	$312.90
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.)(Assist.)	$417.00
47462	Clavicle, treatment of fracture of, not being a service to which item 47465 applies (Anaes.)	$89.30
47465	Clavicle, treatment of fracture of, by open reduction (Anaes.)	$178.75
47466	Sternum, treatment of fracture of, not being a service to which item 47467 applies (Anaes.)	$89.30
47467	Sternum, treatment of fracture of, by open reduction (Anaes.)	$178.75
47468	Scapula, neck or glenoid region of, treatment of fracture of, by open reduction (Anaes.)(Assist.)	$342.50
47471	Ribs (1 or more), treatment of fracture of - each attendance	$33.95
47474	Pelvic ring, treatment of fracture of, not involving disruption of pelvic ring or acetabulum	$148.95
47477	Pelvic ring, treatment of fracture of, with disruption of pelvic ring or acetabulum	$186.25
47480	Pelvic ring, treatment of fracture of, requiring traction (Anaes.)(Assist.)	$372.30

Item	Service	Fee ($)
47483	Pelvic ring, treatment of fracture of, requiring control by external fixation (Anaes.)(Assist.)	$446.80
47486	Pelvic ring, treatment of fracture of, by open reduction and involving internal fixation of anterior segment, including diastasis of pubic symphysis (Anaes.)(Assist.)	$744.70
47489	Pelvic ring, treatment of fracture of, by open reduction and involving internal fixation of posterior segment (including sacro-iliac joint), with or without fixation of anterior segment (Anaes.)(Assist.)	$1,117.05
47492	Acetabulum, treatment of fracture of, and associated dislocation of hip (Anaes.)	$186.25
47495	Acetabulum, treatment of fracture of, and associated dislocation of hip, requiring traction (Anaes.)(Assist.)	$372.30
47498	Acetabulum, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, with or without traction (Anaes.)(Assist.)	$558.50
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.)(Assist.)	$744.70
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.)(Assist.)	$1,117.05
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.)(Assist.)	$1,117.05
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.)(Assist.)	$1,117.05
47513	Sacro-iliac joint disruption, treatment of, requiring internal fixation, being a service associated with a service to which items 47501 to 47510 apply (Anaes.)(Assist.)	$297.90
47516	Femur, treatment of fracture of, by closed reduction or traction (Anaes.)(Assist.)	$342.50
47519	Femur, treatment of trochanteric or subcapital fracture of, by internal fixation (Anaes.)(Assist.)	$685.15
47522	Femur, treatment of subcapital fracture of, by hemi-arthroplasty (Anaes.)(Assist.)	$595.80
47525	Femur, treatment of fracture of, for slipped capital femoral epiphysis (Anaes.)(Assist.)	$685.15
47528	Femur, treatment of fracture of, by internal fixation or external fixation (Anaes.)(Assist.)	$595.80

Item	Service	Fee ($)
47531	Femur, treatment of fracture of shaft, by intramedullary fixation and cross fixation (Anaes.)(Assist.)	$759.55
47534	Femur, condylar region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring internal fixation, with or without internal fixation of 1 or more osteochondral fragments (Anaes.)(Assist.)	$856.40
47537	Femur, condylar region of, treatment of fracture of, requiring internal fixation of 1 or more osteochondral fragments, not being a service associated with a service to which item 47534 applies (Anaes.)(Assist.)	$342.50
47540	Hip spica or shoulder spica, application of, as an independent procedure (Anaes.)	$171.20
47543	Tibia, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies (Anaes.)	$178.75
47546	Tibia, plateau of, treatment of medial or lateral fracture of, by closed reduction (Anaes.)	$268.10
47549	Tibia, plateau of, treatment of medial or lateral fracture of, by open reduction (Anaes.)(Assist.)	$357.45
47552	Tibia, plateau of, treatment of both medial and lateral fractures of, not being a service to which item 47555 or 47558 applies (Anaes.)(Assist.)	$297.90
47555	Tibia, plateau of, treatment of both medial and lateral fractures of, by closed reduction (Anaes.)	$446.80
47558	Tibia, plateau of, treatment of both medial and lateral fractures of, by open reduction (Anaes.)(Assist.)	$595.80
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.)	$215.90
47564	Tibia, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.)	$323.95
47565	Tibia, shaft of, treatment of fracture of, by internal fixation or external fixation (Anaes.)(Assist.)	$563.45
47566	Tibia, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (Anaes.)(Assist.)	$718.30
47567	Tibia, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.)(Assist.)	$376.00
47570	Tibia, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Anaes.)(Assist.)	$431.90
47573	Tibia, shaft of, treatment of intra-articular fracture of, by open reduction, with or without treatment of fibular fracture (Anaes.)(Assist.)	$539.85
47576	Fibula, treatment of fracture of (Anaes.)	$89.30

Item	Service	Fee ($)
47579	Patella, treatment of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.)	$126.65
47582	Patella, treatment of fracture of, by excision of patella or pole with reattachment of tendon (Anaes.)(Assist.)	$260.70
47585	Patella, treatment of fracture of, by internal fixation (Anaes.)(Assist.)	$335.15
47588	Knee joint, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes.)(Assist.)	$1,042.50
47591	Knee joint, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar and tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes.)(Assist.)	$1,266.10
47594	Ankle joint, treatment of fracture of, not being a service to which item 47597 applies (Anaes.)	$171.20
47597	Ankle joint, treatment of fracture of, by closed reduction (Anaes.)	$256.95
47600	Ankle joint, treatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis (Anaes.)(Assist.)	$342.50
47603	Ankle joint, treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or diastasis (Anaes.)(Assist.)	$446.80
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.)	$186.25
47609	Calcaneum or talus, treatment of fracture of, by closed reduction, with or without dislocation (Anaes.)(Assist.)	$279.25
47612	Calcaneum or talus, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.)(Assist.)	$323.95
47615	Calcaneum or talus, treatment of fracture of, by open reduction, with or without dislocation (Anaes.)(Assist.)	$372.30
47618	Calcaneum or talus, treatment of intra-articular fracture of, by open reduction, with or without dislocation (Anaes.)(Assist.)	$465.50
47621	Tarso-metatarsal, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.)(Assist.)	$323.95
47624	Tarso-metatarsal, treatment of fracture of, by open reduction, with or without dislocation (Anaes.)(Assist.)	$446.80
47627	Tarsus (excluding calcaneum or talus), treatment of fracture of (Anaes.)	$126.65
47630	Tarsus (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (Anaes.)(Assist.)	$268.10
47633	Metatarsal, 1 of, treatment of fracture of (Anaes.)	$89.30

Item	Service	Fee ($)
47636	Metatarsal, 1 of, treatment of fracture of, by closed reduction (Anaes.)	$134.05
47639	Metatarsal, 1 of, treatment of fracture of, by open reduction (Anaes.)	$178.75
47642	Metatarsals, 2 of, treatment of fracture of (Anaes.)	$119.20
47645	Metatarsals, 2 of, treatment of fracture of, by closed reduction (Anaes.)	$178.75
47648	Metatarsals, 2 of, treatment of fracture of, by open reduction (Anaes.)(Assist.)	$238.20
47651	Metatarsals, 3 or more of, treatment of fracture of (Anaes.)	$186.25
47654	Metatarsals, 3 or more of, treatment of fracture of, by closed reduction (Anaes.)(Assist.)	$279.25
47657	Metatarsals, 3 or more of, treatment of fracture of, by open reduction (Anaes.)(Assist.)	$372.30
47663	Phalanx of great toe, treatment of fracture of, by closed reduction (Anaes.)	$111.75
47666	Phalanx of great toe, treatment of fracture of, by open reduction (Anaes.)	$186.25
47672	Phalanx of toe (other than great toe), 1 of, treatment of fracture of, by open reduction (Anaes.)	$89.30
47678	Phalanx of toe (other than great toe), more than 1 of, treatment of fracture of, by open reduction (Anaes.)	$134.05
47681	Spine (excluding sacrum), treatment of fracture of transverse process, vertebral body, or posterior elements - each attendance	$33.95
47684	Spine, treatment of fracture, dislocation or fracture-dislocation, without spinal cord involvement, including immobilisation by calipers (Anaes.)(Assist.)	$595.80
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.)	$1,042.50
47690	Spine, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, including immobilisation by calipers, requiring reduction by closed manipulation (Anaes.)(Assist.)	$819.15
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.)	$1,042.50
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.)(Assist.)	$297.90
47699	Spine, treatment of fracture, dislocation or fracture-dislocation without cord involvement requiring open reduction with or without internal fixation (Anaes.)(Assist.)	$1,191.50

Item	Service	Fee ($)
47702	Spine, treatment of fracture, dislocation or fracture-dislocation with cord involvement requiring open reduction with or without internal fixation, including up to 14 days post-operative care (Anaes.)(Assist.)	$1,489.45
47703	Skull, treatment of fracture of, each attendance	$33.95
47705	Skull calipers, insertion of, as an independent procedure (Anaes.)(Assist.)	$223.30
47708	Plaster jacket, application of, as an independent procedure (Anaes.)	$171.20
47711	Halo, application of, as an independent procedure (Anaes.)(Assist.)	$253.25
47714	Halo, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.)	$189.90
47717	Halo-thoracic traction - application of both halo and thoracic jacket (Anaes.)(Assist.)	$335.15
47720	Halo-femoral traction, as an independent procedure (Anaes.)(Assist.)	$335.15
47723	Halo-femoral traction in conjunction with a major spine operation (Anaes.)(Assist.)	$335.15
47726 Note T8.75	Bone graft, harvesting of, via separate incision, in conjunction with another service - autogenous - small quantity (Anaes.)	$111.75
47729 Note T8.75	Bone graft, harvesting of, via separate incision, in conjunction with another service - autogenous - large quantity (Anaes.)	$186.25
47732	Vascularised pedicle bone graft, harvesting of, in conjunction with another service (Anaes.)(Assist.)	$297.90
47735	Nasal bones, treatment of fracture of, not being a service to which item 47738 or 47741 applies - each attendance	$33.95
47738	Nasal bones, treatment of fracture of, by reduction (Anaes.)	$186.25
47741	Nasal bones, treatment of fracture of, by open reduction involving osteotomies (Anaes.)(Assist.)	$379.90
47753	Maxilla, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.)(Assist.)	$321.65
47756	Mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.)(Assist.)	$321.65
47762	Zygomatic bone, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.)	$188.95
47765	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.)(Assist.)	$310.15
47768	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.)(Assist.)	$379.90

Item	Service	Fee ($)
47771	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.)(Assist.)	$436.45
47774	Maxilla, treatment of fracture of, requiring open operation (Anaes.)(Assist.)	$344.65
47777	Mandible, treatment of fracture of, requiring open reduction (Anaes.)(Assist.)	$344.65
47780	Maxilla, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.)(Assist.)	$447.95
47783	Mandible, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.)(Assist.)	$447.95
47786	Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.)(Assist.)	$568.55
47789	Mandible, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.)(Assist.)	$568.55
47900	Bone cyst, injection into or aspiration of (Anaes.)	$134.05
47903	Epicondylitis, open operation for (Anaes.)	$186.25
47904	Digital nail of toe, removal of, not being a service to which item 47906 applies (Anaes.)	$44.70
47906	Digital nail of toe, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes.)	$89.30
47912 Note T8.7	Pulp space infection, paronychia of foot, incision for, not being a service to which another item in this Group applies (excluding aftercare) (Anaes.)	$44.70
47915	Ingrowing nail of toe, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed (Anaes.)	$134.05
47916	Ingrowing nail of toe, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.)	$67.30
47918	Ingrowing toenail, radical excision of nailbed (Anaes.)	$186.25
47920	Bone growth stimulator, insertion of (Anaes.)(Assist.)	$301.20
47921	Orthopaedic pin or wire, insertion of, as an independent procedure (Anaes.)	$89.30
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.)	$29.75
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.)	$111.75

Item	Service	Fee ($)
47930	Plate, rod or nail and associated wires, pins or screws, 1 or more of, all of which were inserted for internal fixation purposes, removal of, not being a service associated with a service to which item 47924 or 47927 applies - per bone (Anaes.)(Assist.)	$208.55
47933	Exostosis of small bone, excision of, including simple removal of bunion and any associated bursa (Anaes.)	$163.80
47936	Exostosis of large bone, excision of (Anaes.)(Assist.)	$201.05
47948	External fixation, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes.)	$126.65
47951	External fixation, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.)	$148.95
47954	Tendon, repair of, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$297.90
47957	Tendon, large, lengthening of, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$223.30
47960	Tenotomy, subcutaneous, not being a service to which another item in this Group applies (Anaes.)	$104.30
47963	Tenotomy, open, with or without tenoplasty, not being a service to which another item in this Group applies (Anaes.)	$171.20
47966	Tendon or ligament transfer, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$342.50
47969	Tenosynovectomy, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$208.55
47972	Tendon sheath, open operation for teno-vaginitis, not being a service to which another item in this Group applies (Anaes.)	$166.60
47975	Forearm or calf, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (Anaes.)(Assist.)	$291.95
47978	Forearm or calf, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (Anaes.)	$177.35
47981	Forearm, calf or interosseous muscle space of hand, decompression fasciotomy of, not being a service to which another item applies (Anaes.)	$119.00
47982	Forage (Drill decompression), of neck or head of femur, or both (Anaes.)(Assist.)	$288.65
48200	Femur, bone graft to (Anaes.)(Assist.)	$595.80
48203	Femur, bone graft to, with internal fixation (Anaes.)(Assist.)	$722.40
48206	Tibia, bone graft to (Anaes.)(Assist.)	$447.25

Item	Service	Fee ($)
48209	Tibia, bone graft to, with internal fixation (Anaes.)(Assist.)	$573.40
48212	Humerus, bone graft to (Anaes.)(Assist.)	$447.25
48215	Humerus, bone graft to, with internal fixation (Anaes.)(Assist.)	$573.40
48218	Radius or ulna, bone graft to (Anaes.)(Assist.)	$447.25
48221	Radius and ulna, bone graft to, with internal fixation of 1 or both bones (Anaes.)(Assist.)	$595.80
48224	Radius or ulna, bone graft to (Anaes.)(Assist.)	$297.90
48227	Radius or ulna, bone graft to, with internal fixation of 1 or both bones (Anaes.)(Assist.)	$387.25
48230	Scaphoid, bone graft to, for non-union (Anaes.)(Assist.)	$335.15
48233	Scaphoid, bone graft to, for non-union, with internal fixation (Anaes.)(Assist.)	$484.05
48236	Scaphoid, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (Anaes.)(Assist.)	$633.00
48239 Note T8.75	Bone graft, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$350.00
48242 Note T8.75	Bone graft, with internal fixation, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$484.05
48400	Phalanx, metatarsal, accessory bone or sesamoid bone, osteotomy or osteectomy of, excluding services to which item 49848 or 49851 applies (Anaes.)(Assist.)	$260.70
48403	Phalanx or metatarsal, osteotomy or osteectomy of, with internal fixation (Anaes.)(Assist.)	$409.60
48406	Fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, osteotomy or osteectomy of (Anaes.)(Assist.)	$260.70
48409	Fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, osteotomy or osteectomy, with internal fixation (Anaes.)(Assist.)	$409.60
48412	Humerus, osteotomy or osteectomy of (Anaes.)(Assist.)	$498.85
48415	Humerus, osteotomy or osteectomy of, with internal fixation (Anaes.)(Assist.)	$633.00
48418	Tibia, osteotomy or osteectomy of (Anaes.)(Assist.)	$498.85
48421	Tibia, osteotomy or osteectomy of, with internal fixation (Anaes.)(Assist.)	$633.00
48424	Femur or pelvis, osteotomy or osteectomy of (Anaes.)(Assist.)	$595.80
48427	Femur or pelvis, osteotomy or osteectomy of, with internal fixation (Anaes.)(Assist.)	$722.40

Item	Service	Fee ($)
48500	Femur, epiphysiodesis of (Anaes.)(Assist.)	$260.70
48503	Tibia and fibula, epiphysiodesis of (Anaes.)(Assist.)	$260.70
48506	Femur, tibia and fibula, epiphysiodesis of (Anaes.)(Assist.)	$387.25
48509	Epiphysiodesis, staple arrest of hemiepiphysis (Anaes.)	$186.25
48512	Epiphysiolysis, operation to prevent closure of plate (Anaes.)(Assist.)	$707.40
48600	Spine, manipulation of, performed in the operating theatre of a hospital or approved day-hospital facility (Anaes.)	$74.35
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.)	$111.75
48606	Scoliosis or Kyphosis, spinal fusion for (without instrumentation) (Anaes.)(Assist.)	$1,042.50
48609	Scoliosis or Kyphosis, spinal fusion for, using Harrington or other nonsegmental fixation (Anaes.)(Assist.)	$1,303.20
48612	Scoliosis, spinal fusion for, using segmental instrumentation (C D, Zielke, Luque, or similar) (Anaes.)(Assist.)	$1,936.25
48613	Scoliosis or kyphosis, spinal fusion for, using segmental instrumentation, reconstruction using separate anterior and posterior approaches (Anaes.)(Assist.)	$2,754.10
48615	Scoliosis, re-exploration for, involving adjustment or removal of instrumentation or simple bone grafting procedure (Anaes.)(Assist.)	$350.00
48618	Scoliosis, revision of failed scoliosis surgery, involving more than 1 of multiple osteotomy, fusion or instrumentation (Anaes.)(Assist.)	$1,936.25
48621	Scoliosis, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke, or similar) - not more than 4 levels (Anaes.)(Assist.)	$1,266.10
48624	Scoliosis, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes.)(Assist.)	$1,563.95
48627	Scoliosis, spinal fusion for, combined with segmental instrumentation (C D, Zielke or similar) down to and including pelvis (Anaes.)(Assist.)	$2,010.65
48630	Scoliosis, requiring anterior decompression of spinal cord with resection of vertebrae including bone graft and instrumentation in the presence of spinal cord involvement (Anaes.)(Assist.)	$2,234.05
48632	Scoliosis, congenital, vertebral resection and fusion for (Anaes.)(Assist.)	$1,234.95
48636	Percutaneous lumbar discectomy, 1 or more levels (Anaes.)(Assist.)	$640.35

Item	Service	Fee ($)
48639	Vertebral body, total or subtotal excision of, including bone grafting or other form of fixation (Anaes.)(Assist.)	$1,079.80
48640	Vertebral body, disease of, excision and spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes.)(Assist.)	$2,754.10
48642 Note T8.78	Spine, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - 1 or 2 levels (Anaes.)(Assist.)	$633.00
48645 Note T8.78	Spine, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - more than 2 levels (Anaes.)(Assist.)	$856.40
48648 Note T8.78	Spine, bone graft to, (postero-lateral fusion) - 1 or 2 levels (Anaes.)(Assist.)	$856.40
48651 Note T8.78	Spine, bone graft to, (postero-lateral fusion) - more than 2 levels (Anaes.)(Assist.)	$1,191.50
48654 Note T8.78	Spinal fusion (posterior interbody), with laminectomy, 1 level (Anaes.)(Assist.)	$856.40
48657 Note T8.78	Spinal fusion (posterior interbody), with laminectomy, more than 1 level (Anaes.)(Assist.)	$1,191.50
48660 Note T8.78	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (Anaes.)(Assist.)	$856.40
48663 Note T8.78	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - principal surgeon (Anaes.)(Assist.)	$640.35
48666 Note T8.78	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - assisting surgeon(Assist.)	$387.25
48669 Note T8.78	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (Anaes.)(Assist.)	$1,154.30
48672 Note T8.78	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - principal surgeon (Anaes.)(Assist.)	$863.95
48675 Note T8.78	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - assisting surgeon(Assist.)	$521.35
48678 Note T8.78	Spine, simple internal fixation of, involving 1 or more of facetal screw, wire loop or similar, being a service associated with a service to which items 48642 to 48675 apply (Anaes.)(Assist.)	$447.25
48681 Note T8.78	Spine, non-segmental internal fixation of (Harrington or similar), other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies (Anaes.)(Assist.)	$744.70

Item	Service	Fee ($)
48684 Note T8.78	Spine, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies - 1 or 2 levels (Anaes.)(Assist.)	$744.70
48687 Note T8.78	Spine, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - 3 or 4 levels (Anaes.)(Assist.)	$1,042.50
48690 Note T8.78	Spine, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - more than 4 levels (Anaes.)(Assist.)	$1,191.50
48900	Shoulder, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Anaes.)(Assist.)	$223.30
48903	Shoulder, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (Anaes.)(Assist.)	$446.80
48906	Shoulder, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both - not being a service associated with a service to which item 48900 applies (Anaes.)(Assist.)	$446.80
48909	Shoulder, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, not being a service associated with a service to which item 48903 applies (Anaes.)(Assist.)	$595.80
48912	Shoulder, arthrotomy of (Anaes.)(Assist.)	$260.70
48915	Shoulder, hemi-arthroplasty of (Anaes.)(Assist.)	$595.80
48918	Shoulder, total replacement arthroplasty of, including any associated rotator cuff repair (Anaes.)(Assist.)	$1,191.50
48921	Shoulder, total replacement arthroplasty, revision of (Anaes.)(Assist.)	$1,228.75
48924	Shoulder, total replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or both (Anaes.)(Assist.)	$1,415.00
48927	Shoulder prosthesis, removal of (Anaes.)(Assist.)	$290.35
48930	Shoulder, stabilisation procedure for recurrent anterior or posterior dislocation (Anaes.)(Assist.)	$595.80
48933	Shoulder, stabilisation procedure for multi-directional instability, anterior or posterior (or both) repair when performed (Anaes.)(Assist.)	$781.95
48936	Shoulder, synovectomy of, as an independent procedure (Anaes.)(Assist.)	$595.80
48939	Shoulder, arthrodesis of (Anaes.)(Assist.)	$856.40
48942	Shoulder, arthrodesis of, including removal of prosthesis, requiring bone grafting or internal fixation (Anaes.)(Assist.)	$1,117.05

Item	Service	Fee ($)
48945	Shoulder, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.)(Assist.)	$215.90
48948	Shoulder, arthroscopic surgery of, involving any 1 or more of: removal of loose bodies; decompression of calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.)(Assist.)	$484.05
48951	Shoulder, arthroscopic division of coraco-acromial ligament including acromioplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.)(Assist.)	$707.40
48954	Shoulder, arthroscopic total synovectomy of, including release of contracture when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.)(Assist.)	$744.70
48957	Shoulder, arthroscopic stabilisation of, for recurrent instability including labral repair or reattachment when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.)(Assist.)	$856.40
48960	Shoulder, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed - not being a service associated with any other procedure of the shoulder region (Anaes.)(Assist.)	$744.70
49100	Elbow, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (Anaes.)(Assist.)	$260.70
49103	Elbow, ligamentous stabilisation of (Anaes.)(Assist.)	$558.50
49106	Elbow, arthrodesis of (Anaes.)(Assist.)	$744.70
49109	Elbow, total synovectomy of (Anaes.)(Assist.)	$558.50
49112	Elbow, silastic or other replacement of radial head (Anaes.)(Assist.)	$558.50
49115	Elbow, total joint replacement of (Anaes.)(Assist.)	$893.60
49118	Elbow, diagnostic arthroscopy of, including biopsy (Anaes.)(Assist.)	$215.90
49121	Elbow, arthroscopic surgery involving any 1 or more of: drilling of defect, removal of loose body; release of contracture or adhesions; chondroplasty; or osteoplasty - not being a service associated with any other arthroscopic procedure of the elbow (Anaes.)(Assist.)	$484.05
49200 Note T8.79	Wrist, arthrodesis of, including bone graft, with or without internal fixation of the radiocarpal joint (Anaes.)(Assist.)	$647.80
49203 Note T8.79	Wrist, limited arthrodesis of the intercarpal joint, including bone graft (Anaes.)(Assist.)	$484.05
49206 Note T8.79	Wrist, proximal carpectomy of, including styloidectomy when performed (Anaes.)(Assist.)	$446.80

Item	Service	Fee ($)
49209 Note T8.79	Wrist, total replacement arthroplasty of (Anaes.)(Assist.)	$595.80
49212 Note T8.79	Wrist, arthrotomy of (Anaes.)	$186.25
49215 Note T8.79	Wrist, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy (Anaes.)(Assist.)	$513.90
49218 Note T8.79	Wrist, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy) - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.)(Assist.)	$215.90
49221 Note T8.79	Wrist, arthroscopic surgery of, involving any 1 or more of: drilling of defect; removal of loose body, release of adhesions; local synovectomy; or debridement of one area - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.)(Assist.)	$484.05
49224 Note T8.79	Wrist, arthroscopic debridement of 2 or more distinct areas; or osteoplasty including excision of the distal ulna; or total synovectomy (Anaes.)(Assist.)	$558.50
49227 Note T8.79	Wrist, arthroscopic pinning of osteochondral fragment or stabilisation procedure for ligamentous disruption - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.)(Assist.)	$558.50
49300	Sacroiliac joint arthrodesis of (Anaes.)(Assist.)	$412.30
49303	Hip, arthrotomy of, including lavage, drainage or biopsy when performed (Anaes.)(Assist.)	$431.90
49306	Hip arthrodesis of (Anaes.)(Assist.)	$856.40
49309	Hip, arthrectomy or excision arthroplasty of, including removal of prosthesis (Austin Moore or similar (non cement)) (Anaes.)(Assist.)	$595.80
49312	Hip, arthrectomy or excision arthroplasty of, including removal of prosthesis (cemented, porous coated or similar) (Anaes.)(Assist.)	$744.70
49315	Hip, arthroplasty of, unipolar or bipolar (Anaes.)(Assist.)	$670.25
49318	Hip, total replacement arthroplasty of, including minor bone grafting (Anaes.)(Assist.)	$1,042.50
49319	Hip, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.)(Assist.)	$1,831.35
49321	Hip, total replacement arthroplasty of, including major bone grafting, including obtaining of graft (Anaes.)(Assist.)	$1,266.10
49324	Hip, total replacement arthroplasty of, revision procedure including removal of prosthesis (Anaes.)(Assist.)	$1,489.45
49327	Hip, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (Anaes.)(Assist.)	$1,712.80
49330	Hip, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Anaes.)(Assist.)	$1,712.80

Item	Service	Fee ($)
49333	Hip, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Anaes.)(Assist.)	$1,936.25
49336	Hip, treatment of a fracture of the femur where revision total hip replacement is required as part of the treatment of the fracture (not including intra-operative fracture), being a service associated with a service to which items 49324 to 49333 apply (Anaes.)(Assist.)	$282.95
49339	Hip, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cm in length (Anaes.)(Assist.)	$2,196.80
49342	Hip, revision total replacement of, requiring anatomic specific allograft of acetabulum (Anaes.)(Assist.)	$2,196.80
49345	Hip, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (Anaes.)(Assist.)	$2,606.45
49346	Hip, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (Anaes.)(Assist.)	$670.25
49360	Hip, diagnostic arthroscopy of (Anaes.)(Assist.)	$272.10
49363	Hip, diagnostic arthroscopy of, with synovial biopsy (Anaes.)(Assist.)	$327.60
49366	Hip, arthroscopic surgery of (Anaes.)(Assist.)	$484.05
49500	Knee, arthrotomy of, involving 1 or more of; capsular release, biopsy or lavage, or removal of loose body or foreign body (Anaes.)(Assist.)	$297.90
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.)(Assist.)	$387.25
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.)(Assist.)	$580.90
49509	Knee, total synovectomy or arthrodesis of (Anaes.)(Assist.)	$595.80
49512	Knee, arthrodesis of, with removal of prosthesis (Anaes.)(Assist.)	$856.40
49515	Knee, removal of prosthesis, cemented or uncemented, including associated cement, as the first stage of a 2 stage procedure (Anaes.)(Assist.)	$670.25
49517	Knee, hemiarthroplasty of (Anaes.)(Assist.)	$954.25
49518	Knee, total replacement arthroplasty of (Anaes.)(Assist.)	$1,042.50
49519	Knee, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.)(Assist.)	$1,831.35

Item	Service	Fee ($)
49521	Knee, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft (Anaes.)(Assist.)	$1,266.10
49524	Knee, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including obtaining of graft (Anaes.)(Assist.)	$1,489.45
49527	Knee, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.)(Assist.)	$1,266.10
49530	Knee, total replacement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, including obtaining of graft and including removal of prosthesis (Anaes.)(Assist.)	$1,563.95
49533	Knee, total replacement arthroplasty of, revision procedure, requiring bone grafting to both femur and tibia, including obtaining of graft and including removal of prosthesis (Anaes.)(Assist.)	$1,787.30
49534	Knee, patello-femoral joint of, total replacement arthroplasty as a primary procedure (Anaes.)(Assist.)	$355.50
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.)(Assist.)	$744.70
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.)(Assist.)	$744.70
49542	Knee, reconstructive surgery of cruciate ligaments (open or arthroscopic, or both), including notchplasty, meniscus repair, extracapsular procedure and debridement when performed (Anaes.)(Assist.)	$1,042.50
49545	Knee, revision arthrodesis of (Anaes.)(Assist.)	$595.80
49548	Knee, revision of patello-femoral stabilisation (Anaes.)(Assist.)	$744.70
49551	Knee, revision of procedures to which item 49536, 49539 or 49542 applies (Anaes.)(Assist.)	$1,042.50
49554	Knee, revision of total replacement of, by anatomic specific allograft of tibia or femur (Anaes.)(Assist.)	$1,489.45
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.)(Assist.)	$215.90
49558	Knee, arthroscopic surgery of, involving 1 or more of: debridement, osteoplasty or chrondroplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.)(Assist.)	$215.90
49559	Knee, arthroscopic surgery of, involving chrondroplasty requiring multiple drilling or carbon fibre (or similar) implant; including any associated debridement or oestoplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.)(Assist.)	$323.20

Item	Service	Fee ($)
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.)(Assist.)	$436.30
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.)(Assist.)	$533.20
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.)(Assist.)	$581.75
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.)(Assist.)	$630.15
49564	Knee, patello-femoral stabilisation of, combined arthroscopic and open procedure, including lateral release, medial capsulorrhaphy and tendon transfer (Anaes.)(Assist.)	$726.90
49566	Knee, arthroscopic total synovectomy of (Anaes.)(Assist.)	$595.80
49569	Knee, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (Anaes.)(Assist.)	$595.80
49700	Ankle, diagnostic arthroscopy of, including biopsy (Anaes.)(Assist.)	$215.90
49703	Ankle, arthroscopic surgery of (Anaes.)(Assist.)	$484.05
49706	Ankle, arthrotomy of, involving 1 or more of: lavage, removal of loose body or division of contracture (Anaes.)(Assist.)	$260.70
49709	Ankle, ligamentous stabilisation of (Anaes.)(Assist.)	$558.50
49712	Ankle, arthrodesis of (Anaes.)(Assist.)	$595.80
49715	Ankle, total joint replacement of (Anaes.)(Assist.)	$893.60
49718	Ankle, Achilles' tendon or other major tendon, repair of (Anaes.)(Assist.)	$297.90
49721	Ankle, Achilles' tendon rupture managed by non-operative treatment	$186.25
49724	Ankle, Achilles' tendon, secondary repair or reconstruction of (Anaes.)(Assist.)	$521.35
49727	Ankle, Achilles' tendon, operation for lengthening (Anaes.)(Assist.)	$223.30
49800	Foot, flexor or extensor tendon, primary repair of (Anaes.)	$104.30
49803	Foot, flexor or extensor tendon, secondary repair of (Anaes.)	$134.05
49806	Foot, subcutaneous tenotomy of, 1 or more tendons (Anaes.)	$104.30

Item	Service	Fee ($)
49809	Foot, open tenotomy of, with or without tenoplasty (Anaes.)	$171.20
49812	Foot, tendon or ligament transplantation of, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$342.50
49815	Foot, triple arthrodesis of (Anaes.)(Assist.)	$595.80
49818	Foot, excision of calcaneal spur (Anaes.)(Assist.)	$215.90
49821	Foot, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - unilateral (Anaes.)(Assist.)	$342.50
49824	Foot, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - bilateral (Anaes.)(Assist.)	$599.50
49827	Foot, correction of hallux valgus by transfer of adductor hallucis tendon - unilateral (Anaes.)(Assist.)	$372.30
49830	Foot, correction of hallux valgus by transfer of adductor hallucis tendon - bilateral (Anaes.)(Assist.)	$651.60
49833	Foot, correction of hallux valgus by osteotomy of first metatarsal including internal fixation where performed - unilateral (Anaes.)(Assist.)	$409.60
49836	Foot, correction of hallux valgus by osteotomy of first metatarsal including internal fixation where performed - bilateral (Anaes.)(Assist.)	$707.40
49837	Foot, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, including internal fixation where performed - unilateral (Anaes.)(Assist.)	$512.00
49838	Foot, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, including internal fixation where performed - bilateral (Anaes.)(Assist.)	$884.20
49839	Foot, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (Anaes.)(Assist.)	$409.60
49842	Foot, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Anaes.)(Assist.)	$707.40
49845	Foot, arthrodesis of, first metatarso-phalangeal joint (Anaes.)(Assist.)	$372.30
49848	Foot, correction of claw or hammer toe (Anaes.)	$126.65
49851	Foot, correction of claw or hammer toe with internal fixation (Anaes.)	$163.80
49854	Foot, radical plantar fasciotomy or fasciectomy of (Anaes.)(Assist.)	$297.90
49857	Foot, metatarso-phalangeal joint replacement (Anaes.)(Assist.)	$275.50
49860	Foot, synovectomy of metatarso-phalangeal joint, single joint (Anaes.)(Assist.)	$223.30
49863	Foot, synovectomy of metatarso-phalangeal joint, 2 or more joints (Anaes.)(Assist.)	$335.15

Item	Service	Fee ($)
49866	Foot, neurectomy for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes.)(Assist.)	$238.20
49878	Talipes equinovarus, calcaneo valgus or metatarsus varus, treatment by cast, splint or manipulation - each attendance (Anaes.)	$44.70
50100	Joint, diagnostic arthroscopy of (including biopsy), not being a service to which another item in this Group applies and not being a service associated with any other arthroscopic procedure (Anaes.)(Assist.)	$215.90
50102	Joint, arthroscopic surgery of, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$484.05
50103	Joint, arthrotomy of, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$260.70
50104	Joint, synovectomy of, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$247.00
50106	Joint, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$372.30
50109	Joint, arthrodesis of, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$372.30
50112	Cicatricial flexion or extension contraction of joint, correction of, involving tissues deeper than skin and subcutaneous tissue, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$285.60
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.)	$111.75
50118	Subtalar joint, arthrodesis of (Anaes.)(Assist.)	$342.50
50121	Greater Trochanter, transplantation of ileopsoas tendon to (Anaes.)(Assist.)	$670.25
50124 Note T8.80	Joint or other synovial cavity, aspiration of, or injection into, or both of these procedures; payable on not more than 25 occasions in any 12 month period (Anaes.)	$23.40
50125 Note T8.80	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.)	$23.40
50127	Joint or joints, arthroplasty of, by any technique not being a service to which another item applies (Anaes.)(Assist.)	$555.70
50130	Joint or joints, application of external fixator to, other than for treatment of fractures (Anaes.)(Assist.)	$247.00
50200	Aggressive or potentially malignant bone or deep soft tissue tumour, biopsy of (not including aftercare) (Anaes.)	$148.95

Item	Service	Fee ($)
50203	Bone or malignant deep soft tissue tumour, lesional or marginal excision of (Anaes.)(Assist.)	$327.65
50206	Bone tumour, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.)(Assist.)	$484.05
50209	Bone tumour, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.)(Assist.)	$595.80
50212	Malignant or aggressive soft tissue tumour affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, without reconstruction (Anaes.)(Assist.)	$1,303.20
50215	Malignant or aggressive soft tissue tumour affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, with intercalary reconstruction (prosthesis, allograft or autograft) (Anaes.)(Assist.)	$1,638.35
50218	Malignant tumour of long bone, enbloc resection of, with replacement or arthrodesis of adjacent joint (Anaes.)(Assist.)	$2,159.65
50221	Malignant or aggressive soft tissue tumour of pelvis, sacrum or spine; or scapula and shoulder, enbloc resection of (Anaes.)(Assist.)	$2,010.65
50224	Malignant or aggressive soft tissue tumour of pelvis, sacrum or spine; or scapula and shoulder, enbloc resection of, with reconstruction by prosthesis, allograft or autograft (Anaes.)(Assist.)	$2,234.05
50227	Malignant bone tumour, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement (Anaes.)(Assist.)	$2,606.45
50230	Benign tumour, resection of, requiring anatomic specific allograft, with or without internal fixation (Anaes.)(Assist.)	$1,340.45
50233	Malignant tumour, amputation for, hemipelvectomy or interscapulo-thoracic (Anaes.)(Assist.)	$1,712.80
50236	Malignant tumour, amputation for, hip disarticulation, shoulder disarticulation or proximal third femur (Anaes.)(Assist.)	$1,340.45
50239	Malignant tumour, amputation for, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$893.60
50300	Joint deformity, slow correction of, using ring fixator or similar device, including all associated attendances - payable only once in any 12 month period (Anaes.)(Assist.)	$915.70
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.)(Assist.)	$1,250.20

Item	Service	Fee ($)
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.)(Assist.)	$1,952.10
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.)(Assist.)	$241.20
50312	Ankle, synovectomy of (Anaes.)(Assist.)	$553.80
50315	Talipes equinovarus, posterior release of (Anaes.)(Assist.)	$548.35
50318	Talipes equinovarus, medial release of (Anaes.)(Assist.)	$548.35
50321	Talipes equinovarus, combined postero-medial release of (Anaes.)(Assist.)	$734.75
50324	Talipes equinovarus, combined postero-medial release of, revision procedure (Anaes.)(Assist.)	$1,047.35
50327	Talipes equinovarus, bilateral procedures (Anaes.)(Assist.)	$1,277.55
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.)	$180.90
50333	Tarsal coalition, excision of, with interposition of muscle, fat graft or similar graft (Anaes.)(Assist.)	$488.00
50336	Talus, vertical, congenital, combined anterior and posterior reconstruction (Anaes.)(Assist.)	$729.30
50339	Foot and ankle, tibialis anterior tendon (split or whole) transfer to lateral column (Anaes.)(Assist.)	$444.20
50342	Foot and ankle, tibialis or tibialis posterior tendon transfer, through the interosseous membrane to anterior or posterior aspect of foot (Anaes.)(Assist.)	$515.40
50345	Hyperextension deformity of toe, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (Anaes.)(Assist.)	$274.20
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.)	$180.90
50349	Hip, congenital dislocation of, treatment of, by closed reduction (Anaes.)	$126.65
50350	Hip, congenital dislocation of, open reduction of (Anaes.)(Assist.)	$670.25
50351	Hip, developmental dislocation of, open reduction of (Anaes.)(Assist.)	$789.60
50352	Hip, congenital dislocation of, treatment of, involving supervision of splint, harness or cast - each attendance (Anaes.)	$44.70

Item	Service	Fee ($)
50353	Hip spica, initial application of, for congenital dislocation of hip (excluding aftercare) (Anaes.)(Assist.)	$280.65
50354	Tibia, pseudarthrosis of, congenital, resection and internal fixation (Anaes.)(Assist.)	$1,036.35
50357	Knee, leg or thigh, rectus femoris tendon transfer or medial or lateral hamstring tendon transfer (Anaes.)(Assist.)	$444.20
50360	Knee, leg or thigh, combined medial and lateral hamstring tendon transfer (Anaes.)(Assist.)	$515.40
50363	Knee, contracture of, posterior release involving multiple tendon lengthening or tenotomies, unilateral (Anaes.)(Assist.)	$394.85
50366	Knee, contracture of, posterior release involving multiple tendon lengthening or tenotomies, bilateral (Anaes.)(Assist.)	$690.95
50369	Knee, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, unilateral (Anaes.)(Assist.)	$515.40
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.)(Assist.)	$904.75
50375	Hip, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, unilateral (Anaes.)(Assist.)	$394.85
50378	Hip, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, bilateral (Anaes.)(Assist.)	$690.95
50381	Hip, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, unilateral (Anaes.)(Assist.)	$515.40
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.)(Assist.)	$904.75
50387	Hip, iliopsoas tendon transfer to greater trochanter, or transfer of abdominal musculature to greater trochanter, or transfer or adductors to ischium (Anaes.)(Assist.)	$515.40
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.)	$180.90
50393	Pelvis, bone graft or shelf procedures for acetabular dysplasia (Anaes.)(Assist.)	$668.95
50394	Acetabular dysplasia, treatment of, by multiple peri-acetabular osteotomy, including internal fixation where performed (Anaes.)(Assist.)	$2,196.80

Item	Service	Fee ($)
50396	Hand, congenital abnormalities or duplication of digits, amputation or splitting of phalanx or phalanges, with ligament or joint reconstruction (Anaes.)(Assist.)	$367.45
50399	Forearm, radial aplasia or dysplasia (radial club hand), centralisation or radialisation of (Anaes.)(Assist.)	$729.30
50402	Torticollis, bipolar release of sternocleidomastoid muscle and associated soft tissue (Anaes.)(Assist.)	$334.50
50405	Elbow, flexorplasty, or tendon transfer to restore elbow function (Anaes.)(Assist.)	$455.10
50408	Shoulder, congenital or developmental dislocation, open reduction of (Anaes.)(Assist.)	$789.60
50411	Lower limb deficiency, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion (Anaes.)(Assist.)	$1,036.35
50414	Lower limb deficiency, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion and rotationplasty (Anaes.)(Assist.)	$1,398.20
50417	Lower limb deficiency, treatment of congenital deficiency of the tibia by reconstruction of the knee, involving transfer of fibula or tibia, and repair of quadriceps mechanism (Anaes.)(Assist.)	$1,036.35
50420	Patella, congenital dislocation of, reconstruction of the quadriceps (Anaes.)(Assist.)	$855.40
50423	Tibia, fibula or both, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes.)(Assist.)	$789.60
50426	Diaphyseal aclasia, removal of lesion or lesions from bone - 1 approach (Anaes.)(Assist.)	$367.45
	GROUP T9 - ASSISTANCE AT OPERATIONS	
51300 Note T9.2 Note T9.5 Note OC.6	Assistance at any operation under an item in group T8 identified by the word "Assist." for which the fee does not exceed $441.65 or at a series or combination of operations under items in group T8 identified by the word "Assist." for which the aggregate fee does not exceed $441.65	$68.30
51303 Note T9.3 Note T9.5 Note OC.6	Assistance at any operation under an item in group T8 identified by the word "Assist." for which the fee exceeds $441.65 or at a series or combination of operations under items in group T8 identified by the word "Assist." for which the aggregate fee exceeds $441.65	Derived Fee
51306 Note T9.4	Assistance at a delivery involving Caesarean section	$98.65
51309 Note T9.4	Assistance at a series or combination of operations which have been identified by the word "Assist." and assistance at a delivery involving Caesarean section	Derived Fee
51312 Note DIA.6	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615, 16627 and 16633	Derived Fee

Item	Service	Fee ($)
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	$215.45
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	$142.20
	ORAL AND MAXILLOFACIAL SERVICES	
	GROUP O1 - CONSULTATIONS	
51700 Note OC.5 Note DIA.6	Professional attendance (other than a second or subsequent attendance in a single course of treatment) by an approved dental practitioner in the practice of oral and maxillofacial surgery, at consulting rooms, hospital or residential aged care facility where the patient is referred to him or her	$67.65
51703 Note OC.5	Professional attendance by an approved dental practitioner in the practice of oral and maxillofacial surgery, each attendance subsequent to the first in a single course of treatment at consulting rooms, hospital or residential aged care facility where the patient is referred to him or her	$33.95
	GROUP O2 - ASSISTANCE AT OPERATION	
51800 Note OC.6	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 $441.65 or at a series or combination of operations in groups O3 to O9 identified by the word "Assist." for which the aggregate fee does not exceed $441.65	$68.30
51803 Note OC.6	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 $441.65 or at a series or combination of operations identified by the word "Assist." where the aggregate fee exceeds $441.65	Derived Fee
	GROUP O3 - GENERAL SURGERY	
51900 Note OC.6 Note OC.7	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.)(Assist.)**	$257.85
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.)	$58.45
51904 Note OC.4 Note OC.6	Lipectomy - in the oral and maxillofacial region - wedge excision of skin or fat - 1 excision (Anaes.)(Assist.)	$359.80

Item	Service	Fee ($)
51906 Note OC.6 Note OC.7	Lipectomy - in the oral and maxillofacial region - wedge excision of skin or fat - 2 or more excisions (Anaes.)(Assist.)	$547.25
52000	Skin and subcutaneous tissue or mucous membrane, repair of recent wound of, on face or neck, small (not more than 7 cm long), superficial (Anaes.)	$65.25
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.)	$92.95
52006	Skin and subcutaneous tissue or mucous membrane, repair of recent wound of, on face or neck, large (more than 7 cm long), superficial (Anaes.)	$92.95
52009	Skin and subcutaneous tissue or mucous membrane, repair of recent wound of, on face or neck, large (more than 7 cm long), involving deeper tissue (Anaes.)	$146.90
52010 Note OC.6	Full thickness laceration of ear, eyelid, nose or lip, repair of, with accurate apposition of each layer of tissue (Anaes.)(Assist.)	$200.90
52012	Superficial foreign body, in the oral and maxillofacial region, removal of, as an independent procedure (Anaes.)	$18.55
52015	Subcutaneous foreign body, in the oral and maxillofacial region, removal of, requiring incision and suture, as an independent procedure (Anaes.)	$86.95
52018 Note OC.6	Foreign body in muscle, tendon or other deep tissue, in the oral and maxillofacial region, removal of, as an independent procedure (Anaes.)(Assist.)	$218.90
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.)	$23.30
52024	Biopsy of skin or mucous membrane, in the oral and maxillofacial region, as an independent procedure (Anaes.)	$41.30
52025	Lymph node of neck, biopsy of (Anaes.)	$145.45
52027	Biopsy of lymph gland, muscle or other deep tissue or organ, in the oral and maxillofacial region, as an independent procedure and not being a service to which item 52025 applies (Anaes.)	$118.45
52030	Sinus, in the oral and maxillofacial region, excision of, involving superficial tissue only (Anaes.)	$71.15
52033	Sinus, in the oral and maxillofacial region, excision of, involving muscle and deep tissue (Anaes.)	$145.45
52034	Premalignant lesions of the oral mucous, treatment by cryotherapy, diathermy or carbon dioxide laser	$33.95
52035 Note OC.7	Endoscopic laser therapy for neoplasia and benign vascular lesions of the oral cavity (Anaes.)	$376.60

Item	Service	Fee ($)
52036 Note OC.7	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 52039 applies (Anaes.)	$100.45
52039 Note OC.6 Note OC.7	Tumours, cysts, ulcers or scars (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.)(Assist.)	$257.85
52042 Note OC.7	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.)	$136.45
52045 Note OC.7	Tumour, cyst (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ulcer or scar (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, removal of, not being a service to which another item in Groups O3 to O9 applies, involving muscle, bone, or other deep tissue (Anaes.)	$194.95
52048 Note OC.6 Note OC.7	Tumour or deep cyst (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), in the oral and maxillofacial region, removal of, requiring wide excision, not being a service to which another item in Groups O3 to O9 applies (Anaes.)(Assist.)	$293.85
52051 Note OC.6 Note OC.7	Tumour, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.)(Assist.)	$397.30
52054 Note OC.6 Note OC.7	Tumour, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.)(Assist.)	$464.85
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)	$21.60
52056 Note OC.7	Haematoma in the oral and maxillofacial region, aspiration of (Anaes.)	$21.60
52057 Note OC.3	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.)	$128.95
52058	Percutaneous drainage of deep abscess in the oral and maxillofacial region, using interventional imaging techniques - but not including imaging (Anaes.)	$187.95

Item	Service	Fee ($)
52059	Abscess in the oral and maxillofacial region drainage tube, exchange of using interventional imaging techniques - but not including imaging (Anaes.)	$211.70
52060	Muscle in the oral and maxillofacial region, excision of (Anaes.)	$149.80
52061	Muscle, in the oral and maxillofacial region, ruptured, repair of (limited), not associated with external wound (Anaes.)	$176.90
52062 Note OC.6	Muscle, in the oral and maxillofacial region, ruptured, repair of (extensive), not associated with external wound (Anaes.)(Assist.)	$233.90
52063 Note OC.6	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.)(Assist.)	$281.90
52064	Bone cyst in the oral and maxillofacial region, injection into or aspiration of (Anaes.)	$134.05
52066 Note OC.6	Submandibular gland, extirpation of (Anaes.)(Assist.)	$352.35
52069	Sublingual gland, extirpation of (Anaes.)	$157.05
52072	Salivary gland, dilatation or diathermy of duct (Anaes.)	$46.50
52073	Salivary gland, repair of cutaneous fistula of (Anaes.)	$118.45
52075	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.)	$118.45
52078 Note OC.6	Tongue, partial excision of (Anaes.)(Assist.)	$233.90
52081	Tongue tie, division or excision of frenulum (Anaes.)	$36.80
52084	Tongue tie, mandibular frenulum or maxillary frenulum, division or excision of frenulum, in a person aged not less than 2 years (Anaes.)	$94.50
52087	Ranula or mucous cyst of mouth, removal of (Anaes.)	$161.95
52090 Note OC.6	Operation on mandible or maxilla (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.)(Assist.)	$281.90
52092 Note OC.6	Operation on skull for osteomyelitis (Anaes.)(Assist.)	$367.40
52094 Note OC.6	Operation on any combination of adjoining bones, being bones in the oral and maxillofacial region referred to in item 52092 (Anaes.)(Assist.)	$464.80
52095 Note OC.6	Bone growth stimulator in the oral and maxillofacial region, insertion of (Anaes.)(Assist.)	$301.20
52096	Orthopaedic pin or wire, insertion of, into maxilla or mandible or zygoma, as an independent procedure (Anaes.)	$89.30
52097	External fixation in the oral and maxillofacial region, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes.)	$126.65

Item	Service	Fee ($)
52098	External fixation in the oral and maxillofacial region, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.)	$148.95
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.)	$111.75
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.)	$111.75
52105 Note OC.6	Plate, 1 or more of, and associated screw and wire which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, not being a service associated with a service to which item 52099 or 52102 applies (Anaes.)(Assist.)	$208.55
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.)	$86.15
52108 Note OC.6	Lip, full thickness wedge excision of, with repair by direct sutures (Anaes.)(Assist.)	$257.85
52111 Note OC.6	Vermilionectomy (Anaes.)(Assist.)	$257.85
52114 Note OC.6	Mandible or maxilla, segmental resection of, for tumours or cysts (Anaes.)(Assist.)	$464.85
52117 Note OC.6	Mandible, including lower border, or maxilla, sub-total resection of (Anaes.)(Assist.)	$553.25
52120 Note OC.6	Mandible, hemimandiblectomy of, including condylectomy where performed (Anaes.)(Assist.)	$652.20
52122 Note OC.6	Mandible, hemi-mandibular reconstruction of, or maxilla reconstruction of, with bone graft, plate, tray or alloplast, not being a service associated with a service to which item 52123 applies (Anaes.)(Assist.)	$654.35
52123 Note OC.6	Mandible, total resection of both sides, including condylectomies where performed (Anaes.)(Assist.)	$740.85
52126 Note OC.6	Maxilla, total resection of (Anaes.)(Assist.)	$712.25
52129 Note OC.6	Maxilla, total resection of both maxillae (Anaes.)(Assist.)	$953.40
52130 Note OC.6 Note OC.7	Bone graft in the oral and maxillofacial region, not being a service to which another item in Groups O3 to O9 applies (Anaes.)(Assist.)	$350.00

Item	Service	Fee ($)
52131 Note OC.6 Note OC.7	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.)(Assist.)	$484.05
52132	Tracheostomy (Anaes.)	$188.95
52133	Cricothyrostomy by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.)	$72.00
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.)	$114.20
52138 Note OC.6	Maxillary artery, ligation of (Anaes.)(Assist.)	$352.35
52141 Note OC.6	Facial, mandibular or lingual artery or vein or artery and vein, ligation of, not being a service to which item 52138 applies (Anaes.)(Assist.)	$350.95
52144 Note OC.6	Foreign body, in the oral and maxillofacial region, deep, removal of using interventional imaging techniques (Anaes.)(Assist.)	$327.10
52147 Note OC.6	Duct of major salivary gland, transposition of (Anaes.)(Assist.)	$308.70
52148 Note OC.6	Parotid duct, repair of, using micro-surgical techniques (Anaes.)(Assist.)	$545.60
52158 Note OC.6	Submandibular ducts, relocation of, for surgical control of drooling (Anaes.)(Assist.)	$878.55
52180	Aggressive or potentially malignant bone or deep soft tissue tumour in the oral and maxillofacial region, biopsy of (not including aftercare) (Anaes.)	$148.95
52182 Note OC.6	Bone or malignant deep soft tissue tumour in the oral and maxillofacial region, lesional or marginal excision of (Anaes.)(Assist.)	$327.65
52184 Note OC.6	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.)(Assist.)	$484.05
52186 Note OC.6	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.)(Assist.)	$595.80
	GROUP O4 - PLASTIC & RECONSTRUCTIVE	
52300 Note OC.6	Single-stage local flap, in the oral and maxillofacial region, where indicated, repair to 1 defect, with skin or mucosa **(Anaes.)(Assist.)**	$224.95
52303 Note OC.6	Single-stage local flap, in the oral and maxillofacial region, where indicated, repair to 1 defect, with buccal pad of fat (Anaes.)(Assist.)	$321.10
52306 Note OC.6	Single-stage local flap, in the oral and maxillofacial region, where indicated, repair to 1 defect, using temporalis muscle (Anaes.)(Assist.)	$476.60
52309	Free grafting (mucosa or split skin) of a granulating area in the oral and maxillofacial region, (Anaes.)	$161.95

Item	Service	Fee ($)
52312 Note OC.6	Free grafting (mucosa, split skin or connective tissue) to 1 defect in the oral and maxillofacial region, including elective dissection (Anaes.)(Assist.)	$224.95
52315 Note OC.6	Free grafting, full thickness, to 1 defect (mucosa or skin) in the oral and maxillofacial region (Anaes.)(Assist.)	$374.80
52318 Note OC.7	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.)	$111.75
52319 Note OC.7	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.)	$185.95
52321 Note OC.6	Foreign implant (non-biological), insertion of in the oral and maxillofacial region, for contour reconstruction of pathological deformity, not being a service associated with a service to which item 52624 applies (Anaes.)(Assist.)	$374.80
52324 Note OC.6	Direct flap repair, using tongue, first stage (Anaes.)(Assist.)	$374.80
52327	Direct flap repair, using tongue, second stage (Anaes.)	$185.95
52330 Note OC.6	Palatal defect (oro-nasal fistula), plastic closure of, including services to which item 52300, 52303, 52306 or 52324 applies (Anaes.)(Assist.)	$618.55
52333 Note OC.6	Cleft palate, primary repair (Anaes.)(Assist.)	$618.55
52336 Note OC.6	Cleft palate, secondary repair, closure of fistula using local flaps (Anaes.)(Assist.)	$386.60
52337 Note OC.6	Alveolar cleft (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.)(Assist.)	$845.65
52339 Note OC.6	Cleft palate, secondary repair, lengthening procedure (Anaes.)(Assist.)	$440.30
52342 Note OC.6 Note OC.7	Mandible or maxilla, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.)(Assist.)	$764.75
52345 Note OC.6 Note OC.7	Mandible or maxilla, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.)(Assist.)	$862.45
52348 Note OC.6 Note OC.7	Mandible or maxilla, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.)(Assist.)	$974.60
52351 Note OC.6 Note OC.7	Mandible or maxilla, bilateral osteotomy of osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.)(Assist.)	$1,094.45

Item	Service	Fee ($)
52354 Note OC.6 Note OC.7	Mandible or maxilla, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.)(Assist.)	$1,109.50
52357 Note OC.6 Note OC.7	Mandible or maxilla, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.)(Assist.)	$1,249.15
52360 Note OC.6 Note OC.7	Mandible and maxilla, osteotomies or osteectomies of, involving 2 such procedures of each jaw including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.)(Assist.)	$1,274.35
52363 Note OC.6 Note OC.7	Mandible and maxilla, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.)(Assist.)	$1,433.55
52366 Note OC.6 Note OC.7	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.)(Assist.)	$1,401.90
52369 Note OC.6 Note OC.7	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.)(Assist.)	$1,576.20
52372 Note OC.6 Note OC.7	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.)(Assist.)	$1,529.40
52375 Note OC.6 Note OC.7	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.)(Assist.)	$1,713.10
52378 Note OC.6 Note OC.7	Genioplasty including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.)(Assist.)	$592.20
52379 Note OC.6	Face, contour reconstruction of 1 region, using autogenous bone or cartilage graft (Anaes.)(Assist.)	$1,011.15
52380 Note OC.6	Midfacial osteotomies - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.)(Assist.)	$1,723.35

Item	Service	Fee ($)
52382 Note OC.6	Midfacial osteotomies - Le Fort ii, Modified Le Fort iii (Nasomalar), Modified Le Fort iii (Malar-Maxillary), Le Fort iii involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.)(Assist.)	$2,065.75
52420	Mandible, fixation by intermaxillary wiring, excluding wiring for obesity	$190.75
52424 Note OC.6	Dermis, dermofat or fascia graft (excluding transfer of fat by injection) in the oral and maxillofacial region (Anaes.)(Assist.)	$374.70
52430 Note OC.6	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.)(Assist.)	$862.45
52440 Note OC.6	Cleft lip, unilateral - primary repair, 1 stage, without anterior palate repair (Anaes.)(Assist.)	$428.25
52442 Note OC.6	Cleft lip, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.)(Assist.)	$535.40
52444 Note OC.6	Cleft lip, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.)(Assist.)	$594.80
52446 Note OC.6	Cleft lip, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.)(Assist.)	$701.95
52450	Cleft lip, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.)	$237.90
52452 Note OC.6	Cleft lip, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.)(Assist.)	$386.60
52456 Note OC.6	Cleft lip reconstruction using full thickness flap (Abbe or similar), first stage (Anaes.)(Assist.)	$654.35
52458	Cleft lip reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.)	$237.90
52460	Velo-pharyngeal incompetence, pharyngeal flap for, or pharyngoplasty for (Anaes.)	$618.55
52480 Note OC.6	Composite graft (Chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Anaes.)(Assist.)	$397.30
52482 Note OC.6	Macrocheilia or macroglossia, operation for (Anaes.)(Assist.)	$382.25
52484 Note OC.6	Macrostomia, operation for (Anaes.)(Assist.)	$455.05
	GROUP O5 - PREPROSTHETIC	
52600 Note OC.6	Mandibular or palatal exostosis, excision of **(Anaes.)(Assist.)**	$267.60
52603 Note OC.6	Mylohyoid ridge, reduction of (Anaes.)(Assist.)	$255.80

Item	Service	Fee ($)
52606 Note OC.6	Maxillary tuberosity, reduction of (Anaes.)	$195.10
52609 Note OC.6	Papillary hyperplasia of the palate, removal of - less than 5 lesions (Anaes.)(Assist.)	$255.80
52612 Note OC.6	Papillary hyperplasia of the palate, removal of - 5 to 20 lesions (Anaes.)(Assist.)	$321.10
52615 Note OC.6	Papillary hyperplasia of the palate, removal of - more than 20 lesions (Anaes.)(Assist.)	$398.60
52618 Note OC.6	Vestibuloplasty, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.)(Assist.)	$463.85
52621 Note OC.6	Floor of mouth lowering (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.)(Assist.)	$463.85
52624 Note OC.6	Alveolar ridge augmentation with bone or alloplast or both - unilateral (Anaes.)(Assist.)	$374.70
52626 Note OC.6	Alveolar ridge augmentation - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.)(Assist.)	$229.75
52627 Note OC.6	Osseo-integration procedure - in the practice of oral and maxillofacial surgery, extra oral implantation of titanium fixture (Anaes.)(Assist.)	$398.60
52630	Osseo-integration procedure - in the practice of oral and maxillofacial surgery, fixation of transcutaneous abutment (Anaes.)	$147.50
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.)	$398.60
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.)	$147.50
	GROUP O6 - NEUROSURGICAL	
52800 Note OC.6	Neurolysis by open operation, in the oral and maxillofacial region, without transposition, not being a service associated with a service to which item 52803 applies **(Anaes.)(Assist.)**	$218.90
52803 Note OC.6	Nerve trunk, internal (interfascicular), in the oral and maxillofacial region, neurolysis of, using microsurgical techniques (Anaes.)(Assist.)	$315.20
52806 Note OC.6	Neurectomy, neurotomy or removal of tumour from superficial peripheral nerve in the oral and maxillofacial region (Anaes.)(Assist.)	$218.90
52809 Note OC.6	Neurectomy, neurotomy or removal of tumour from deep peripheral nerve in the oral and maxillofacial region (Anaes.)(Assist.)	$374.80
52812 Note OC.6	Nerve trunk, in the oral and maxillofacial region, primary repair of, using microsurgical techniques (Anaes.)(Assist.)	$535.40

Item	Service	Fee ($)
52815 Note OC.6	Nerve trunk, in the oral and maxillofacial region, secondary repair of, using microsurgical techniques (Anaes.)(Assist.)	$565.00
52818 Note OC.6	Nerve, in the oral and maxillofacial region, transposition of (Anaes.)(Assist.)	$374.80
52821 Note OC.6	Nerve graft to nerve trunk, in the oral and maxillofacial region (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.)(Assist.)	$814.85
52824 Note OC.6	Peripheral branches of the trigeminal nerve, cryosurgery of, for pain relief (Anaes.)(Assist.)	$350.95
52826	Injection of primary branch of trigeminal nerve with alcohol, cortisone, phenol, or similar substance (Anaes.)	$187.95
52828 Note OC.6	Cutaneous nerve, in the oral and maxillofacial region, primary repair of, using microsurgical techniques (Anaes.)(Assist.)	$279.55
52830 Note OC.6	Cutaneous nerve, in the oral and maxillofacial region, secondary repair of, using microsurgical techniques (Anaes.)(Assist.)	$368.70
52832 Note OC.6	Cutaneous nerve, in the oral and maxillofacial region, nerve graft to, using microsurgical techniques (Anaes.)(Assist.)	$505.60
	GROUP O7 - EAR, NOSE & THROAT	
53000	Maxillary antrum, proof puncture and lavage of **(Anaes.)**	$25.70
53003	Maxillary antrum, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.)	$72.80
53004	Maxillary antrum, lavage of - each attendance at which the procedure is performed, including any associated consultation (Anaes.)	$26.55
53006 Note OC.6	Antrostomy (radical) (Anaes.)(Assist.)	$412.30
53009 Note OC.6	Antrum, intranasal operation on, or removal of foreign body from (Anaes.)(Assist.)	$233.90
53012	Antrum, drainage of, through tooth socket (Anaes.)	$92.95
53015 Note OC.6	Oro-antral fistula, plastic closure of (Anaes.)(Assist.)	$464.85
53016 Note OC.6	Nasal septum, septoplasty, submucous resection or closure of septal perforation (Anaes.)(Assist.)	$382.25
53017 Note OC.6	Nasal septum, reconstruction of (Anaes.)(Assist.)	$476.95
53019 Note OC.6	Maxillary sinus, bone graft to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.)(Assist.)	$459.45
53052	Post-nasal space, direct examination of, with or without biopsy (Anaes.)	$97.10

Item	Service	Fee ($)
53054	Nasendoscopy or sinoscopy or fibreoptic examination of nasopharynx one or more of these procedures (Anaes.)	$97.05
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.)	$56.95
53058	Nasal haemorrhage, posterior, arrest of, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.)	$97.05
53060	Cauterisation (other than by chemical means) or cauterisation by chemical means when performed under general anaesthesia or diathermy of septum, turbinates for obstruction or haemorrhage secondary to surgery (or trauma) - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.)	$79.45
53062	Post surgical nasal haemorrhage, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.)	$71.15
53064	Cryotherapy to nose in the treatment of nasal haemorrhage (Anaes.)	$128.95
53068	Turbinectomy or turbinectomies, partial or total, unilateral (Anaes.)	$106.70
53070	Turbinates, submucous resection of, unilateral (Anaes.)	$140.85
	GROUP O8 - TEMPOROMANDIBULAR JOINT	
53200	Mandible, treatment of a dislocation of, not requiring open reduction **(Anaes.)**	$55.90
53203	Mandible, treatment of a dislocation of, requiring open reduction (Anaes.)	$94.00
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.)	$113.00
53209 Note OC.6	Glenoid fossa, zygomatic arch and temporal bone, reconstruction of (Obwegeser technique) (Anaes.)(Assist.)	$1,304.40
53212 Note OC.6	Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.)(Assist.)	$704.70
53215 Note OC.6	Temporomandibular joint, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.)(Assist.)	$323.20
53218 Note OC.6	Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more of such procedures (Anaes.)(Assist.)	$517.10
53220 Note OC.6	Temporomandibular joint, arthrotomy of, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$260.70
53221 Note OC.6	Temporomandibular joint, open surgical exploration of, with or without microsurgical techniques (Anaes.)(Assist.)	$690.00

Item	Service	Fee ($)
53224 Note OC.6	Temporomandibular joint, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.)(Assist.)	$764.90
53225 Note OC.6	Arthrocentesis, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.)(Assist.)	$229.75
53226 Note OC.6	Temporomandibular joint, synovectomy of, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$247.00
53227 Note OC.6	Temporomandibular joint, open surgical exploration of, with or without meniscus or capsular surgery, including meniscectomy when performed, with or without microsurgical techniques (Anaes.)(Assist.)	$939.85
53230 Note OC.6	Temporomandibular joint, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.)(Assist.)	$1,058.75
53233 Note OC.6	Temporomandibular joint, surgery of, involving procedures to which items 53224, 53226, 53227 and 53230 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.)(Assist.)	$1,189.65
53236 Note OC.6	Temporomandibular joint, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$372.30
53239 Note OC.6	Temporomandibular joint, arthrodesis of, not being a service to which another item in this Group applies (Anaes.)(Assist.)	$372.30
53242 Note OC.6	Temporomandibular joint or joints, application of external fixator to, other than for treatment of fractures (Anaes.)(Assist.)	$247.00
	GROUP O9 - TREATMENT OF FRACTURES	
53400 Note OC.7	Maxilla, unilateral or bilateral, treatment of fracture of, not requiring splinting	$102.20
53403 Note OC.7	Mandible, treatment of fracture of, not requiring splinting	$124.85
53406 Note OC.6 Note OC.7	Maxilla, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.)(Assist.)	$321.65
53409 Note OC.6 Note OC.7	Mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.)(Assist.)	$321.65
53410 Note OC.7	Zygomatic bone, treatment of fracture of, not requiring surgical reduction	$67.75
53411 Note OC.7	Zygomatic bone, treatment of fracture of, requiring surgical reduction, by temporal, intra-oral or other approach (Anaes.)	$188.95
53412 Note OC.6 Note OC.7	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.)(Assist.)	$310.15
53413 Note OC.6 Note OC.7	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.)(Assist.)	$379.00

Item	Service	Fee ($)
53414 Note OC.6 Note OC.7	Zygomatic bone, treatment of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.)(Assist.)	$436.45
53415 Note OC.6 Note OC.7	Maxilla, treatment of fracture of, requiring open reduction (Anaes.)(Assist.)	$344.65
53416 Note OC.6 Note OC.7	Mandible, treatment of fracture of, requiring open reduction (Anaes.)(Assist.)	$344.65
53418 Note OC.6 Note OC.7	Maxilla, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.)(Assist.)	$447.95
53419 Note OC.6 Note OC.7	Mandible, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.)(Assist.)	$447.95
53422 Note OC.6 Note OC.7	Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.)(Assist.)	$568.55
53423 Note OC.6 Note OC.7	Mandible, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.)(Assist.)	$568.55
53424 Note OC.6 Note OC.7	Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.)(Assist.)	$487.80
53425 Note OC.6 Note OC.7	Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.)(Assist.)	$487.80
53427 Note OC.6 Note OC.7	Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.)(Assist.)	$666.25
53429 Note OC.6 Note OC.7	Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.)(Assist.)	$666.25
53439 Note OC.7	Mandible, treatment of a closed fracture of, involving a joint surface (Anaes.)	$188.95
53453 Note OC.6	Orbital cavity, reconstruction of a wall or floor with or without foreign implant (Anaes.)(Assist.)	$382.25
53455 Note OC.6	Orbital cavity, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.)(Assist.)	$449.00
53458	Nasal bones, treatment of fracture of, not being a service to which item 53459 or 53460 applies	$34.00
53459	Nasal bones, treatment of fracture of, by reduction (Anaes.)	$186.25
53460 Note OC.6 Note DIA.6	Nasal bones, treatment of fractures of, by open reduction involving osteotomies (Anaes.)(Assist.)	$379.90

GROUP O10 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

Item	Service	Fee ($)
53600 Note OC.8	Skin sensitivity testing for allergens to anaesthetics and materials used in oms surgery, using 1 to 20 allergens	$30.80
	GROUP O11 - REGIONAL OR FIELD NERVE BLOCKS	
53700	(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.)) trigeminal nerve, primary division of, injection of an anaesthetic agent	$98.75
53702	Trigeminal nerve, peripheral branch of, injection of an anaesthetic agent	$49.45
53704	Facial nerve, injection of an anaesthetic agent	$29.75
53706 Note OC.9	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	$98.75
	DIAGNOSTIC IMAGING SERVICES	
	GROUP I1 - ULTRASOUND	
	Subgroup 1 - General	
55028 Interpretation Note DIH.2	Head, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$99.90
55029 Note DIA.1 Note DIH.2	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)	$34.65
55030 Interpretation Note DIH.2	Orbital contents, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)	$99.90
55031 Note DIA.1 Note DIH.2	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)	$34.65
55032 Interpretation Note DIH.2	Neck, 1 or more structures of, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$99.90

Item	Service	Fee ($)
55033 Note DIA.1 Note DIH.2	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)	$34.65
55036 Interpretation Note DIH.2	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: (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 providing 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)	$101.95
55037 Note DIA.1 Note DIH.2	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)	$34.65
55038 Interpretation Note DIH.2	Urinary tract, ultrasound scan of but not being a service associated with the service described in item 55600 or item 55603, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55036, 55044 or 55731 on the same patient within 24 hours (R)	$99.90
55039 Note DIA.1 Interpretation Note DIH.2	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)	$34.65
55044 Interpretation Note DIH.2	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: (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 providing practitioner is a member; and (c) the service is not performed with item 55036 or 55038 on the same patient within 24 hours (R)	$101.95
55045 Note DIA.1 Interpretation Note DIH.2	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)	$34.65
55048 Interpretation Note DIH.2	Scrotum, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)	$100.30

Item	Service	Fee ($)
55049 Note DIA.1 Note DIH.2	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)	$34.65
55054 Note DIA.1 Note DIH.2	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)	$99.90
55070 Interpretation	Breast, one, ultrasound scan of, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)	$90.00
55073 Note DIA.1	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)	$31.20
55076 Interpretation	Breasts, both, ultrasound scan of, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)	$99.90
55079 Note DIA.1	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)	$34.65
	Subgroup 2 - Cardiac	
55113 Note DIH.1	M-mode and 2 dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup, applies, for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain (r)	$244.75
55114 Note DIH.1	M-mode and 2 dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup, applies, for the investigation of suspected or known acquired valvular, aortic, pericardial, thrombotic, or embolic disease, or heart tumour (r)	$244.75

Item	Service	Fee ($)
55115 Note DIH.1	M-mode and 2 dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup, applies, for the investigation of symptoms or signs of congenital heart disease (r)	$244.75
55116 Note DIH.1	Exercise stress echocardiography performed in conjunction with item 11712, with two-dimensional recordings before exercise (baseline) from at least three acoustic windows and matching recordings from the same windows at, or immediately after, peak exercise, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup, applies. Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (r)	$244.75
55117 Note DIH.1	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, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup, applies. Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (r)	$244.75
55118 Note DIH.1	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, or another item in this Subgroup, applies (r) (Anaes.)	$244.20
55130 Note DIA.1	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.)	$353.60
	Subgroup 3 - Vascular	
55238 Note DIH.5	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb or of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R)	$169.45
55244 Note DIH.5	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R)	$169.45

Item	Service	Fee ($)
55246 Note DIH.5	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R)	$169.45
55248 Note DIH.5	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limb or of arteries and bypass grafts in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R)	$169.45
55252 Note DIH.5	Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R)	$169.45
55256 Note DIH.5	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 - (R)	$169.45
55262 Note DIH.5	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 - (R)	$169.45
55264 Note DIH.5	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 - (R)	$169.45
55266 Note DIH.5	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 - (R)	$169.45
55270 Note DIH.5	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 - (R)	$169.45
55274 Note DIH.5	Duplex scanning, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of extra-cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri-orbital Doppler examination, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Groups applies - (R)	$169.45

Item	Service	Fee ($)
55276 Note DIH.5	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 - (R)	$169.45
55277 Note DIH.5	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 - (R)	$109.40
55278 Note DIH.5	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 - (R)	$169.45
55279 Note DIH.5	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 - (R)	$109.40
55280 Note DIH.5	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-cranial vessels, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R)	$169.45
55282 Note DIH.5	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 - (R)	$169.45

Item	Service	Fee ($)
55284 Note DIH.5	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal tissue of the penis to confirm a diagnosis and, where indicated, assess the progress and management of: (a) priapism; or (b) fibrosis of any type; or (c) fracture of the tunica; or (d) arteriovenous malformations; where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Groups applies - (R)	$169.45
55288 Note DIH.5	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 55256 and 55256; block (b) - item 55244, 55246, 55262, and 55264; block (c) - item 55248, and 55266; block (d) - item 55252, 55270; 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 - (r)	$298.65
55290 Note DIH.5	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 and 55256, block (b) - item 55244, 55246, 55262 and 55264; block (c) - item 55248 and 55266; block (d) - item 55252 and 55270; 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 - (r)	$298.65
55292 Note DIH.5	Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of surgically created arteriovenous fistula or surgically created arteriovenous access graft in the upper or lower limb, not being a serivce associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies (r)	$169.45
55294 Note DIH.5	Duplex scanning, involving b mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or veins or arteries and veins, for mapping of bypass conduit prior to vascular surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054), 3 or 4 of this Group applies - including any associated skin marking (r)	$169.45

Item	Service	Fee ($)
55296 Note DIH.5	Duplex scanning, unilateral, involving b mode ultrasound imaging and integrated Doppler flow spectral analysis and marking of veins in the lower limb below the inguinal ligament prior to varicose vein surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054), 3 or 4 of this Group applies - including any associated skin marking (r)	$101.70
	Subgroup 4 - Urological	
55600 Interpretation Note DIH.6 Note DIH.8	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 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)	$99.90
55603 Interpretation Note DIH.6 Note DIH.8	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)	$99.90
	Subgroup 5 - Obstetric And Gynaecological	
55700 Interpretation Note DIH.2	Pelvis or abdomen, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (R)	$60.00

Item	Service	Fee ($)
55703 Note DIA.1 Note DIH.2	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)	$35.00
55704 Interpretation Note DIH.2	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (R)	$70.00

Item	Service	Fee ($)
55705 Note DIA.1 Note DIH.2	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)	$35.00
55706 Interpretation Note DIH.2 Note DIH.10	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner; and (b) the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) the service is not performed in the same pregnancy as item 55709 (R)	$100.00
55709 Note DIA.1 Note DIH.2 Note DIH.10	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)	$38.00
55712 Interpretation Note DIH.2 Note DIH.10 Note DIH.11 Note DIH.12 Note DIH.13	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (r)	$115.00

Item	Service	Fee ($)
55715 Note DIA.1 Note DIH.2 Note DIH.10	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where the providing practitioner 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)	$40.00
55718 Interpretation Note DIH.2 Note DIH.10 Note DIH.11	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:(a) the patient is referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d)the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) the service is not performed in the same pregnancy as item 55723; 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)	$100.00
55721 Interpretation Note DIH.2 Note DIH.10 Note DIH.11 Note DIH.12 Note DIH.13	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of by any or all approaches, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (r)	$115.00

Item	Service	Fee ($)
55723 Note DIA.1 Note DIH.2 Note DIH.10 Note DIH.11	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 (r)	$38.00
55725 Note DIA.1 Interpretation Note DIH.2 Note DIH.10 Note DIH.11	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where the providing practitioner 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)	$40.00
55728 Interpretation Note DIH.2 Note DIH.11 Note DIH.12 Note DIH.13	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) 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)	$100.00

Subgroup 1 - General

Item	Service	Fee ($)
55729 Note DIH.2	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 - (R)	$27.25
	Subgroup 5 - Obstetric And Gynaecological	
55731 Interpretation Note DIH.2	Pelvis, female, ultrasound scan of, by any or all approaches, where: (a) the patient is reffered 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 providing practitioner is a member; and (d) the service is not performed with item 55036 or 55038 on the same patient within 24 hours (R)	$98.00
55733 Note DIA.1 Note DIH.2	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)	$35.00
55736 Interpretation Note DIH.2	Pelvis, female, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of medical practitioners of which the providing practitioner is a member; and (d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R)	$127.00
55739 Note DIA.1 Note DIH.2	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)	$57.00
55759 Interpretation Note DIH.2 Note DIH.10	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) the service is not performed in conjunction with item 55706, 55709, 55712, or 55715 during the same pregnancy (r)	$150.00

Item	Service	Fee ($)
55762 Note DIA.1 Note DIH.2 Note DIH.10	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)	$60.00
55764 Interpretation Note DIH.2 Note DIH.10	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) further examination is clinically indicated in the same pregnancy to which item 55759 or 55762 has been performed; and (g) not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy (r)	$160.00
55766 Note DIA.1 Note DIH.2 Note DIH.10	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)	$65.00
55768 Interpretation Note DIH.2 Note DIH.10	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where: (a) dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) the ultrasound confirms a multiple pregnancy; and (c) the patient is referred by a medical practitioner; and (d) the service is not performed in the same pregnancy as item 55770; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which theproviding 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)	$150.00

Item	Service	Fee ($)
55770 Note DIA.1 Note DIH.2 Note DIH.10	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)	$60.00
55772 Interpretation Note DIH.2 Note DIH.10	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55723, 55725 or 55728 during the same pregnancy (r)	$160.00
55774 Note DIA.1 Note DIH.2 Note DIH.10	Pelvis or abdomen, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where the providing practitioner 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)	$65.00
	Subgroup 2 - Cardiac	
55800 Interpretation Note DIH.2 Note DIH.3	Hand or wrist, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$99.90
	Subgroup 1 - General	
55802 Note DIA.1 Note DIH.2 Note DIH.3	Hand or wrist, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr)	$34.65
	Subgroup 2 - Cardiac	

Item	Service	Fee ($)
55804 Interpretation Note DIH.2 Note DIH.3	Forearm or elbow, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$99.90
	Subgroup 1 - General	
55806 Note DIA.1 Note DIH.2 Note DIH.3	Forearm or elbow, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr)	$34.65
	Subgroup 2 - Cardiac	
55808 Interpretation Note DIH.2 Note DIH.3	Shoulder or upper arm, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member. (r)	$99.90
	Subgroup 1 - General	
55810 Note DIA.1 Note DIH.2 Note DIH.3	Shoulder or upper arm, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr)	$34.65
	Subgroup 2 - Cardiac	
55812 Interpretation Note DIH.2 Note DIH.3	Chest or abdominal wall, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$99.90
	Subgroup 1 - General	
55814 Note DIA.1 Note DIH.2 Note DIH.3	Chest or abdominal wall, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr)	$34.65
	Subgroup 2 - Cardiac	
55816 Interpretation Note DIH.2 Note DIH.3	Hip or groin, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$99.90
	Subgroup 1 - General	
55818 Note DIA.1 Note DIH.2 Note DIH.3	Hip or groin, 1 or both sides, ultrasound scan of, 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)	$34.65
	Subgroup 2 - Cardiac	
55820 Interpretation Note DIH.2 Note DIH.3	Paediatric hip examination for dysplasia, 1 or both sides, ultrasound scan of, 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 providing practitioner is a member (r)	$99.90
	Subgroup 1 - General	

Item	Service	Fee ($)
55822 Note DIA.1 Note DIH.2 Note DIH.3	Paediatric hip examination for dysplasia, 1 or both sides, ultrasound scan of, 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)	$34.65
	Subgroup 2 - Cardiac	
55824 Interpretation Note DIH.2 Note DIH.3	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 providing practitioner is a member (r)	$99.90
	Subgroup 1 - General	
55826 Note DIA.1 Note DIH.2 Note DIH.3	Buttock or thigh, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr)	$34.65
	Subgroup 2 - Cardiac	
55828 Interpretation Note DIH.2 Note DIH.3	Knee, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$99.90
	Subgroup 1 - General	
55830 Note DIA.1 Note DIH.2 Note DIH.3	Knee, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (nr)	$34.65
	Subgroup 2 - Cardiac	
55832 Interpretation Note DIH.2 Note DIH.3	Lower leg, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$99.90
	Subgroup 1 - General	
55834 Note DIA.1 Note DIH.2 Note DIH.3	Lower leg, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (nr)	$34.65
	Subgroup 2 - Cardiac	
55836 Interpretation Note DIH.2 Note DIH.3	Ankle or hind foot, 1 or both sides, ultrasound scan of, where: (a) the services is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$99.90
	Subgroup 1 - General	
55838 Note DIA.1 Note DIH.2 Note DIH.3	Ankle or hind foot, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (nr)	$34.65

Item	Service	Fee ($)
	Subgroup 2 - Cardiac	
55840 Interpretation Note DIH.2 Note DIH.3	Mid foot or fore foot, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$99.90
	Subgroup 1 - General	
55842 Note DIA.1 Note DIH.2 Note DIH.3	Mid foot or fore foot, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr)	$34.65
	Subgroup 2 - Cardiac	
55844 Interpretation Note DIH.2 Note DIH.3	Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$80.00
	Subgroup 1 - General	
55846 Note DIA.1 Interpretation Note DIH.2 Note DIH.3	Assessment of a mass associated with the skin or subcutaneous structures, not being a part of the musculoskeletal system, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in subgroups 2 or 3 of this group applies; and (b) the patient is not referred by a medical practitioner (nr)	$34.65
	Subgroup 2 - Cardiac	
55848 Note DIA.1 Note DIH.2 Note DIH.3	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)	$99.90
	Subgroup 1 - General	
55850 Note DIA.1 Interpretation Note DIH.2 Note DIH.3	Musculoskeletal cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, where: (a) the referring practitioner has indicated on a referral for a musculoskeletal ultrasound that a ultrasound guided intervention be performed if clinically indicated; (b) the service is not performed in conjunction with items 55054, or 55800 to 55848, and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$140.00
	Subgroup 6 - Musculoskeletal	
55852	Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of, where: a) the patient is referred by a medical practitioner b) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (r)	$99.90

Item	Service	Fee ($)
55854 Note DIA.1	Paediatric spine, spinal cord and overlying subcutaneous tissues, Ultrasound scan of, where: a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and b) the patient is not referred by a medical practitioner (nr)	$34.65
	GROUP I2 - COMPUTED TOMOGRAPHY	
56001 Note DII.12	computed tomography - scan of brain without intravenous contrast medium, not being a service to which item 57001 applies (r) (k) (Anaes.)	$185.25
56007 Note DII.12 Note DII.13	computed tomography - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57007 applies (r) (k) (Anaes.)	$237.50
56010	Computed tomography - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (r) (k) (Anaes.)	$239.50
56013	Computed tomography - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) (Anaes.)	$237.50
56016	Computed tomography - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (K) (Anaes.)	$275.50
56022	Computed tomography - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (K) (Anaes.)	$213.75
56028	Computed tomography - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to intravenous contrast injection, when undertaken (R) (K) (Anaes.)	$319.95
56030 Note DII.4	Computed tomography - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (K) (Anaes.)	$213.75
56036 Note DII.4	Computed tomography - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (K) (Anaes.)	$319.95
56041 Note DII.11	Computed tomography - scan of brain wihtout intravenous contrast medium, not being a service to which item 57041 applies (R) (NK) (Anaes.)	$93.80
56047 Note DII.11 Note DII.13	Computed tomography - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57047 applies (R) (NK) (Anaes.)	$119.80
56050 Note DII.11	Computed tomography - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) (Anaes.)	$121.75

Item	Service	Fee ($)
56053 Note DII.11	Computed tomography - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) (Anaes.)	$121.75
56056 Note DII.11	Computed tomography - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (NK) (Anaes.)	$147.65
56062 Note DII.11	Computed tomography - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (NK) (Anaes.)	$107.50
56068 Note DII.11	Computed tomography - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to intravenous contrast injection, when undertaken (R) (NK) (Anaes.)	$160.00
56070 Note DII.4 Note DII.11	Computed tomography - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (NK) (Anaes.)	$107.50
56076 Note DII.4 Note DII.11	Computed tomography - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (NK) (Anaes.)	$160.00
56101	Computed tomography - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56801 applies (R) (K) (Anaes.)	$218.50
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 associated with a service to which item 56807 applies (R) (K) (Anaes.)	$323.00
56141 Note DII.11	Computed tomography - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56841 applies (R) (NK) (Anaes.)	$110.60
56147 Note DII.11	Computed tomography - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) - with intravenous contrast medium and with any scans of soft tissues of neck including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) prior to intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56847 applies (r) (nk) (Anaes.)	$163.00
56219 Note DII.7 Note DIJ.9	Computed tomography - scan of spine, 1 or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated plain X-rays, not being a service to which item 59724 applies (R) (K) (Anaes.)	$309.90

Item	Service	Fee ($)
56220 Note DII.3 Note DII.7 Note DIJ.9	Computed tomography - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$228.00
56221 Note DII.3 Note DII.7 Note DIJ.9	Computed tomography - scan of spine, thoracic region, without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$228.00
56223 Note DII.3 Note DII.7 Note DIJ.9	Computed tomography - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$228.00
56224 Note DII.3	Computed tomography - scan of spine, cervical region, with intravenous contrast medium and with any scans of the cervical region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$333.80
56225 Note DII.3	Computed tomography - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$333.80
56226 Note DII.3	Computed tomography - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$333.80
56227 Note DII.3	Computed tomography - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$116.40
56228 Note DII.3	Computed tomography - scan of spine, thoracic region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$116.40
56229 Note DII.3	Computed tomography - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$116.40
56230 Note DII.3	Computed tomography - scan of spine, cervical region, with intravenous contrast medium, and with any scans to the cerival region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$168.60
56231 Note DII.3	Computed tomography - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$168.60
56232 Note DII.3	Computed tomography - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$168.60

Item	Service	Fee ($)
56233 Note DII.3	Note: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item computed tomography - scan of spine, two examinations of the kind referred to in items 56220, 56221 and 56223 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$228.00
56234 Note DII.3	Note: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item computed tomography - scan of spine, two examinations of the kind referred to in items 56224, 56225 and 56226 with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$333.80
56235 Note DII.3	Note: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item computed tomography - scan of spine, two examinations of the kind referred to in items 56227, 56228 and 56229 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$116.35
56236 Note DII.3	Note: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item computed tomography - scan of spine, two examinations of the kind referred to in items 56230, 56231 and 56232 with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$168.60
56237 Note DII.3	Computed tomography - scan of spine, three regions cervical, thoracic and lumbosacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$228.00
56238 Note DII.3	Computed tomography - scan of spine, three regions cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit, payable whether 1 or more attendances are required to complete the service (r) (k) (Anaes.)	$333.80
56239 Note DII.3	Computed tomography - scan of spine, three regions cervical, thoracic and lumbosacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$116.35
56240 Note DII.3	computed tomography - scan of spine, three regions cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit, payable whether 1 or more attendances are required to complete the service (r) (nk) (Anaes.)	$168.60

Item	Service	Fee ($)
56259 Note DII.11	Computed tomography - scan of spine, 1 or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated plain X-rays, not being a service to which item 59724 applies (R) (NK) (Anaes.)	$156.55
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) (Anaes.)	$280.25
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) (Anaes.)	$380.00
56341 Note DII.11	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) (Anaes.)	$142.00
56347 Note DII.11	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) (Anaes.)	$191.90
56401	Computed tomography - scan of upper abdomen only (diaphragm to iliac crest) without intravenous contrast medium, not being a service to which item 56301, 56501, 56801 or 57001 applies (R) (K) (Anaes.)	$237.50
56407	Computed tomography - scan of upper abdomen only (diaphragm to iliac crest) with intravenous contrast medium, and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56307, 56507, 56807 or 57007 applies (R) (K) (Anaes.)	$342.00
56409	Computed tomography - scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium not being a service associated with a service to which item 56401 applies (R) (K) (Anaes.)	$237.50
56412	Computed tomography - scan of pelvis only (iliac crest to pubic symphysis) with intravenous contrast medium and with any scans of pelvis (iliac crest to pubic symphysis) prior to intravenous contrast injection, when undertaken, not being a service to which item 56407 applies (R) (K) (Anaes.)	$342.00
56441	Computed tomography - scan of upper abdomen only (diaphragm to iliac crest), without intravenous contrast medium, not being a service to which item 56341, 56541, 56841 or 57041 applies (R) (NK) (Anaes.)	$120.45

Item	Service	Fee ($)
56447 Note DII.11	Computed tomography - scan of upper abdomen only (diaphragm to iliac crest), with intravenous contrast medium, and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56347, 56547, 56847 or 57047 applies (R) (NK) (Anaes.)	$172.40
56449 Note DII.11	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) (Anaes.)	$120.45
56452 Note DII.11	Computed tomography - scan of pelvis only (iliac crest to pubic symphysis) with intravenous contrast medium, and with any scans of pelvis (iliac crest to pubic symphysis) prior to intravenous contrast injection, when undertaken, not being a service to which item 56447 applies (R) (NK) (Anaes.)	$172.40
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) (Anaes.)	$365.75
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) (Anaes.)	$456.00
56541 Note DII.11	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) (Anaes.)	$183.45
56547 Note DII.11	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) (Anaes.)	$231.55
56619 Note DII.6	Computed tomography - scan of extremities, 1 or more regions without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.)	$209.00
56625	Computed tomography - scan of extremities, 1 or more regions with intravenous contrast medium and with any scans of extremities prior to intravenous contrast injection, when undertaken; only 1 benefit is payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.)	$317.90
56659 Note DII.11	Computed tomography - scan of extremities, 1 or more regions without intravenous contrast medium, payable once only whether 1 or more attendances are required to complete (R) (NK) (Anaes.)	$106.50
56665 Note DII.11	Computed tomography - scan of extremities, 1 or more regions with intravenous contrast medium, and with any scans of extremities prior to intravenous contrast injection, when undertaken; only 1 benefit is payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.)	$159.00

Item	Service	Fee ($)
56801	Computed tomography - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium, not including a study performed to exclude coronary artery calcification (R) (K) (Anaes.)	$443.20
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) (Anaes.)	$532.00
56841 Note DII.11	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) (Anaes.)	$221.65
56847 Note DII.11	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) (Anaes.)	$269.65
57001 Note DII.6	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) (Anaes.)	$443.30
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) (Anaes.)	$539.35
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) (Anaes.)	$221.70
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) (Anaes.)	$269.70
57201	Computed tomography - pelvimetry (R) (K) (Anaes.)	$147.45
57247 Note DII.11	Computed tomography - pelvimetry (R) (NK) (Anaes.)	$73.70
57341 Note DIA.1	Computed tomography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (K) (Anaes.)	$446.50
57345 Note DIA.1 Note DII.11	Computed tomography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (NK) (Anaes.)	$229.50

Item	Service	Fee ($)
57350 Note DII.5	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) (Anaes.)	$484.50
57351 Note DII.5	Computed tomography - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: a) the service is not a service to which another item in this group applies; and b) the service is performed for the exclusion of: acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgy; acute ruptured aneurysm; or acute dissection of the aorta, cartoid or vertebral artery; and c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months. (r) (k) (Anaes.)	$484.50
57355 Note DII.11	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) (Anaes.)	$250.95
57356 Note DII.5	Computed tomography - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: a) the service is not a service to which another item in this group applies; and b) the service is performed for the exclusion of: acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgy; or acute ruptured aneurysm; acute dissection of the aorta, cartoid or vertebral artery; and c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months. (r) (nk) (Anaes.)	$250.95
	GROUP I3 - DIAGNOSTIC RADIOLOGY	
	Subgroup 1 - Radiographic Examination Of Extremities	
57506 Note DIA.1	Hand, wrist, forearm, elbow or humerus (NR)	$28.05
57509	Hand, wrist, forearm, elbow or humerus (R)	$37.50
57512 Note DIA.1	Hand, wrist and forearm, or forearm and elbow, or elbow and humerus (NR)	$38.15

Item	Service	Fee ($)
57515	Hand, wrist and forearm, or forearm and elbow, or elbow and humerus (R)	$50.90
57518 Note DIA.1	Foot, ankle, leg, knee or femur (NR)	$30.65
57521	Foot, ankle, leg, knee or femur (R)	$40.90
57524 Note DIA.1	Foot and ankle, or ankle and leg, or leg and knee, or knee or femur (NR)	$46.55
57527	Foot and ankle, or ankle and leg, or leg and knee, or knee and femur (R)	$62.00
	Subgroup 2 - Radiographic Examination Of Shoulder Or Pelvis	
57700 Note DIA.1	Shoulder or scapula (NR)	$38.15
57703	Shoulder or scapula (R)	$50.90
57706 Note DIA.1	Clavicle (NR)	$30.65
57709	Clavicle (R)	$40.90
57712 Note DIA.4.7	Hip joint (R)	$44.45
57715 Note DIA.4.7	Pelvic girdle (R)	$57.45
57721	Femur, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R)	$93.55
	Subgroup 3 - Radiographic Examination Of Head	
57901 Note DIA.4.7	Skull, not in association with item 57902 (R)	$60.80
57902 Note DIA.4.7	Cephalometry, not in association with item 57901 (R)	$60.80
57903 Note DIA.4.7	Sinuses (R)	$44.55
57906	Mastoids (R)	$60.80
57909	Petrous temporal bones (R)	$60.80
57912 Note DIA.4.7	Facial bones orbit, maxilla or malar, any or all (R)	$44.45
57915 Note DIA.4.7	Mandible, not by orthopantomography technique (R)	$44.45
57918	Salivary calculus (R)	$44.45
57921	Nose (R)	$44.45
57924	Eye (R)	$44.45
57927	Temporomandibular joints (R)	$46.80

Item	Service	Fee ($)
57930	Teeth single area (R)	$31.00
57933	Teeth full mouth (R)	$73.75
57939	Palatopharyngeal studies with fluoroscopic screening (R)	$60.80
57942	Palatopharyngeal studies without fluoroscopic screening (R)	$46.80
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)	$40.90
57948 Note DIJ.4	Teeth, Orthopantomography, for diagnostic survey of the mandible or of the maxilla or of the mandible and the maxilla, and the associated dental structures (r)	$44.65
57951 Note DIJ.4	Teeth, Orthopantomography, for exclusion of a fracture following significant trauma, infection or tumour of the mandible or of the maxilla or of the mandible and the maxilla (r)	$44.65
57954 Note DIJ.4	Teeth, Orthopantomography, for further investigation or monitoring of a fracture, infection, or tumour of the mandible or of the maxilla or of the mandible and the maxilla (r)	$44.65
57957 Note DIJ.4	Teeth, Orthopantomography, for monitoring following surgery to the mandible or of the maxilla or of the mandible and the maxilla or to associated dental structures (r)	$44.65
	Subgroup 4 - Radiographic Examination Of Spine	
58100 Note DIA.4.7 Note DIJ.5	Spine cervical (R)	$63.30
58103 Note DIA.4.7 Note DIJ.5	Spine thoracic (R)	$51.95
58106 Note DIA.4.7 Note DIJ.5	Spine lumbosacral (R)	$72.55
58108 Note DIA.4.7	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (r)	$125.30
58109 Note DIA.4.7	Spine sacrococcygeal (R)	$44.30
58112 Note DIA.4.7 Note DIJ.5	Note: An account issued or a patient assignment form must show the item numbers of the examiniations performed under this item Spine, two examinations of the kind referred to in items 58100, 58103, 58106 and 58109 (r)	$91.65
58115 Note DIA.4.7 Note DIJ.5	Spine 3 or more regions (R)	$125.30

Item	Service	Fee ($)
	Subgroup 5 - Bone Age Study And Skeletal Surveys	
58300	Bone age study (R)	$37.80
58306	Skeletal survey (R)	$84.25
	Subgroup 6 - Radiographic Examination Of Thoracic Region	
58500 Note DIA.1	Chest (lung fields) by direct radiography (NR)	$33.30
58503	Chest (lung fields) by direct radiography (R)	$44.45
58506	Chest (lung fields) by direct radiography with fluoroscopic screening (R)	$57.30
58509	Thoracic inlet or trachea (R)	$37.50
58521 Note DIA.4.7	Left ribs, right ribs or sternum (R)	$40.90
58524 Note DIA.4.7	Left and right ribs, left ribs and sternum, or right ribs and sternum (R)	$53.25
58527 Note DIA.4.7	Left ribs, right ribs and sternum (R)	$65.45
	Subgroup 7 - Radiographic Examination Of Urinary Tract	
58700 Note DIA.4.7	Plain renal only (R)	$43.40
58706	Intravenous pyelography, with or without preliminary plain films and with or without tomography - (r)	$148.85
58715	antegrade or retrograde pyelography, with or without preliminary plain films and with preparation and contrast injection - 1 side - (r)	$142.85
58718	Retrograde cystography or retrograde urethrography with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.)	$118.90
58721	Retrograde micturating cysto-urethrography, with preparation and contrast injection - (R) (Anaes.)	$130.30
	Subgroup 8 - Radiographic Examination Of Alimentary Tract And Biliary System	
58900 Note DIA.1 Note DIJ.6	Plain abdominal only, not being a service associated with a service to which item 58909, 58912, 58915 or 58924 applies (NR)	$33.65
58903 Note DIJ.6	Plain abdominal only, not being a service associated with a service to which item 58909, 58912, 58915 or 58924 applies (R)	$44.85
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 - (R)	$84.80

Item	Service	Fee ($)
58912	Barium or other opaque meal of oesophagus, stomach, duodenum and follow through to colon, with or without screening of chest and with or without preliminary plain film (R)	$103.95
58915	Barium or other opaque meal, small bowel series only, with or without preliminary plain film (R)	$74.40
58916	Small bowel enema, barium or other opaque study of the small bowel, including duodenal intubation, with or without preliminary plain films, not being a service associated with a service to which item 30488 applies - (R) (Anaes.)	$130.55
58921	Opaque enema, with or without air contrast study and with or without preliminary plain films - (R)	$127.50
58924 Note DIA.4.7	Graham's test (cholecystography), with preliminary plain films and with or without tomography - (R)	$79.20
58927	Cholegraphy direct, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 30439 applies - (R)	$72.05
58933	Cholegraphy, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection - (R)	$193.80
58936	Cholegraphy, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography - (R)	$184.70
58939	Defaecogram (R)	$131.30
	Subgroup 9 - Radiographic Examination For Localisation Of Foreign Bodies	
59103 Note DIA.4.7	Foreign body, localisation of and report, not being a service to which another item in this Group applies (R)	Derived Fee
	Subgroup 10 - Radiographic Examination Of Breasts	
59300 Note DIA.4.2 Note DIJ.8	Radiographic examination of both breasts, (with or without thermography) 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)	$82.00
59303 Note DIA.4.2 Note DIJ.8	Radiographic examination of 1 breast, (with or without thermography) and (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)	$49.45
59306	Mammary ductogram (galactography) - 1 breast (R)	$94.55
59309	Mammary ductogram (galactography) - 2 breasts (R)	$189.10
59312 Note DIA.1	Radiographic examination of both breasts, in conjunction with a surgical procedure on each breast, using interventional techniques - (R)	$82.00

Item	Service	Fee ($)
59314 Note DIA.1	Radiographic examination of 1 breast, in conjunction with a surgical procedure using interventional techniques - (R)	$49.45
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 - (R)	$44.35
	Subgroup 11 - Radiographic Examination In Connection With Pregnancy	
59503	Pelvimetry, not being a service associated with a service to which item 57201 applies (R)	$84.25
	Subgroup 12 - Radiographic Examination With Opaque Or Contrast Media	
59700	Discography, each disc, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.)	$91.00
59703	Dacryocystography, 1 side, with or without preliminary plain film and with preparation and contrast injection - (R)	$71.55
59712	Hysterosalpingography, with without preliminary plain films and with preparation and contrast injection - (R) (Anaes.)	$107.20
59715	Bronchography, 1 side, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.)	$135.30
59718	Phlebography, 1 side, with or without preliminary plain films and with preparation and contrast injection - (r) (Anaes.)	$126.95
59724 Note DII.7 Note DIJ.9	Myelography, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 56219 applies - (R) (Anaes.)	$213.45
59733	Sialography, 1 side, with preparation and contrast injection, not being a service associated with a service to which item 57918 applies - (R)	$101.50
59736	Vasoepididymography, 1 side, for other than an investigation for reversal of previous sterilisation - (R)	$58.45
59739	Sinogram or fistulogram, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection - (R)	$69.50
59751	Arthrography, each joint, excluding the facet (zygapophyseal) joints of the spine, single or double contrast study, with or without preliminary plain films and with preparation and contrast injection - (R)	$131.15
59754	Lymphangiography, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection - (R)	$206.75
59760	Peritoneogram (herniography) with or without contrast medium including preparation - performed on a person over 14 years of age (R)	$108.55
59763	Air insufflation during video - fluoroscopic imaging including associated consultation (R)	$126.20
	Subgroup 13 - Angiography	

Item	Service	Fee ($)
59903 Note DIJ.10	Angiocardiography including the service described in item 59970, 59974 or 61109, not being a service to which item 59912 or 59925 applies (r) (k) (Anaes.)	$120.60
59912 Note DIJ.10	Selective coronary arteriography (r) (k), including the services described in item 59970, 59974 or 61109, not being a service to which item 59903 or 59925 applies (Anaes.)	$321.25
59925 Note DIJ.10	Selective coronary arteriography and angiocardiography, including the services described in items 59903, 59912, 59970, 59974 or 61109 (r) (k) (Anaes.)	$381.55
59970 Note DIJ.10	Angiography and/or digital subtraction angiography with fluoroscopy and image acquisition using a mobile image intensifier, one or more regions including any preliminary plain films, preparation and contrast injection (R) (K) (Anaes.)	$158.65
59971 Note DIJ.10	Angiocardiography including the service described in item 59970, 59974 or 61109, not being a service to which item 59972 or 59973 applies (r) (nk) (Anaes.)	$60.30
59972 Note DIJ.10	Selective coronary arteriography (r) (nk), including the service described in item 59970, 59974 or 61109, not being a service to which item 59971 or 59973 applies (Anaes.)	$160.65
59973 Note DIJ.10	Selective coronary arteriography and angiocardiography, including the services described in items 59970, 59971, 59972, 59974 or 61109 (r) (nk) (Anaes.)	$190.80
59974 Note DIJ.10	Angiography and/or digital subtraction angiography with fluoroscopy and image acquisition using a mobile image intensifier, 1 or more regions including any preliminary plain films, preparation and contrast injection (r) (nk) (Anaes.)	$79.35
60000 Note DIJ.11	Digital subtraction angiography, examination of head and neck with or without arch aortography - 1 to 3 data acquisition runs (R) (Anaes.)	$531.60
60003 Note DIJ.11	Digital subtraction angiography, examination of head and neck with or without arch aortography - 4 to 6 data acquisition runs (R) (Anaes.)	$779.60
60006 Note DIJ.11	Digital subtraction angiography, examination of head and neck with or without arch aortography - 7 to 9 data acquisition runs (R) (Anaes.)	$1,108.60
60009 Note DIJ.11	Digital subtraction angiography, examination of head and neck with or without arch aortography - 10 or more data acquisition runs (R) (Anaes.)	$1,297.30
60012 Note DIJ.11	Digital subtraction angiography, examination of thorax - 1 to 3 data acquisition runs (R) (Anaes.)	$531.60
60015 Note DIJ.11	Digital subtraction angiography, examination of thorax - 4 to 6 data acquisition runs (R) (Anaes.)	$779.60
60018 Note DIJ.11	Digital subtraction angiography, examination of thorax - 7 to 9 data acquisition runs (R) (Anaes.)	$1,108.60
60021 Note DIJ.11	Digital subtraction angiography, examination of thorax - 10 or more data acquisition runs (R) (Anaes.)	$1,297.30

Item	Service	Fee ($)
60024 Note DIJ.11	Digital subtraction angiography, examination of abdomen - 1 to 3 data acquisition runs (R) (Anaes.)	$531.60
60027 Note DIJ.11	Digital subtraction angiography, examination of abdomen - 4 to 6 data acquisition runs (R) (Anaes.)	$779.60
60030 Note DIJ.11	Digital subtraction angiography, examination of abdomen - 7 to 9 data acquisition runs (R) (Anaes.)	$1,108.60
60033 Note DIJ.11	Digital subtraction angiography, examination of abdomen - 10 or more data acquisition runs (R) (Anaes.)	$1,297.30
60036 Note DIJ.11	Digital subtraction angiography, examination of upper limb or limbs - 1 to 3 data acquisition runs (R) (Anaes.)	$531.60
60039 Note DIJ.11	Digital subtraction angiography, examination of upper limb or limbs - 4 to 6 data acquisition runs (R) (Anaes.)	$779.60
60042 Note DIJ.11	Digital subtraction angiography, examination of upper limb or limbs - 7 to 9 data acquisition runs (R) (Anaes.)	$1,108.60
60045 Note DIJ.11	Digital subtraction angiography, examination of upper limb or limbs - 10 or more data acquisition runs (R) (Anaes.)	$1,297.30
60048 Note DIJ.11	Digital subtraction angiography, examination of lower limb or limbs - 1 to 3 data acquisition runs (R) (Anaes.)	$531.60
60051 Note DIJ.11	Digital subtraction angiography, examination of lower limb or limbs - 4 to 6 data acquisition runs (R) (Anaes.)	$779.60
60054 Note DIJ.11	Digital subtraction angiography, examination of lower limb or limbs - 7 to 9 data acquisition runs (R) (Anaes.)	$1,108.60
60057 Note DIJ.11	Digital subtraction angiography, examination of lower limb or limbs - 10 or more data acquisition runs (R) (Anaes.)	$1,297.30
60060 Note DIJ.11	Digital subtraction angiography, examination of aorta and lower limb or limbs - 1 to 3 data acquisition runs (R) (Anaes.)	$531.60
60063 Note DIJ.11	Digital subtraction angiography, examination of aorta and lower limb or limbs - 4 to 6 data acquisition runs (R) (Anaes.)	$779.60
60066 Note DIJ.11	Digital subtraction angiography, examination of aorta and lower limb or limbs - 7 to 9 data acquisition runs (R) (Anaes.)	$1,108.60
60069 Note DIJ.11	Digital subtraction angiography, examination of aorta and lower limb or limbs - 10 or more data acquisition runs (R) (Anaes.)	$1,297.30
60072 Note DIA.1 Note DIJ.11	Selective arteriography or selective venography by digital subtraction angiography technique - 1 vessel (NR) (Anaes.)	$45.35
60075 Note DIA.1 Note DIJ.11	Selective arteriography or selective venography by digital subtraction angiography technique - 2 vessels (NR) (Anaes.)	$90.60

Item	Service	Fee ($)
60078 Note DIA.1 Note DIJ.11	Selective arteriography or selective venography by digital subtraction angiography technique - 3 or more vessels (NR) (Anaes.)	$135.95
	Subgroup 14 - Tomography	
60100	Tomography of any region (R) (Anaes.)	$57.30
	Subgroup 15 - Fluoroscopic Examination	
60500	Fluoroscopy, with general anaesthesia (not being a service associated with a radiographic examination) (R) (Anaes.)	$40.90
60503	Fluoroscopy, without general anaesthesia (not being a service associated with a radiographic examination)(R)	$28.05
60506 Note DIA.1	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)	$60.10
60509 Note DIA.1	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)	$93.20
	Subgroup 16 - Preparation For Radiological Procedure	
60918 Note DIA.1 Note DIJ.12	Arteriography (peripheral) or phlebography 1 vessel, when used in association with a service to which items 59903, 59912, 59925, 59970, 59971 59972, 59973 or 59974 applies, not being a service associated with a service to which items 60000 to 60078 inclusive apply (nr) (Anaes.)	$49.65
60927 Note DIA.1 Note DIJ.12	Selective arteriogram or phlebogram, when used in association with a service to which items 59903, 59912, 59925, 59970, 59971 59972, 59973 or 59974 applies, not being a service associated with a service to which items 60000 to 60078 inclusive apply (nr) (Anaes.)	$40.05
	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)	$244.05
	GROUP I4 - NUCLEAR MEDICINE IMAGING	
61302 Note DIK.5	Single stress or rest myocardial perfusion study - planar imaging	$397.10
61303 Note DIK.5	Single stress or rest myocardial perfusion study - with single photon emission tomography and with planar imaging when undertaken (R)	$500.15
61306 Note DIK.6	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)	$627.90
61307 Note DIK.6	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)	$738.65
61310	Myocardial infarct-avid-study, with planar imaging and single photon emission tomography, or planar imaging or single photon emission tomography (R)	$324.95

Item	Service	Fee ($)
61313	Gated cardiac blood pool study, (equilibrium), with planar imaging and single photon emission tomography, or planar imaging or single photon emission tomography (R)	$268.40
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)	$371.60
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)	$337.20
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)	$435.60
61320	Cardiac first pass blood flow study or cardiac shunt study, not being a service to which another item in this Group applies (R)	$202.55
61328	Lung perfusion study, with planar imaging and single photon emission tomography or planar imaging, or single photon emission tomography (R)	$201.40
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)	$223.85
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)	$392.25
61352	Liver and spleen study (colloid) - planar imaging (R)	$229.45
61353	Liver and spleen study (colloid), with single photon emission tomography and with planar imaging when undertaken (R)	$342.00
61356	Red blood cell spleen or liver study, including single photon emission tomography when undertaken (R)	$347.50
61360 Note DIK.7	Hepatobiliary study, including morphine administration or pre-treatment with cholecystokinin (CCK) when undertaken (R)	$356.85
61361 Note DIK.8	Hepatobiliary study with formal quantification following baseline imaging, using an infusion of cholecystokinin (CCK) (R)	$408.25
61364	Bowel haemorrhage study (R)	$439.65
61368	Meckel's diverticulum study (R)	$197.35
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)	$1,783.35

Item	Service	Fee ($)
61372	Salivary study (R)	$197.35
61373	Gastro-oesophageal reflux study, including delayed imaging on a separate occasion when undertaken (R)	$433.25
61376	Oesophageal clearance study (R)	$126.85
61381	Gastric emptying study, using single tracer (R)	$508.15
61383	Combined solid and liquid gastric emptying study using dual isotope technique or the same isotope on separate days (R)	$552.95
61384	Radionuclide colonic transit study (R)	$608.45
61386	Renal study, including perfusion and renogram images and computer analysis or cortical study with planar imaging (R)	$294.15
61387	Renal cortical study, with single photon emission tomography and planar quantification (R)	$381.10
61389	Single renal study with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R)	$327.85
61390	Renal study with diuretic administration following a baseline study (R)	$362.75
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)	$535.70
61397	Cystoureterogram (R)	$218.40
61401	Testicular study (R)	$143.55
61402	Cerebral perfusion study, with single photon emission tomography and with planar imaging when undertaken (R)	$535.30
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)	$306.10
61409	Cerebro-spinal fluid transport study, with imaging on 2 or more separate occasions (R)	$772.80
61413	Cerebro-spinal fluid shunt patency study (R)	$199.90
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)	$105.10
61421	Bone study - whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R)	$424.50
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)	$531.45

Item	Service	Fee ($)
61426 Note DIK.9	Whole body study using iodine (R)	$490.85
61429 Note DIK.9	Whole body study using gallium (R)	$480.40
61430 Note DIK.9	Whole body study using gallium, with single photon emission tomography (R)	$583.40
61433 Note DIK.9	Whole body study using cells labelled with technetium (R)	$439.65
61434 Note DIK.9	Whole body study using cells labelled with technetium, with single photon emission tomography (R)	$544.45
61437 Note DIK.9	Whole body study using thallium (R)	$480.20
61438 Note DIK.9	Whole body study using thallium, with single photon emission tomography (R)	$595.40
61441	Bone marrow study - whole body using technetium labelled bone marrow agents (R)	$433.25
61442	Whole body study, using gallium -- with single photon emission tomography of 2 or more body regions acquired separately (R)	$665.60
61445	Bone marrow study - localised using technetium labelled agent (R)	$253.75
61446	Localised bone or joint study, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (R)	$295.10
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)	$403.65
61450	Localised study using gallium (R)	$351.70
61453	Localised study using gallium, with single photon emission tomography (R)	$455.35
61454	Localised study using cells labelled with technetium (R)	$307.95
61457	Localised study using cells labelled with technetium, with single photon emission tomography (R)	$416.25
61458	Localised study using thallium (R)	$351.15
61461	Localised study using thallium, with single photon emission tomography (R)	$467.00
61462 Note DIK.4 Note DIK.10	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
61465	Venography (R)	$234.90
61469	Lymphoscintigraphy (R)	$307.95

Item	Service	Fee ($)
61473 Note DIK.11	Thyroid study including uptake measurement when undertaken (R)	$155.15
61480	Parathyroid study, planar imaging and single photon emission tomography when undertaken (R)	$342.25
61484	Adrenal study, with imaging on 2 or more separate occasions (r)	$779.30
61485	Adrenal study, with imaging on 2 or more occasions and renal localisation and single photon emission tomography when undertaken (R)	$884.05
61495	Tear duct study (R)	$197.35
61499	Particle perfusion study (infra-arterial) or Le Veen shunt study (R)	$223.85
61506	Test item reserved for item fee map - do not use for any procedure	$0.05
61523	Whole body FDG PET study, performed for evaluation of a solitary pulmonary nodule where the lesion is considered unsuitable for transthoracic fine needle aspiration, or for which an attempt at pathological characterisation has failed.	$953.00
61526	Whole body FDG PET study, performed for evaluation of a solitary nodule where the lesion is considered unsuitable for transthoracic fine needle aspiration, or for which an attempt at pathological characterisation has failed, with catheterisation of the bladder	$975.00
61529	Whole body FDG PET study, performed for the primary staging of proven non-small cell lung cancer, where curative surgery or radiotherapy is planned	$953.00
61532	Whole body FDG PET study, performed for the primary staging of proven non-small cell lung cancer, where curative surgery or radiotherapy is planned, with catheterisation of the bladder	$975.00
61535	FDG PET study of the brain performed for the evaluation of a suspected primary brain tumour to guide surgical biopsy of the lesion and to assist in treatment planning	$901.00
61538	FDG PET study of the brain performed for the evaluation of a residual structural brain lesion based on anatomical imaging findings, after definitive therapy for glioma	$901.00
61541	Whole body FDG PET study, performed in a symptomatic patient for the evaluation of a residual structural lesion, after definitive therapy for colorectal cancer	$953.00
61544	Whole body FDG PET study, performed in a symptomatic patient for the evaluation of a residual structural lesion after definitive therapy for colorectal cancer, with catheterisation of the bladder	$975.00
61547	Whole body FDG PET study, performed for the evaluation of apparently isolated liver or pulmonary metastases, following previous therapy for colorectal carcinoma, where surgical resection is planned	$953.00

Item	Service	Fee ($)
61550	Whole body FDG PET study, performed for the evaluation of apparently isolated liver or pulmonary metastases, following previous therapy for colorectal carcinoma, where surgical resection is planned, with catheterisation of the bladder	$975.00
61553	Whole body FDG PET study, performed for the evaluation of apparently limited metastatic disease from malignant melanoma, where surgical resection is planned	$999.00
61556	Whole body FDG PET study, performed for the evaluation of apparently limited metastatic disease from malignant melanoma, where surgical resection is planned, with catheterisation of the bladder	$1,021.00
61559	FDG PET study of the brain, performed for the evaluation of refractory epilepsy which is being evaluated for surgery, where results of standard assessment are inconclusive for localisation of the epileptogenic focus	$918.00
61562	FDG PET study of the heart, performed for the evaluation of ischaemic heart disease and impaired left ventricular function, where revascularisation surgery is being considered and standard myocardial viability tests are negative or equivocal for ischaemia	$899.00
61565	Whole body FDG PET study, performed for the evaluation of epithelial ovarian carcinoma with suspected tumour recurrence following initial therapy, based on equivocal anatomical imaging findings or an elevation of CA-125	$953.00
61568	Whole body FDG PET study, performed for the evaluation of epithelial ovarian carcinoma with suspected tumour recurrence following initial therapy, based on equivocal anatomical imaging findings or an elevation of CA-125, with catheterisation of the bladder	$975.00
61571	Whole body FDG PET study, performed for the primary staging of proven carcinoma of the uterine cervix, prior to planned radical radiation therapy or combined modality therapy	$953.00
61574	Whole body FDG PET study, performed for the primary staging of proven carcinoma of the uterine cervix, prior to planned radical radiation therapy or combined modality therapy, with catheterisation of the bladder	$975.00
61577	Whole body FDG PET study, performed for the staging of proven oesophageal carcinoma, where curative surgery or chemoradiation is planned	$953.00
61580	Whole body FDG PET study, performed for the staging of proven oesophageal carcinoma, where curative surgery or chemoradiation is planned, with catheterisation of the bladder	$975.00
61583	Whole body FDG PET study, performed for the staging of proven gastric carcinoma, where curative surgery is planned	$953.00
61586	Whole body FDG PET study, performed for the staging of proven gastric carcinoma, where curative surgery is planned, with catheterisation of the bladder	$975.00

Item	Service	Fee ($)
61589	FDG PET study for follow-up of a cancer shown to be positive by an earlier FDG PET service (the earlier service), if (a) the earlier service was eligible for Medicare benefit because of Health Insurance Determination HS/3/1997, (b) the service is not eligible for Medicare benefit otherwise than because of Health Insurance Determination HS/02/2001, and (c) the service is required to assess response to treatment or possible tumour recurrence	$953.00
61592	FDG PET study, with catheterisation of the bladder, for follow-up of a cancer shown to be positive by an earlier FDG PET service (the earlier service), if (a) the earlier service was eligible for Medicare benefit because of Health Insurance Determination HS/3/1997, (b) the service is not eligible for Medicare benefit otherwise than because of Health Insurance Determination HS/02/2001, and (c) the service is required to assess response to treatment or possible tumour recurrence	$975.00
	GROUP I5 - MAGNETIC RESONANCE IMAGING	
	Subgroup 1 - Scan Of Head - For The Exclusion Of Specified Conditons	
63000 Note DIL.2	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for the exclusion of tumour of the brain or meninges (R) (Anaes.)	$475.00
63003	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for the exclusion of skull base or orbital tumour (R) (Anaes.)	$475.00
63006	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for the exclusion of acoustic neuroma (R) (Anaes.)	$475.00
63009	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for the exclusion of pituitary tumour (R) (Anaes.)	$475.00
63012	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for the exclusion of inflammation of brain or meninges (R) (Anaes.)	$475.00
63015	MRI - scan of head (with or without intravenous contrast and including MRA if performed) for the exclusion of toxic or metabolic or ischaemic encephalopathy (R) (Anaes.)	$475.00
63018	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for the exclusion of demyelinating disease of the brain (R) (Anaes.)	$475.00
63021	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for the exclusion of congenital malformation of brain or meninges (R)	$475.00
63024	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for the exclusion of venous sinus thrombosis (R) (Anaes.)	$475.00
	Subgroup 2 - Scan Of Head And Cervical Spine - For The Exclusion Of Specified Conditions	
63050	MRI - scan of head and cervical spine (with or without intravenous contrast and including MRA, if performed) for the exclusion of tumour of the central nervous system or meninges (R) (Anaes.)	$475.00

Item	Service	Fee ($)
63053	MRI - scan of head and cervical spine (with or without intravenous contrast and including MRA, if performed) for the exclusion of inflammation of the central nervous system or meninges (R) (Anaes.)	$475.00
63056	MRI - scan of head and cervical spine (with or without intravenous contrast and including MRA, if performed) for the exclusion of demyelinating disease of the central nervous system (R) (Anaes.)	$475.00
63059	MRI - scan of head and cervical spine (with or without intravenous contrast and including MRA, if performed) for the exclusion of congenital malformation of the central nervous system or meninges (R) (Anaes.)	$475.00
63062	MRI - scan of head and cervical spine (with or without intravenous contrast and including MRA, if performed) for the exclusion of syrinx - congenital or acquired (R) (Anaes.)	$475.00
	Subgroup 3 - Scan Of Head - For Further Investigation Of Specified Conditions	
63100	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for further investigation of tumour of the brain or meninges (R) (Anaes.)	$475.00
63103	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for further investigation of skull base or orbital tumour (R) (Anaes.)	$475.00
63106	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for further investigation of acoustic neuroma (R) (Anaes.)	$475.00
63109	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for further investigation of pituitary tumour (R) (Anaes.)	$475.00
63112	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for further investigation of inflammation of the brain or meninges (R) (Anaes.)	$475.00
63115	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for further investigation of toxic or metabolic or ischaemic encephalopathy (R) (Anaes.)	$475.00
63118	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for further investigation of demyelinating disease of the brain (R) (Anaes.)	$475.00
63121	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for further investigation of congenital malformation of the brain or meninges (R) (Anaes.)	$475.00
63124	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for further investigation of head trauma (R) (Anaes.)	$475.00
63127	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for further investigation of epilepsy (R) (Anaes.)	$475.00

Item	Service	Fee ($)
63130	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for further investigation of stroke (R) (Anaes.)	$475.00
63133	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for further investigation of venous sinus thrombosis (R) (Anaes.)	$475.00
	Subgroup 4 - Scan Of Head And Cervical Spine - For Further Investigation Of Specified Conditions	
63150	MRI - scan of head and cervical spine (with or without intravenous contrast and including MRA, if performed) for further investigation of tumour of the central nervous system or meninges (R) (Anaes.)	$475.00
63153	MRI - scan of head and cervical spine (with or without intravenous contrast and including MRA, if performed) for further investigation of inflammation of the central nervous system or meninges (R) (Anaes.)	$475.00
63156	MRI - scan of head and cervical spine (with or without intravenous contrast and including MRA, if performed) for further investigation of demyelinating disease of the central nervous system (R) (Anaes.)	$475.00
63159	MRI - scan of head and cervical spine (with or without intravenous contrast and including MRA, if performed) for further investigation of congenital malformation of the central nervous system or meninges (R) (Anaes.)	$475.00
63162	MRI - scan of head and cervical spine (with or without intravenous contrast and and including MRA, if performed) for further investigation of syrinx - congenital or acquired (R) (Anaes.)	$475.00
	Subgroup 5 - Scan Of Head - For Monitoring Of Specified Conditions	
63200	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for monitoring of acoustic neuroma (R) (Anaes.)	$475.00
63203	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for monitoring of pituitary tumour (R) (Anaes.)	$475.00
63206	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for monitoring of demyelinating disease of the brain (R) (Anaes.)	$475.00
63209	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for monitoring of congenital malformation of brain or meninges (R) (Anaes.)	$475.00
63212	MRI - scan of head (with or without intravenous contrast, and including MRA, if performed) for monitoring of head trauma (R) (Anaes.)	$475.00
63215	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for monitoring of epilepsy (R) (Anaes.)	$475.00
63218	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for monitoring of stroke (R) (Anaes.)	$475.00
63221	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for monitoring of toxic or metabolic or ischaemic encephalopathy (R) (Anaes.)	$475.00

Item	Service	Fee ($)
	Subgroup 6 - Scan Of Head And Cervical Spine - For Monitoring Of Specified Conditions	
63250	MRI - scan of head and cervical spine (with or without intravenous contrast and including MRA, if performed) for monitoring of demyelinating disease of the central nervous system (R) (Anaes.)	$475.00
63253	MRI - scan of head and cervical spine (with or without intravenous contrast and including MRA, if performed) for monitoring of congenital malformation of the central nervous system or meninges (R) (Anaes.)	$475.00
63256	MRI - scan of head and cervical spine (with or without intravenous contrast and including MRA, if performed) for monitoring of syrinx - congenital or acquired (R) (Anaes.)	$475.00
	Subgroup 7 - Scan Of Head - For Monitoring Of Specified Conditions	
63270	MRI - scan of head (with or without intravenous contrast and including MRA if performed) for monitoring of tumour of the brain or meninges (R) (Anaes.)	$475.00
63273	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for monitoring of skull base or orbital tumour (R) (Anaes.)	$475.00
63276	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for monitoring of inflammation of brain or meninges (R) (Anaes.)	$475.00
63279	MRI - scan of head (with or without intravenous contrast and including MRA, if performed) for monitoring of venous sinus thrombosis (R) (Anaes.)	$475.00
	Subgroup 8 - Scan Of Head And Cervical Spine - For Monitoring Of Specified Conditions	
63290	MRI - scan of head and cervical spine (with or without intravenous contrast and including MRA, if performed) for monitoring of tumour of the central nervous system or meninges (R) (Anaes.)	$475.00
63293	MRI - scan of head and cervical spine (with or without intravenous contrast and including MRA, if performed) for monitoring of inflammation of the central nervous system or meninges (R) (Anaes.)	$475.00
	Subgroup 9 - Scan Of Spine - One Region Or Two Contiguous Regions - For The Exclusion Of A Specified Condition	
63300	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for the exclusion of infection (R) (Anaes.)	$475.00
63303	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for the exclusion of tumour (R) (Anaes.)	$475.00
63306	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for the exclusion of demyelinating disease (R) (Anaes.)	$475.00
63309	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for the exclusion of congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.)	$475.00
63312	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for the exclusion of myelopathy (R) (Anaes.)	$475.00

Item	Service	Fee ($)
63315	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for the exclusion of syrinx - congenital or acquired (R) (Anaes.)	$475.00
	Subgroup 10 - Scan Of Spine - Three Contiguous Or Two Non Contiguous Regions - For The Exclusion Of Specified Conditions	
63350	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for the exclusion of infection (R) (Anaes.)	$475.00
63353	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for the exclusion of tumour (R) (Anaes.)	$475.00
63356	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for the exclusion of demyelinating disease (R) (Anaes.)	$475.00
63359	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for the exclusion of congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.)	$475.00
63362	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for the exclusion of myelopathy (R) (Anaes.)	$475.00
63365	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for the exclusion of syrinx - congenital or acquired (R) (Anaes.)	$475.00
	Subgroup 11 - Scan Of Spine - One Region Or Two Contiguous Regions - For Further Investigation Of Specified Conditions	
63400	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for further investigation of infection (R) (Anaes.)	$475.00
63403	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for further investigation of tumour (R) (Anaes.)	$475.00
63406	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for further investigation of demyelinating disease (R) (Anaes.)	$475.00
63409	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for further investigation of congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.)	$475.00
63412	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for further investigation of myelopathy (R) (Anaes.)	$475.00
63415	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for further investigation of syrinx - congenital or acquired (R) (Anaes.)	$475.00

Item	Service	Fee ($)
63418	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for further investigation of cervical radiculopathy (R) (Anaes.)	$475.00
63421	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for further investigation of sciatica (R) (Anaes.)	$475.00
63424	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for further investigation of spinal canal stenosis (R) (Anaes.)	$475.00
63427	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast)for further investigation of previous spinal surgery (R) (Anaes.)	$475.00
63430	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for further investigation of trauma (R) (Anaes.)	$475.00
	Subgroup 12 - Scan Of Spine - Three Contiguous Or Two Non Contiguous Regions - For Further Investigation Of Specified Conditions	
63450	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for further investigation of infection (R) (Anaes.)	$475.00
63453	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for further investigation of tumour (R) (Anaes.)	$475.00
63456	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for further investigation of demyelinating disease (R) (Anaes.)	$475.00
63459	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for the further investigation of congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.)	$475.00
63462	MRI - scan of 3 contiguous regions or 2 non contiguous regions of the spine (with or without intravenous contrast) for further investigation of myelopathy (R) (Anaes.)	$475.00
63465	MRI - scan of 3 contiguous regions or 2 non contiguous regions of the spine (with or without intravenous contrast) for further investigation of syrinx - congenital or acquired (R) (Anaes.)	$475.00
63468	MRI - scan of 3 contiguous regions or 2 non contiguous regions of the spine (with or without intravenous contrast) for the further investigation cervical radiculopathy (R) (Anaes.)	$475.00
63471	MRI - scan of 3 contiguous regions or 2 non contiguous regions of the spine (with or without intravenous contrast) for the further investigation of sciatica (R) (Anaes.)	$475.00

Item	Service	Fee ($)
63474	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for the further investigation of spinal canal stenosis (R) (Anaes.)	$475.00
63477	MRI - scan of 3 contiguous regions or 2 non contiguous regions of the spine (with or without intravenous contrast) for the further investigation of previous spinal surgery (R) (Anaes.)	$475.00
63480	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for the further investigation of trauma (R) (Anaes.)	$475.00
	Subgroup 13 - Scan Of Spine - One Region Or Two Contiguous Regions - For Monitoring Of Specified Conditions	
63500	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for monitoring of demyelinating disease (R) (Anaes.)	$475.00
63503	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for monitoring of congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.)	$475.00
63506	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for monitoring of myelopathy (R) (Anaes.)	$475.00
63509	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for monitoring of syrinx - congenital or acquired (R) (Anaes.)	$475.00
63512	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for monitoring of cervical radiculopathy (R) (Anaes.)	$475.00
63515	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for monitoring of sciatica (R) (Anaes.)	$475.00
63518	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for monitoring of spinal canal stenosis (R) (Anaes.)	$475.00
63521	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for monitoring of previous spinal surgery (R) (Anaes.)	$475.00
63524	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for monitoring of trauma (R) (Anaes.)	$475.00
	Subgroup 14 - Scan Of Spine - Three Contiguous Or Two Non Contiguous Regions - For Monitoring Of Specified Conditions	
63550	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for monitoring of demyelinating disease (R) (Anaes.)	$475.00
63553	MRI - scan of 3 contiguous regions or 2 non contiguous regions of the spine (with or without intravenous contrast) for the monitoring of congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.)	$475.00

Item	Service	Fee ($)
63556	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for the monitoring of myelopathy (R) (Anaes.)	$475.00
63559	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for the monitoring of syrinx - congenital or acquired (R) (Anaes.)	$475.00
63562	MRI - scan of up to 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for monitoring of cervical radiculopathy (R) (Anaes.)	$475.00
63565	MRI - scan of up to 3 contiguous regions or 2 non contiguous regions of the spine (with or without intravenous contrast) for monitoring of sciatica (R) (Anaes.)	$475.00
63568	MRI - scan of up to 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for monitoring of spinal canal stenosis (R) (Anaes.)	$475.00
63571	MRI - scan of up to 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for monitoring of previous spinal surgery (R) (Anaes.)	$475.00
63574	MRI - scan of 3 contiguous regions or 2 non contiguous regions of the spine (with or without intravenous contrast) for monitoring of trauma (R) (Anaes.)	$475.00
	Subgroup 15 - Scan Of Spine - One Region Or Two Contiguous Regions - For Monitoring Of Specified Conditions	
63580	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for monitoring of infection (R) (Anaes.)	$475.00
63583	MRI - scan of 1 region or 2 contiguous regions of the spine (with or without intravenous contrast) for monitoring of tumour (R) (Anaes.)	$475.00
	Subgroup 16 - Scan Of Spine - Three Contiguous Or Two Non Contiguous Regions - For Monitoring Of Specified Conditions	
63590	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for monitoring of infection (R) (Anaes.)	$475.00
63593	MRI - scan of 3 contiguous regions or 2 non-contiguous regions of the spine (with or without intravenous contrast) for monitoring of tumour (R) (Anaes.)	$475.00
	Subgroup 17 - Scan Of Musculoskeletal System - For The Exclusion Of Specified Conditions	
63600	MRI - scan of musculoskeletal system (with or without intravenous contrast) for the exclusion of tumour arising in bone or other connective tissue (R) (Anaes.)	$475.00
63603	MRI - scan of musculoskeletal system (with or without intravenous contrast) for the exclusion of infection arising in bone or other connective tissue (R) (Anaes.)	$475.00
63606	MRI - scan of musculoskeletal system (with or without intravenous contrast) for the exclusion of osteonecrosis (R) (Anaes.)	$475.00

Item	Service	Fee ($)
63609 Note DIL.3	MRI - scan of musculoskeletal system (with or without intravenous contrast) for the exclusion of - derangement of hip or its supporting structures (R) (Anaes.)	$475.00
63612	MRI - scan of musculoskeletal system (with or without intravenous contrast) for the exclusion of derangement of shoulder or its supporting structures (R) (Anaes.)	$475.00
63615	MRI - scan of musculoskeletal system (with or without intravenous contrast) for the exclusion of derangement of knee or its supporting structures (R) (Anaes.)	$475.00
63618	MRI - scan of musculoskeletal system (with or without intravenous contrast) for the exclusion of derangement of ankle or its supporting structures (R) (Anaes.)	$475.00
63621 Note DIL.2	MRI - scan of musculoskeletal system (with or without intravenous contrast) for the exclusion of derangement of temporomandibular joint or its supporting structures (R) (Anaes.)	$475.00
63624	MRI - scan of musculoskeletal system (with or without intravenous contrast) for the exclusion of derangement of wrist or its supporting structures (R) (Anaes.)	$475.00
63627	MRI - scan of musculoskeletal system (with or without intravenous contrast) for the exclusion of derangement of elbow or its supporting structures (R) (Anaes.)	$475.00
	Subgroup 18 - Scan Of Musculoskeletal System - For Further Investigation Of Specified Conditions	
63650	MRI - scan of musculoskeletal system (with or without intravenous contrast) for further investigation of tumour arising in bone or other connective tissue (R) (Anaes.)	$475.00
63653	MRI - scan of musculoskeletal system (with or without intravenous contrast) for further investigation of infection arising in bone or other connective tissue (R) (Anaes.)	$475.00
63656	MRI - scan of musculoskeletal system (with or without intravenous contrast) for further investigation of osteonecrosis (R) (Anaes.)	$475.00
63659	MRI - scan of musculoskeletal system (with or without intravenous contrast) for further investigation of derangement of hip or its supporting structures (R) (Anaes.)	$475.00
63662	MRI - scan of musculoskeletal system (with or without intravenous contrast) for further investigation of derangement of shoulder or its supporting structures (R) (Anaes.)	$475.00
63665	MRI - scan of musculoskeletal system (with or without intravenous contrast) for further investigation of derangement of knee or its supporting structures (R) (Anaes.)	$475.00

Item	Service	Fee ($)
63668	MRI - scan of musculoskeletal system (with or without intravenous contrast) for further investigation of derangement of ankle or its supporting structures (R) (Anaes.)	$475.00
63671 Note DIL.2	MRI - scan of musculoskeletal system (with or without intravenous contrast) for further investigation of derangement of temporomandibular joint or its supporting structures (R) (Anaes.)	$475.00
63674	MRI - scan of musculoskeletal system (with or without intravenous contrast) for further investigation of derangement of wrist or its supporting structures (R) (Anaes.)	$475.00
63677	MRI - scan of musculoskeletal system (with or without intravenous contrast) for further investigation of derangement of elbow or its supporting structures (R) (Anaes.)	$475.00
63680	MRI - scan of musculoskeletal system (with or without intravenous contrast) for further investigation of post inflammatory or post traumatic physeal fusion in a person under 16 years of age (R) (Anaes.)	$475.00
	Subgroup 19 - Scan Of Musculoskeletal System - For Monitoring Of Specified Conditions	
63700	MRI - scan of musculoskeletal system (with or without intravenous contrast) for monitoring of derangement of hip or its supporting structures (R) (Anaes.)	$475.00
63703	MRI - scan of musculosketal system (with or without intravenous contrast) for monitoring of derangement of shoulder or its supporting structures (R) (Anaes.)	$475.00
63706	MRI - scan of musculosketal system (with or without intravenous contrast) for monitoring of derangement of knee or its supporting structures (R) (Anaes.)	$475.00
63709	MRI - scan of musculosketal system (with or without intravenous contrast) for monitoring of derangement of ankle or its supporting structures (R) (Anaes.)	$475.00
63712 Note DIL.2	MRI - scan of musculosketal system (with or without intravenous contrast) for monitoring of derangement of temporomandibular joint or its supporting structures (R) (Anaes.)	$475.00
63715	MRI - scan of musculosketal system (with or without intravenous contrast) for monitoring of derangement of wrist or its supporting structures (R) (Anaes.)	$475.00
63718	MRI - scan of musculosketal system (with or without intravenous contrast) for monitoring of derangement of elbow or its supporting structures (R) (Anaes.)	$475.00
63721	MRI - scan of musculosketal system (with or without intravenous contrast) for monitoring of post inflammatory or post traumatic physeal fusion in a person under 16 years of age (R) (Anaes.)	$475.00
	Subgroup 20 - Scan Of Musculoskelatal System - For Monitoring Of Specified Conditions	
63736	MRI - scan of musculosketal system (with or without intravenous contrast) for monitoring of osteonecrosis (R) (Anaes.)	$475.00
63739	MRI - scan of musculosketal system (with or without intravenous contrast) for monitoring of tumour arising in bone or other connective tissue (R) (Anaes.)	$475.00

Item	Service	Fee ($)
63742	MRI - scan of musculosketal system (with or without intravenous contrast) for monitoring of infection arising in bone or other connective tissue (R) (Anaes.)	$475.00
	Subgroup 21 - Scan Of Musculoskeletal System - For Further Investigation Or Monitoring Of Specified Conditions	
63745	MRI - scan of the musculosketal system (with or without intravenous contrast) for further investigation or monitoring, of Gaucher disease (R) (Anaes.)	$475.00
	Subgroup 22 - Scan Of Cardiovascular System - For Further Investigation Of Specified Conditions	
63750	MRI - scan of the cardiovascular system (with or without intravenous contrast and including MRA, if performed) for further investigation of congenital disease of the heart or a great vessel (R) (Anaes.)	$475.00
63753	MRI - scan of the cardiovascular system (with or without intravenous contrast and including MRA, if performed) for further investigation of tumour of the heart or a great vessel (R) (Anaes.)	$475.00
63756	MRI - scan of the cardiovascular system (with or without intravenous contrast and including MRA, if performed) for further investigation of abnormality of thoracic aorta (R) (Anaes.)	$475.00
	Subgroup 23 - Scan Of Cardiovascular System - For Monitoring Of Specified Conditions	
63800	MRI - scan of the cardiovascular system (with or without intravenous contrast and including MRA, if performed) for monitoring of congenital disease of the heart or a great vessel (R) (Anaes.)	$475.00
63803	MRI - scan of the cardiovascular system (with or without intravenous contrast and including MRA, if performed) for monitoring of tumour of the heart or a great vessel (R) (Anaes.)	$475.00
63806	MRI - scan of the cardiovascular system (with or without intravenous contrast and including MRA if performed) for monitoring of abnormality of the thoracic aorta (R) (Anaes.)	$475.00
	Subgroup 24 - Magnetic Resonance Angiography - Scan Of Cardiovascular System - For The Exclusion Of Or Further Investigation Of Specified Conditions	
63850	MRA - scan of the cardiovascular system (with or without intravenous contrast) for exclusion, or further investigation, of stroke (R) (Anaes.)	$475.00
63853	MRA - scan of the cardiovascular system (with or without intravenous contrast) for exclusion, or further investigation, of carotid or vertebral artery dissection (R) (Anaes.)	$475.00
63856	MRA - scan of the cardiovascular system (with or without intravenous contrast) for exclusion, or further investigation of intracranial aneurysm (R) (Anaes.)	$475.00
63859	MRA - scan of the cardiovascular system (with or without intravenous contrast) for exclusion, or further investigation of intracranial arteriovenous malformation (R) (Anaes.)	$475.00

Item	Service	Fee ($)
63862	MRA - scan of the cardiovascular system (with or without intravenous contrast) for exclusion, or further investigation of venous sinus thrombosis (R) (Anaes.)	$475.00
63865	MRA - scan of the cardiovascular system (with or without intravenous contrast) for exclusion, or further investigation, of vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R) (Anaes.)	$475.00
63868	MRA - scan of the cardiovascular system (with or without intravenous contrast) for exclusion, or further investigation of obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R) (Anaes.)	$475.00
	Subgroup 25 - Magnetic Resonance Angiography - Scan Of Cardiovascular System - For Further Investigation Of Specified Conditions - Person Under The Age Of 16 Years	
63870	MRA - scan of cardiovascular system in a person under the age of 16 years (with or without intravenous contrast) for further investigation of the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (R) (Anaes.)	$475.00
	Subgroup 26 - Magnetic Resonance Angiography - Scan Of Cardiovascular System - For Monitoring Of Specified Conditions	
63880	MRA - scan of the cardiovascular system (with or without intravenous contrast) for monitoring of carotid or vertebral artery dissection (R) (Anaes.)	$475.00
63883	MRA - scan of the cardiovascular system (with or without intravenous contrast) for monitoring of venous sinus thrombosis (R) (Anaes.)	$475.00
	Subgroup 27 - Scan Of Body - For Further Investigation Of Specified Conditions - Person Under The Age Of 16 Years	
63900	MRI - scan of the body in a person under the age of 16 years (with or without intravenous contrast) for further investigation of pelvic or abdominal mass (R) (Anaes.)	$475.00
63903	MRI - scan of the body in a person under the age of 16 years (with or without intravenous contrast) for further investigation of mediastinal mass (R) (Anaes.)	$475.00
63906	MRI - scan of the body in a person under the age of 16 years (with or without intravenous contrast) for further investigation of congenital uterine or anorectal abnormality (R) (Anaes.)	$475.00
63909	MRI - scan of the body in a person under the age of 16 years (with or without intravenous contrast) for further investigation of Gaucher disease (R) (Anaes.)	$475.00
	Subgroup 28 - Scan Of Body - For Further Investigation Of Specified Conditions	
63920	MRI - scan of the body (with or without intravenous contrast) for further investigation of adrenal mass in a patient with a malignancy which is otherwise resectable (R) (Anaes.)	$475.00
	Subgroup 29 - Scan Of Body - For Monitoring Of Specified Conditions - Person Under The Age Of 16 Years	

Item	Service	Fee ($)
63930	MRI - scan of the body (with or without intravenous contrast) for monitoring of congenital uterine or anorectal abnormality in a person under the age of 16 years (R) (Anaes.)	$475.00
	Subgroup 30 - Scan Of Body - For Monitoring Of Specified Conditions - Person Under The Age Of 16 Years	
63940	MRI - scan of the body of a person under the age of 16 years (with or without intravenous contrast) for monitoring of mediastinal mass (R) (Anaes.)	$475.00
63943	MRI - scan of the body of a person under the age of 16 years (with or without intravenous contrast) for monitoring of pelvic or abdominal mass (R) (Anaes.)	$475.00
63946 Note DIL.2	MRI - scan of the body of a person under the age of 16 years (with or without intravenous contrast) for monitoring of Gaucher disease (R) (Anaes.)	$475.00
	PATHOLOGY SERVICES	
	GROUP P1 - HAEMATOLOGY	
65060 Note PA.3 Note PX.1.16	Haemoglobin, erythrocyte sedimentation rate, blood viscosity 1 or more tests	$7.70
65066	Examination of: (a) a blood film by special stains to demonstrate Heinz bodies, parasites or iron; or (b) a blood film by enzyme cytochemistry for neutrophil alkaline phosphatase, alphanaphthyl 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	$10.25
65070 Note PQ.4 Note PX.1.4 Note PX.1.16	erythrocyte count, haematocrit, haemoglobin, calculation or measurement of red cell index or indices, platelet count, leucocyte count and manual or instrument generated differential count - not being a service where haemoglobin only is requested - one or more instrument generated set of results from a single sample; and (if performed) (a) a morphological assessment of a blood film; (b) any service in item 65060 or 65072	$16.70
65072	Examination for reticulocytes including a reticulocyte count by any method 1 or more tests in any episode	$10.00
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	$51.30
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	$89.00

Item	Service	Fee ($)
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	$95.30
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	$163.70
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	$82.00
65090 Note PA.3 Note PX.1.5	Blood grouping (including back-grouping if performed) - ABO and Rh (D antigen)	$10.90
65093 Note PX.1.5	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)	$21.70
65096 Note PA.3	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	$40.40
65099 Note PX.1.5	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)	$110.00
65102 Note PX.1.5	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 rule 5)	$165.00
65105 Note PX.1.5	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)	$110.00

Item	Service	Fee ($)
65108 Note PX.1.5	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)	$165.00
65111	Examination of serum for blood group antibodies (including identification and, if necessary, quantitation of any antibodies detected)	$22.90
65114	1 or more of the following tests: (a) direct Coombs (antiglobulin) test; (b) qualitative or quantitative test for cold agglutinins or heterophil antibodies	$8.95
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)	$20.00
65120 Note PX.1.16	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	$13.65
65123	2 tests described in item 65120	$20.00
65126	3 tests described in item 65120	$27.50
65129	4 or more tests described in item 65120	$35.00
Note PQ.4 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	$25.00
65133	2 tests described in item 65132	$48.00
65134	3 tests described in item 65132	$71.00
65135	4 tests described in item 65132	$94.00
65136	5 tests described in item 65132	$117.00
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	$25.00
65139	Quantitation of plasminogen - 1 test	$25.00
65140	Quantitation of euglobulin clot lysis time - 1 test	$25.00
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	$25.00

Item	Service	Fee ($)
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	$55.80
65147	Quantitation of anti-Xa activity when monitoring is required for a patient receiving a low molecular weight heparin or heparinoid - 1 test	$37.40
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	$70.00
65153	2 tests described in item 65150	$140.00
65156	3 or more tests described in item 65150	$210.00
65159	Quantitation of circulating coagulation factor inhibitors by Bethesda assay - 1 test	$70.00
65162	Examination of a maternal blood film for the presence of fetal red blood cells (Kleihauer test)	$10.25
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	$34.00
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	$36.00
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	$25.00
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	$36.00
	GROUP P2 - CHEMICAL	
66500 Note PQ.4 Note PX.1.4 Note PX.1.8 Note PX.1.16	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, total cholesterol, triglycerides, urate or urea - 1 test	$9.45
66503 Note PX.1.4 Note PX.1.16	2 tests described in item 66500	$11.40

Item	Service	Fee ($)
66506 Note PX.1.4 Note PX.1.16	3 tests described in item 66500	$13.35
66509 Note PQ.4 Note PX.1.4 Note PX.1.16	4 tests described in item 66500	$15.30
66512 Note PX.1.4 Note PX.1.16	5 tests described in item 66500	$17.25
66515 Note PQ.4 Note PX.1.4 Note PX.1.16	6 or more tests described in item 66500	$19.20
66518 Note PQ.4	Investigation of cardiac or skeletal muscle damage by measurement of creatine kinase isoenzymes (by any method), troponin or myoglobin in plasma or serum - testing on 1 specimen in a 24 hour period	$19.80
66519 Note PQ.4	Investigation of cardiac or skeletal muscle damage by measurement of creatine kinase isoenzymes (by any method), troponin or myoglobin in plasma or serum - testing on 2 or more specimens in a 24 hour period	$39.60
66536 Note PX.1.16	Quantitation of hdl cholesterol	$10.90
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	$30.20
66542	Oral glucose tolerance test for the diagnosis of diabetes mellitus that includes: (a) administration of glucose; (b) at least 2 measurements of blood glucose; and if performed (c) any test described in item 66695	$18.70
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	$15.60
66548	Oral glucose tolerance test in pregnancy for the diagnosis of gestational diabetes that includes: (a) administration of glucose; and (b) at least 3 measurements of blood glucose; and (c) any test in item 66695 (if performed)	$19.70
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	$16.60

Item	Service	Fee ($)
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)	$16.60
66557	Quantitation of fructosamine performed in the management of established diabetes - each test to a maximum of 4 tests in a 12 month period	$9.55
66560	Microalbumin - quantitation in urine	$19.90
66563	Osmolality, estimation by osmometer, in serum or in urine - 1 or more tests	$24.35
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	$33.25
66569	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 2 specimens performed within any 1 day	$42.05
66572	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 3 specimens performed within any 1 day	$50.85
66575	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 4 specimens performed within any 1 day	$59.65
66578	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 5 specimens performed within any 1 day	$68.45
66581	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 6 or more specimens performed within any 1 day	$77.25
66584 Note PX.1.4	Quantitation of ionised calcium (except if performed as part of item 66566) - 1 test	$9.55
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	$46.90
66590	Calculus, analysis of 1 or more	$30.20
66593	Ferritin - quantitation, except if requested as part of iron studies	$17.80
66596 Note PX.1.16	Iron studies, consisting of quantitation of: (a) serum iron; and (b)transferrin or iron binding capacity; and (c) ferritin	$32.10
66599 Note PX.1.21	Serum B12 or red cell folate and, if required, serum folate (Item is subject to rule 21)	$23.35
66602 Note PX.1.21	Serum B12 and red cell folate and, if required, serum folate, (Item is subject to rule 21)	$42.45
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	$30.20

Item	Service	Fee ($)
66608	Vitamin D or D fractions - 1 or more tests	$41.70
66611 Note PB.2.6 Note PP.5 Note PP.6 Note PX.1.6	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)	$20.45
66614 Note PX.1.6	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)	$32.60
66617 Note PX.1.6	3 or more tests described in item 66611 (Item is subject to rule 6)	$44.80
66620 Note PB.2.6 Note PE.2 Note PO.5 Note PO.10 Note PX.1.6 Note PX.1.18	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)	$12.20
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	$41.00
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	$23.80
66629	Beta-2-microglobulin - quantitation in serum, urine or other body fluids - 1 or more tests	$19.90
66632	Caeruloplasmin, haptoglobins, or prealbumin - quantitation in serum, urine or other body fluids - 1 or more tests	$19.90
66635	Alpha-1-antitrypsin - quantitation in serum, urine or other body fluid - 1 or more tests	$19.90
66638	Isoelectric focussing or similar methods for determination of alpha-1-antitrypsin phenotype in serum - 1 or more tests	$28.80

Item	Service	Fee ($)
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	$28.80
66644	C-1 esterase inhibitor - quantitation	$19.90
66647	C-1 esterase inhibitor - functional assay	$44.50
66650	Alph-afetoprotein, 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	$24.00
66653	2 or more tests described in item 66650	$44.00
66655	Prostate specific antigen - quantitation in the assessment of clinically suspected prostatic disease - 1 patient episode in a 12 month period	$19.90
66656	Prostate specific antigen - quantitation in the monitoring of previously diagnosed prostatic disease (including a test described in item 66655) - each patient episode to a maximum of 4 patient episodes in a 12 month period	$19.90
66659	Prostate specific antigen - quantitation of 2 or more fractions of psa and any derived index including (if performed) a test described in item 66656, in the followup of a psa result which lies in the equivocal range of the particular method of assay used to determine the level - 1 patient episode in a 12 month period	$36.65
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	$78.90
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	$30.20
66667	Quantitation of serum zinc in a patient receiving intravenous alimentation - each test	$30.20
66669 Note PX.1.22	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 22)	$30.20
66670 Note PX.1.22	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 22)	$51.75
66671	Quantitation of serum aluminium in a patient in a renal dialysis program - each test	$36.40

Item	Service	Fee ($)
66672 Note PX.1.22	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 22)	$30.20
66673 Note PX.1.22	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 22)	$51.75
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	$39.45
66677	Test for tryptic activity in faeces in the investigation of diarrhoea of longer than 4 weeks duration in children under 6 years old	$11.00
66680	Quantitation of disaccharidases and other enzymes in intestinal tissue - 1 or more tests	$73.45
66683	Enzymes - quantitation in solid tissue or tissues other than blood elements or intestinal tissue - 1 or more tests	$73.45
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	$50.00
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	$80.00
66692	Personal performance by a recognised pathologist of 2 or more tests described in item 66689	$140.00
66695 Note T1.3 Note PX.1.6	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	$29.80
66698 Note T1.3 Note PX.1.6	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)	$42.50
66701 Note T1.3 Note PX.1.6	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)	$55.50

Item	Service	Fee ($)
66704 Note T1.3 Note PX.1.6	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)	$68.50
66707 Note T1.3 Note PX.1.6	5 tests described in item 66695 (Item is subject to rule 6)	$81.50
66710 Note T1.3 Note PX.1.6	6 or more tests described in item 66695 (Item is subject to rule 6)	$94.50
66713 Note T1.3 Note PB.2.6 Note PE.2 Note PO.5 Note PO.10 Note PX.1.6 Note PX.1.18	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)	$13.00
66716	TSH quantitation	$24.70
66719 Note PX.1.9	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 9)	$34.40
66722 Note PX.1.6	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)	$37.40
66725 Note PX.1.6	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)	$50.40
66728 Note PX.1.6	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)	$63.40

Item	Service	Fee ($)
66731 Note PX.1.6	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)	$76.40
66734 Note PX.1.6	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)	$89.40
66737 Note PB.2.6 Note PO.5 Note PO.10 Note PX.1.6 Note PX.1.18	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)	$13.00
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	$54.50
66743	Quantitation of alpha-fetoprotein in serum or other body fluids during pregnancy except if requested as part of item 66740	$19.90
66746	Human placental lactogen or oestriol - quantitation, except if requested as part of item 66740 - 1 test	$31.55
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	$32.50
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	$24.35
66755	2 or more tests described in item 66752	$38.30
66758	Quantitation of angiotensin converting enzyme, or cholinesterase - 1 or more tests	$24.35
66761	Test for reducing substances in faeces by any method (except reagent strip or dipstick)	$13.00
66764 Note PP.1	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	$8.80
66767 Note PP.1	2 examinations by both methods described in item 66764 performed on separately collected and identified specimens	$17.60

Item	Service	Fee ($)
66770 Note PP.1	3 examinations by both methods described in item 66764 performed on separately collected and identified specimens	$26.40
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 D1.16 of explanatory notes to Category 2 - Diagnostic Procedures and Investigations of the Medicare Benefits Schedule)	$24.35
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	$24.35
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	$39.45
66782	Porphyrins or porphyrins precursors - detection in plasma, red cells, urine or faeces - 1 or more tests	$13.00
66785	Porphyrins or porphyrins precursors - quantitation in plasma, red cells, urine or faeces - 1 test	$39.45
66788	Porphyrins or porphyrins precursors - quantitation in plasma, red cells, urine or faeces - 2 or more tests	$65.00
66791	Porphyrin biosynthetic enzymes - measurement of activity in blood cells or other tissues - 1 or more tests	$73.45
66794 Note PX.1.20	Detection of the C282Y genetic mutation of the HFE gene and, if performed, detection of other mutations for haemochromatosis where: (a)the patient has an elevated transferrin saturation or elevated serum ferritin on testing of repeated specimens; or (b) the patient has a first degree relative with haemochromatosis; or (c) the patient has a first degree relative with homozygosity for the C282Y genetic mutation, or with compound heterozygosity for recognised genetic mutations for haemochromatosis (Item is subject to rule 20)	$36.00
	GROUP P3 - MICROBIOLOGY	
69300 Note PX.1.16	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	$12.20
69303 Note PX.1.16	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	$21.50

Item	Service	Fee ($)
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	$33.00
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	$47.00
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	$33.00
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	$64.00
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	$33.00
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	$47.00
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	$42.00

Item	Service	Fee ($)
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	$83.00
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	$125.00
69333	Urine examination (including serial examination) by any means other than simple culture by dip slide, including:(a) cell count; and (b) culture; and (c) colony count; and (d) (if performed) stained preparations; and (e) (if performed) identification of cultured pathogens; and (f) (if performed) antibiotic susceptibility testing; and (g) (if performed) examination for pH, specific gravity, blood, albumin, urobilinogen, sugar, acetone or bile salts	$20.10
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	$18.65
69339	2 examinations described in item 69336 performed on separately collected and identified specimens	$37.25
69342	3 examinations described in item 69336 performed on separately collected and identified specimens	$55.90
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	$51.65
69348	2 examinations described in item 69345 performed on separately collected and identified specimens	$103.30
69351	3 examinations described in item 69345 performed on separately collected and identified specimens	$154.95
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	$30.00

Item	Service	Fee ($)
69357	2 sets of cultures described in item 69354	$60.00
69360	3 sets of cultures described in item 69354	$90.00
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	$25.00
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	$34.10
69369	Detection of chlamydia by any method in specimens from 1 or more sites	$27.80
69370	Detection of chlamydia by any method and Neisseria gonorrhoeae by nucleic acid amplification techniques in specimens from 1 or more sites	$32.80
69372	Detection of microbial antigens (except if the service described in item 69369 or 69370 has been performed) - 1 or more tests	$25.00
69375	Examination for Herpes simplex virus, varicella zoster virus or cytomegalovirus by culture or by nucleic acid amplification technique, including a service described in item 69369 or 69372 (if performed) - 1 or more tests	$28.20
69378 Note PA.3	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	$176.00
69381 Note PA.3	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	$176.00
69382 Note PA.3	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	$176.00
69384 Note PX.1.6	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)	$15.30
69387 Note PQ.4 Note PX.1.6	2 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, 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)	$28.00

Item	Service	Fee ($)
69390 Note PX.1.6	3 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, 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)	$42.00
69393 Note PX.1.6	4 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, 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)	$56.00
69396 Note PX.1.6	5 tests described in item 69384 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, 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)	$70.00
69399 Note PX.1.6	6 or more tests described in item 69384	$84.00
69402 Note PB.2.6 Note PE.2 Note PO.5 Note PO.10 Note PX.1.6 Note PX.1.18	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)	$14.00
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	$15.30
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	$27.15
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	$38.15
69414 Note PX.1.11	Investigation for acute Hepatitis A using: Hepatitis A IgM antibody test (Item is subject to rule 11)	$15.30
69417 Note PX.1.11	Determination of immune status to Hepatitis A using: Hepatitis A IgG antibody test (Item is subject to rule 11)	$15.30

Item	Service	Fee ($)
69420 Note PX.1.11	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 11)	$27.15
69423 Note PX.1.11	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 11)	$38.15
69426 Note PX.1.11	Determination of immune status to Hepatitis B (post exposure) using: Hepatitis B core antibody test (Item is subject to rule 11)	$15.30
69429 Note PX.1.11	Determination of immune status to Hepatitis B (post vaccination) using: Hepatitis B surface antibody test (Item is subject to rule 11)	$15.30
69432 Note PX.1.11	Investigation for chronic Hepatitis B or determination of carriage of Hepatitis B antigen using: Hepatitis B surface antigen test (Item is subject to rule 11)	$15.30
69435 Note PX.1.11	Investigation for chronic Hepatitis B or carriage of Hepatitis B antigen if the Hepatitis B surface antigen test is positive, including: (a) Hepatatis B surface antigen test; and (b) Hepatitis B e antigen test (Item is subject to rule 11)	$27.15
69438 Note PX.1.11	Testing for Hepatitis C using: Hepatitis C antibody test (Item is subject to rule 11)	$16.70
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 11)	$16.70
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 rule19)	$176.00
69443	Nucleic acid amplification and determination of hepatitis c virus (hcv) genotype if:(a) the patient is hcv rna positive and is being evaluated for antiviral therapy of chronic hcv hepatitis; and(b)the request for the test is made by, or on the advice of, the specialist or consultant physician managing the treatment of the patient; No more than 1 episode in a 12 month period	$200.00
69444 Note PX.1.19	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 19)	$90.00

Item	Service	Fee ($)
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 19)	$90.00
69447 Note PX.1.11	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 11)	$15.30
69450 Note PX.1.11	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 11)	$27.15
69453 Note PX.1.11	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 11)	$28.55
69456 Note PX.1.11	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 11)	$39.55
69459 Note PX.1.11	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 11)	$50.55
69462 Note PX.1.11	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 11)	$39.55
69465 Note PX.1.11	Syphilis serology and any 1 of items 69435, 69438 or 69453 (Item is subject to rule 11)	$38.15
69468 Note PX.1.11	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 11)	$30.20
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	$34.10
69472	Detection of antibodies to Epstein Barr Virus using specific serology - 1 test	$15.30
69474	Detection of antibodies to Epstein Barr Virus using specific serology - 2 or more tests	$28.00

GROUP P4 - IMMUNOLOGY

Item	Service	Fee ($)
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	$35.20
71058	Examination as described in item 71057 of 2 or more specimen types	$49.85
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)	$28.80
71060	Examination as described in item 71059 of 2 or more specimen types	$43.45
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	$43.45
71064	Detection and quantitation of cryoglobulins or cryofibrinogen - 1 or more tests	$20.45
71067	Quantitation of total immunoglobulins A, G, M or D by any method in serum, urine or other body fluid - 1 test	$14.35
71069	2 tests described in item 71067	$22.45
71071	3 or more tests described in item 71067	$30.55
71073	Quantitation of all 4 immunoglobulin G subclasses - each patient episode	$104.75
71075	Quantitation of immunoglobulin E (total), with a maximum of 2 patient episodes in any 12 month period - each patient episode	$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	$26.70
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	$26.50
71081	Quantitation of total haemolytic complement	$40.00
71083	Quantitation of complement components C3 and C4 or properdin factor B - 1 test	$19.90
71085	2 tests described in item 71083	$28.55
71087	3 or more tests described in item 71083	$37.20
71089	Quantitation of complement components or breakdown products of complement proteins not elsewhere described in an item in this Schedule - 1 test	$28.75

Item	Service	Fee ($)
71091	2 tests described in item 71089	$52.10
71093	3 or more tests described in item 71089	$75.45
71095 Note PP.4	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	$40.00
71097	Antinuclear antibodies - detection in serum or other body fluids, including quantitation if required	$24.10
71099	Double-stranded DNA antibodies - quantitation by 1 or more methods other than the Crithidia method	$26.20
71101	Antibodies to 1 or more extractable nuclear antigens - detection in serum or other body fluids	$17.15
71103	Characterisation of an antibody detected in a service described in item 71101 (including that service)	$51.35
71106	Rheumatoid factor - detection by any technique in serum or other body fluids, including quantitation if required	$11.15
71109	Antibodies to tissue antigens (acetylcholine receptor, adrenal cortex, cardiolipin, heart, histone, insulin, insulin receptor, intrinsic factor, islet cell, lymphocyte, neuron, ovary, parathyroid, platelet, salivary gland, skeletal muscle, skin basement membrane and intercellular substance, thyroglobulin, thyroid microsome or thyroid stimulating hormone receptor) - detection, including quantitation if required, of 1 antibody	$34.10
71113	Detection of 2 antibodies described in item 71109	$46.80
71115	Detection of 3 antibodies described in item 71109	$59.50
71117	Detection of 4 or more antibodies described in item 71109	$72.20
71119 Note PX.1.12	Antibodies to tissue antigens not elsewhere specified in this Table - detection, including quantitation if required, of 1 antibody	$17.10
71121 Note PX.1.12	Detection of 2 antibodies specified in item 71119	$20.50
71123 Note PX.1.12	Detection of 3 antibodies specified in item 71119	$23.90
71125 Note PX.1.12	Detection of 4 or more antibodies specified in item 71119	$27.30
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	$174.05
71129	2 tests described in item 71127	$215.00

Item	Service	Fee ($)
71131	3 or more tests described in item 71127	$255.95
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	$205.25
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	$29.85
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	$102.65
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	$194.80
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	$256.60
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	$418.95
71147	HLA-B27 typing	$40.00
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	$106.85
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	$117.30
71153	Investigations in the assessment or diagnosis of systemic inflammatory disease or vasculitis - antineutrophil cytoplasmic antibody immunofluorescence (anca test), antineutrophil proteinase 3 antibody (pr-3 anca test), antimyeloperoxidase antibody (mpo anca test) or antiglomerular basement membrane antibody (gbm test) - detection of 1 antibody (item is subject to rule 23)	$34.10
71155	detection of 2 antibodies described in item 71153 (item is subject to rule 23)	$46.80

Item	Service	Fee ($)
71157	Detection of 3 antibodies described in item 71153 (item is subject to rule 23)	$59.50
71159	Detection of 4 or more antibodies described in item 71153 (Item is subject to rule 23)	$72.20
	GROUP P5 - TISSUE PATHOLOGY	
72813 Note PF.3 Note PP.2 Note PR.1 Note PX.1.13	Examination of complexity level 2 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13)	$70.00
72816 Note PF.3 Note PP.2 Note PP.2 Note PP.2 Note PR.1 Note PX.1.13	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen (Item is subject to rule 13)	$84.50
72817 Note PF.3 Note PR.1 Note PX.1.13	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 13)	$94.50
72823 Note PF.3 Note PR.1 Note PX.1.13	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen (Item is subject to rule 13)	$95.00
72824 Note PF.3 Note PP.2 Note PR.1 Note PX.1.13	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 to 4 separately identified specimens (Item is subject to rule 13)	$138.00
72825 Note PF.3 Note PP.2 Note PR.1 Note PX.1.13	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 13)	$176.00
72830 Note PF.3 Note PP.2 Note PR.1 Note PX.1.13	Examination of complexity level 5 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13)	$165.00
72836 Note PF.3 Note PP.2 Note PR.1 Note PX.1.13	Examination of complexity level 6 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13)	$205.00

Item	Service	Fee ($)
72844 Note PP.2	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	$30.00
72846 Note PP.2 Note PR.1	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 13)	$42.00
72847 Note PP.2 Note PR.1	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 13)	$56.00
72851 Note PP.2 Note PR.1	Electron microscopic examination of biopsy material - 1 separately identified specimen (Item is subject to rule 13)	$180.00
72852 Note PP.2 Note PR.1	Electron microscopic examination of biopsy material - 2 or more separately identified specimens (Item is subject to rule 13)	$240.00
72855 Note PP.2 Note PR.1	Intraoperative consultation and examination of biopsy material by frozen section or tissue imprint or smear - 1 separately identified specimen (Item is subject to rule 13)	$180.00
72856 Note PP.2 Note PR.1	Intraoperative consultation and examination of biopsy material by frozen section or tissue imprint or smear - 2 or more separately identified specimens (Item is subject to rule 13)	$240.00
	GROUP P6 - CYTOLOGY	
73043 Note PP.2	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	$22.30
73045 Note PP.2 Note PR.1	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	$47.50
73047 Note PP.2 Note PR.1	Cytology of a series of 3 sputum or urine specimens for malignant cells	$92.50
73049 Note PP.2 Note PR.1	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues	$67.50
73051 Note PP.2 Note PR.1	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	$166.35

Item	Service	Fee ($)
73053 Note PE.2 Note PF.3 Note PO.5 Note PP.2 Note PP.3 Note PX.1.18	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	$19.00
73055 Note PE.2 Note PF.3 Note PO.5 Note PP.2 Note PP.3 Note PX.1.18	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	$19.00
73057 Note PF.3 Note PP.2 Note PP.3	Cytology of smears from vagina, not associated with item 73053 or 73055 nor to monitor hormone replacement therapy - each test	$19.00
73059 Note PP.2 Note PR.1	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	$42.00
73060 Note PP.2 Note PR.1	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	$56.00
	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	$354.00
73289	Chromosome studies, including preparation, count, karyotyping and identification by banding techniques or fragile X-site determination of blood - 1 or more tests	$322.00
	GROUP P8 - INFERTILITY AND PREGNANCY TESTS	
73521 Note T1.3	Semen examination for presence of spermatozoa or examination of cervical mucus for spermatozoa (Huhner's test)	$9.50
73523 Note T1.3	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	$41.20
73525 Note T1.3	Sperm antibodies - sperm-penetrating ability 1 or more tests	$28.00

Item	Service	Fee ($)
73527 Note T1.3 Note PX.1.16	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	$9.90
73529 Note T1.3	Human chorionic gonadotrophin (HCG), quantitation in serum by 1 or more methods (except by latex, membrane, strip or other pregnancy test kit) for diagnosis of threatened abortion, or follow up of abortion or diagnosis of ectopic pregnancy, including any services performed in item 73527 - 1 test	$28.25
	GROUP P9 - SIMPLE BASIC PATHOLOGY TESTS	
73801	Semen examination for presence of spermatozoa	$6.75
73802	Leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin, haematocrit or erythrocyte count 1 test	$4.45
73803	2 tests described in item 73802	$6.20
73804	3 or more tests described in item 73802	$7.95
73805	Microscopy of urine, whether stained or not, or catalase test	$4.45
73806	Pregnancy test by 1 or more immunochemical methods	$9.90
73807	Microscopy for wet film other than urine, including any relevant stain	$6.75
73808	Microscopy of Gram-stained film, including (if performed) a service described in item 73805 or 73807	$8.45
73809	Chemical tests for occult blood in faeces by reagent stick, strip, tablet or similar method	$2.30
73810	Microscopy for fungi in skin, hair or nails - 1 or more sites	$6.75
73811	Mantoux test	$10.95
73840	Quantitation of glycosylated haemoglobin performed in the management of established diabetes - each test to a maximum of 4 tests in a 12 month period - where: (a) the health service is provided in a Commonwealth funded aboriginal and Torres Strait Islander health and medical service; and (b) the Aboriginal and Torres Strait Islander health and medical service participates in a recognised quality assurance program.	$16.60
	GROUP P10 - PATIENT EPISODE INITIATION	
73901 Note PF.3	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	$8.00
73903 Note PF.3	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	$14.30

Item	Service	Fee ($)
73905 Note PF.3	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	$8.00
73907	Initiation of a patient episode by collection of 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	$16.90
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	$17.15
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	$10.00
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 residential aged care home or institution	$17.15
73913	Initiation of a patient episode by collection of a specimen for a service (other than a service described in items 73901, 73903, 73905 or 73907 or items in Group P9) if the specimen is collected from the person by the person	$9.50
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	$9.50
	GROUP P11 - SPECIMEN REFERRED	
73921 Note PX.1.14 Note PX.1.15	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 14(9) and 16(3))	$10.00
	CLEFT LIP & CLEFT PALATE SERVICES	
	GROUP C1 - ORTHODONTIC SERVICES	
75001 Note DIA.6	Initial professional attendance in a single course of treatment by an accredited orthodontist (AO)	$66.60
75004	Professional attendance by an accredited orthodontist subsequent to the first professional attendance by the orthodontist in a single course of treatment (AO)	$33.40

Item	Service	Fee ($)
75006	Production of dental study models (not being a service associated with a service to which item 75004 applies) prior to provision of a service to which: (a) item 75030, 75033, 75034, 75036, 75037, 75039, 75045 or 75051 applies; or (b) an item in Group T8 or Groups 03 to 09 applies; in a single course of treatment	$59.35
75009	Orthodontic radiography orthopantomography (panoramic radiography), including any consultation on the same occasion (AOS)	$53.05
75012	Orthodontic radiography anteroposterior cephalometric radiography with cephalometric tracings or lateral cephalometric radiography with cephalometric tracings including any consultation on the same occasion (AOS)	$84.05
75015	Orthodontic radiography anteroposterior and lateral cephalometric radiography, with cephalometric tracings including any consultation on the same occasion (AOS)	$115.65
75018	Orthodontic radiography anteroposterior and lateral cephalometric radiography, with cephalometric tracings and orthopantomography including any consultation on the same occasion (AOS)	$147.30
75021	Orthodontic radiography handwrist studies (including growth prediction) including any consultation on the same occasion	$180.65
75023	Intraoral radiography - single area, periapical or bitewing film	$36.15
75024	Presurgical infant maxillary arch repositioning, including supply of appliances and all adjustments of appliances and supervision where 1 appliance is used	$467.25
75027	Presurgical infant maxillary arch repositioning, including supply of appliances and all adjustments of appliances and supervision where 2 appliances are used	$640.65
75030	Maxillary ach expansion not being a service associated with a service to which item 75039, 75042, 75045 or 75048 applies, including supply of appliances, all adjustments of the appliances, removal of the appliances and retention	$570.45
75033	Mixed dentition treatment - incisor alignment using fixed applicances in maxillary arch, including supply of appliances, all adjustments of appliances, removal of the appliances and retention	$934.95
75034	Mixed dentition treatment - incisor alignment with or without lateral arch expansion using a removable appliance in the maxillary arch, including supply of appliances, associated adjustments and retention	$475.90
75036	Mixed dentition treatment - lateral arch expansion and incisor alignment using fixed appliances in maxillary arch, including supply of appliances, all adjustments of appliances, removal of appliances and retention	$1,291.45
75037	Mixed dentition treatment - lateral arch expansion and incisor correction - 2 arch (maxillary and mandibular) using fixed appliances in both maxillary and mandibular arches, including supply of appliances, all adjustments of appliances, removal of appliances and retention (AO)	$1,626.55
75039	Permanent dentition treatment - single arch (mandibular or maxillary) treatment (correction and alignment) using fixed appliances, including supply of appliances initial 3 months of active treatment	$432.25

Item	Service	Fee ($)
75042	Permanent dentition treatment - single arch (mandibular or maxillary) treatment (correction and alignment) using fixed appliances, including supply of appliances - each 3 months of active treatment (including all adjustments and maintenance and removal of the appliances) after the first for a maximum of a further 33 months	$161.65
75045	Permanent dentition treatment 2arch (mandibular and maxillary) treatment (correction and alignment) using fixed appliances, including supply of appliances initial 3 months of active treatment	$865.35
75048	Permanent dentition treatment - 2 arch (mandibular and maxillary) treatment (correction and alignment) using fixed appliances, including supply of appliances - each subsequent 3 months of active treatment (including all adjustments and maintenance, and removal of the appliances) after the first for a maximum of a further 33 months	$221.90
75049	Retention, fixed or removable, single arch (mandibular or maxillary) - supply of retainer and supervision of retention	$259.75
75050	Retention, fixed or removable, 2-arch (mandibular and maxillary) -supply of retainers and supervision of retention	$501.40
75051	Jaw growth guidance using removable or functional appliances, including supply of appliances and all adjustments to appliances	$769.75
	GROUP C2 - ORAL AND MAXILLOFACIAL SERVICES	
75150 Note CD.2 Note CG.6	Initial professional attendance in a single course of treatment by an accredited oral and maxillofacial surgeon where the patient is referred to the surgeon by an accredited orthodontist	$66.60
75153 Note CD.2 Note CG.6	Professional attendance by an accredited oral and maxillofacial surgeon subsequent to the first professional attendance by the surgeon in a single course of treatment where the patient is referred to the surgeon by an accredited orthodontist	$33.40
75156 Note CD.2 Note CG.6	Production of dental study models (not being a service associated with a service to which item 75153 applies) prior to provision of a service: (a) to which item 52321, 53212 or 75618 applies; or (b) to which an item in the series 52330 to 52382, 52600 to 52630, 53400 to 53409 or 53415 to 53429 applies; in a single course of treatment	$59.35
75200 Note CB.1 Note CD.2 Note CG.6	Removal of tooth or tooth fragment (not being treatment to which item 75400, 75403, 75406, 75409, 75412 or 75415 applies), where the patient is referred by an accredited orthodontist	$42.75
75203 Note CB.1 Note CD.2 Note CG.6	Removal of tooth or tooth fragment under general anaesthesia, where the patient is referred by an accredited orthodontist	$64.15
75206 Note CB.1 Note CD.2 Note CG.6	Removal of each additional tooth or tooth fragment at the same attendance at which a service to which item 75200 or 75203 applies is rendered	$21.25

Item	Service	Fee ($)
75400 Note CD.2 Note CG.6	Surgical removal of erupted tooth, where the patient is referred by an accredited orthodontist	$128.30
75403 Note CD.2 Note CG.6	Surgical removal of tooth with soft tissue impaction, where the patient is referred by an accredited orthodontist	$147.30
75406 Note CD.2 Note CG.6	Surgical removal of tooth with partial bone impaction, where the patient is referred by an accredited orthodontist	$167.95
75409 Note CD.2 Note CG.6	Surgical removal of tooth with complete bone impaction, where the patient is referred by an accredited orthodontist	$190.15
75412 Note CD.2 Note CG.6	Surgical removal of tooth fragment requiring incision of soft tissue only, where the patient is referred by an accredited orthodontist	$106.20
75415 Note CD.2 Note CG.6	Surgical removal of tooth fragment requiring removal of bone, where the patient is referred by an accredited orthodontist	$128.30
75600 Note CD.2 Note CG.6	Surgical exposure, stimulation and packing of unerupted tooth, where the patient is referred by an accredited orthodontist	$180.65
75603 Note CD.2 Note CG.6	Surgical exposure of unerupted tooth for the purpose of fitting a traction device, where the patient is referred by an accredited orthodontist	$212.30
75606 Note CD.2 Note CG.6	Surgical repositioning of unerupted tooth, where the patient is referred by an accredited orthodontist	$212.30
75609 Note CD.2 Note CG.6	Transplantation of tooth bud, where the patient is referred by an accredited orthodontist	$317.00
75612 Note CD.2 Note CG.6	Surgical procedure for intra oral implantation of osseointegrated fixture (first stage)	$392.30
75615 Note CD.2 Note CG.6	Surgical procedure for fixation of trans-mucosal abutment (second stage of osseointegrated implant)	$145.20
75618 Note CD.2 Note CG.6	Provision and fitting of a bite rising appliance or dental splint for the management of temporomandibular joint dysfunction syndrome	$180.30
75621 Note CD.2 Note CG.6	The provision and fitting of surgical template in conjuction with orthognathic surgical procedures in association with: (a) an item in the series 52342 to 52375; or (b) item 52380 or 52382	$180.30
	GROUP C3 - GENERAL AND PROSTHODONTIC SERVICES	
75800 Note CG.7	Attendance comprising consultation, preventive treatment and prophylaxis, of not less than 30 minutes' duration each attendance to a maximum of 3 attendances in any period of 12 months	$64.15
75803	Provision and fitting of acrylic base partial denture, including retainers 1 tooth	$256.75
75806	Provision and fitting of acrylic base partial denture, including retainers 2 teeth	$301.10
75809	Provision and fitting of acrylic base partial denture, including retainers 3 teeth	$356.55

Item	Service	Fee ($)
75812	Provision and fitting of acrylic base partial denture, including retainers 4 teeth	$396.15
75815	Provision and fitting of acrylic base partial denture, including retainers 5 to 9 teeth	$483.30
75818	Provision and fitting of acrylic base partial denture, including retainers 10 to 12 teeth	$570.45
75821	Provision and fitting of cast metal base (cobalt chromium alloy) partial denture including casting and retainers 1 tooth	$459.50
75824	Provision and fitting of cast metal base (cobalt chromium alloy) partial denture including casting and retainers 2 teeth	$530.85
75827	Provision and fitting of cast metal base (cobalt chromium alloy) partial denture including casting and retainers 3 teeth	$610.10
75830	Provision and fitting of cast metal base (cobalt chromium alloy) partial denture including casting and retainers 4 teeth	$673.50
75833	Provision and fitting of cast metal base (cobalt chromium alloy) partial denture including casting and retainers 5 to 9 teeth	$823.95
75836	Provision and fitting of cast metal base (cobalt chromium alloy) partial denture including casting and retainers 10 to 12 teeth	$942.80
75839	Provision and fitting of retainers (not being treatment associated with treatment to which item 75803, 75806, 75809, 75812, 75815, 75818, 75821, 75824, 75827, 75830, 75833 or 75836 applies) each retainer	$21.25
75842	Adjustment of partial denture (not being treatment associated with treatment to which item 75803, 75806, 75809, 75812, 75815, 75818, 75821, 75824, 75827, 75830, 75833 or 75836 applies)	$31.70
75845	Relining of partial denture by laboratory process and associated fitting	$158.50
75848	Remodelling and fitting of partial denture of more than 4 teeth	$190.15
75851	Repair to cast metal base of partial denture 1 or more points	$95.10
75854 Note DIA.6	Addition of a tooth or teeth to a partial denture to replace extracted tooth or teeth, including taking of necessary impression	$95.10

Medicare Benefits

Item No.	Schedule Fee $	75%	85% max Gap
1	91.40	68.55	77.70
2	91.40	68.55	77.70
3	13.10	9.85	11.15
23	28.75	21.60	24.45
36	54.60	40.95	46.45
44	80.40	60.30	68.35
52	11.00	8.25	9.35
53	21.00	15.75	17.85
54	38.00	28.50	32.30
57	61.00	45.75	51.85
97	78.35	58.80	66.60
98	78.35	58.80	66.60
104	67.65	50.75	57.55
105	33.95	25.50	28.90
106	55.75	41.85	47.40
107	99.20	74.40	84.35
108	62.80	47.10	53.40
110	119.35	89.55	101.45
116	59.75	44.85	50.80
119	33.95	25.50	28.90
122	144.90	108.70	123.20
128	87.55	65.70	74.45
131	63.05	47.30	53.60
160	171.75	128.85	146.00
161	286.25	214.70	243.35
162	400.70	300.55	345.10
163	515.30	386.50	459.70
164	572.60	429.45	517.00
170	93.45	70.10	79.45
171	98.50	73.90	83.75
172	119.80	89.85	101.85
173	21.65	16.25	18.45
193	28.75	21.60	24.45
300	34.25	25.70	29.15
302	68.45	51.35	58.20
304	100.30	75.25	85.30
306	138.45	103.85	117.70
308	168.65	126.50	143.40
310	17.10	12.85	14.55
312	34.25	25.70	29.15
314	50.15	37.65	42.65
316	69.25	51.95	58.90
318	84.40	63.30	71.75
319	138.45	103.85	117.70
320	34.25	25.70	29.15
322	68.45	51.35	58.20
324	100.30	75.25	85.30
326	138.45	103.85	117.70
328	168.65	126.50	143.40
330	62.90	47.20	53.50
332	98.65	74.00	83.90
334	136.85	102.65	116.35
336	165.55	124.20	140.75
338	197.35	148.05	167.75
342	39.00	29.25	33.15
344	51.80	38.85	44.05
346	76.60	57.45	65.15
348	41.40	31.05	35.20
350	93.05	69.80	79.10
352	41.40	31.05	35.20
385	67.65	50.75	57.55
386	33.95	25.50	28.90
387	99.20	74.40	84.35
388	62.80	47.10	53.40
410	13.10	9.85	11.15
411	28.75	21.60	24.45
412	54.60	40.95	46.45
413	80.40	60.30	68.35
444	13.10	9.85	11.15
445	28.75	21.60	24.45
446	54.60	40.95	46.45
447	80.40	60.30	68.35
448	91.40	68.55	77.70
449	109.30	82.00	92.95
601	109.30	82.00	92.95
602	109.30	82.00	92.95
697	94.65	71.00	80.50
698	94.65	71.00	80.50
700	149.90	112.45	127.45
702	212.00	159.00	180.20
704	149.90	112.45	127.45
706	212.00	159.00	180.20
720	192.75	144.60	163.85
722	192.75	144.60	163.85
724	96.40	72.30	81.95
726	38.85	29.15	33.05
728	38.85	29.15	33.05
730	38.85	29.15	33.05
734	75.00	56.25	63.75
736	112.45	84.35	95.60
738	149.90	112.45	127.45
740	75.00	56.25	63.75
742	112.45	84.35	95.60
744	149.90	112.45	127.45
746	75.00	56.25	63.75
749	112.45	84.35	95.60
757	149.90	112.45	127.45
759	53.50	40.15	45.50
762	85.65	64.25	72.85
765	117.75	88.35	100.10
768	53.50	40.15	45.50
771	85.65	64.25	72.85
773	117.75	88.35	100.10
775	53.50	40.15	45.50
778	85.65	64.25	72.85
779	117.75	88.35	100.10
801	185.95	139.50	158.10
803	247.90	185.95	210.75
805	154.45	115.85	131.30
807	205.85	154.40	175.00
809	185.95	139.50	158.10
811	247.90	185.95	210.75
813	154.45	115.85	131.30
815	205.85	154.40	175.00
900	120.00	90.00	102.00

2501	28.75	21.60	24.45
2504	54.60	40.95	46.45
2507	80.40	60.30	68.35
2517	28.75	21.60	24.45
2521	54.60	40.95	46.45
2525	80.40	60.30	68.35
2546	28.75	21.60	24.45
2552	54.60	40.95	46.45
2558	80.40	60.30	68.35
2600	21.00	15.75	17.85
2603	38.00	28.50	32.30
2606	61.00	45.75	51.85
2620	21.00	15.75	17.85
2622	38.00	28.50	32.30
2624	61.00	45.75	51.85
2664	21.00	15.75	17.85
2666	38.00	28.50	32.30
2668	61.00	45.75	51.85
10801	96.30	72.25	81.90
10802	96.30	72.25	81.90
10803	96.30	72.25	81.90
10804	96.30	72.25	81.90
10805	96.30	72.25	81.90
10806	96.30	72.25	81.90
10807	96.30	72.25	81.90
10808	96.30	72.25	81.90
10809	96.30	72.25	81.90
10816	96.30	72.25	81.90
10900	56.15		47.75
10905	56.15		47.75
10907	28.15		23.95
10912	56.15		47.75
10913	56.15		47.75
10914	56.15		47.75
10916	28.15		23.95
10918	28.15		23.95
10921	139.35		118.45
10922	139.25		118.45
10923	139.25		118.45
10924	175.85		149.50
10925	139.35		118.45
10926	139.35		118.45
10927	175.85		149.50
10928	139.35		118.45
10929	175.85		149.50
10930	139.35		118.45
11000	97.35	73.05	82.75
11003	257.65	193.25	219.05
11006	132.10	99.10	112.30
11009	180.15	135.15	153.15
11012	88.55	66.45	75.30
11015	118.60	88.95	100.85
11018	177.15	132.90	150.60
11021	118.60	88.95	100.85
11024	90.10	67.60	76.60
11027	133.60	100.20	113.60
11200	32.25	24.20	27.45
11203	54.55	40.95	46.40
11204	85.60	64.20	72.80
11205	85.60	64.20	72.80
11210	85.60	64.20	72.80
11211	85.60	64.20	72.80
11212	55.50	41.65	47.20
11215	97.25	72.95	82.70
11218	120.15	90.15	102.15
11221	53.60	40.20	45.60
11222	53.60	40.20	45.60
11224	32.30	24.25	27.50
11225	32.30	24.25	27.50
11235	97.00	72.75	82.45
11240	64.40	48.30	54.75
11241	82.00	61.50	69.70
11242	63.40	47.55	53.90
11243	63.40	47.55	53.90
11300	152.25	114.20	129.45
11303	152.25	114.20	129.45
11304	250.70	188.05	213.10
11306	17.35	13.05	14.75
11309	20.80	15.60	17.70
11312	29.35	22.05	24.95
11315	38.95	29.25	33.15
11318	48.00	36.00	40.80
11321	91.25	68.45	77.60
11324	26.00	19.50	22.10
11327	15.60	11.70	13.30
11330	6.25	4.70	5.35
11332	46.30	34.75	39.40
11333	35.25	26.45	30.00
11336	35.25	26.45	30.00
11339	35.25	26.45	30.00
11500	132.10	99.10	112.30
11503	109.70	82.30	93.25
11506	16.25	12.20	13.85
11509	28.25	21.20	24.05
11512	48.85	36.65	41.55
11600	54.80	41.10	46.60
11601	54.80	41.10	46.60
11603	40.90	30.70	34.80
11606	57.95	43.50	49.30
11609	75.20	56.40	63.95
11612	75.20	56.40	63.95
11615	60.00	45.00	51.00
11618	53.35	40.05	45.35
11621	80.35	60.30	68.30
11624	106.75	80.10	90.75
11627	180.85	135.65	153.75
11700	24.70	18.55	21.00
11701	12.35	9.30	10.50
11702	12.35	9.30	10.50
11706	57.00	42.75	48.45
11708	101.15	75.90	86.00
11709	132.50	99.40	112.65
11710	41.00	30.75	34.85
11711	22.35	16.80	19.00
11712	120.30	90.25	102.30
11713	55.15	41.40	46.90
11715	95.55	71.70	81.25
11718	27.45	20.60	23.35
11721	55.15	41.40	46.90
11724	133.60	100.20	113.60

11800	138.05	103.55	117.35
11810	138.05	103.55	117.35
11830	147.70	110.80	125.55
11833	197.55	148.20	167.95
11900	21.80	16.35	18.55
11903	87.90	65.95	74.75
11906	87.90	65.95	74.75
11909	130.55	97.95	111.00
11912	130.55	97.95	111.00
11915	130.55	97.95	111.00
11918	338.80	254.10	288.00
11921	59.35	44.55	50.45
12000	30.80	23.10	26.20
12003	46.55	34.95	39.60
12012	16.45	12.35	14.00
12015	49.40	37.05	42.00
12018	63.60	47.70	54.10
12021	93.20	69.90	79.25
12200	29.40	22.05	25.00
12203	465.10	348.85	409.50
12207	465.10	348.85	409.50
12210	555.10	416.35	499.50
12213	500.10	375.10	444.50
12215	555.10	416.35	499.50
12217	500.10	375.10	444.50
12500	171.30	128.50	145.65
12503	336.05	252.05	285.65
12506	239.90	179.95	203.95
12509	171.30	128.50	145.65
12512	83.00	62.25	70.55
12515	181.85	136.40	154.60
12518	83.00	62.25	70.55
12521	100.20	75.15	85.20
12524	125.20	93.90	106.45
12527	67.15	50.40	57.10
12530	100.20	75.15	85.20
12533	66.90	50.20	56.90
13020	204.70	153.55	174.00
13025	91.55	68.70	77.85
13030	129.30	97.00	109.95
13100	108.10	81.10	91.90
13103	56.30	42.25	47.90
13106	96.05	72.05	81.65
13109	180.15	135.15	153.15
13110	180.70	135.55	153.60
13112	108.10	81.10	91.90
13200	1581.40	1186.05	1525.80
13203	395.35	296.55	339.75
13206	677.70	508.30	622.10
13209	67.65	50.75	57.55
13212	288.05	216.05	244.85
13215	90.40	67.80	76.85
13218	677.70	508.30	622.10
13221	41.25	30.95	35.10
13290	161.60	121.20	137.40
13292	323.20	242.40	274.75
13300	45.05	33.80	38.30
13303	66.80	50.10	56.80
13306	264.25	198.20	224.65
13309	225.30	169.00	191.55
13312	22.45	16.85	19.10
13318	179.95	135.00	153.00
13319	179.95	135.00	153.00
13400	76.60	57.45	65.15
13500	142.65	107.00	121.30
13503	285.30	214.00	242.55
13506	145.90	109.45	124.05
13700	263.65	197.75	224.15
13703	94.50	70.90	80.35
13706	66.00	49.50	56.10
13709	38.30	28.75	32.60
13750	108.10	81.10	91.90
13755	108.10	81.10	91.90
13757	57.70	43.30	49.05
13760	603.25	452.45	547.65
13815	67.40	50.55	57.30
13818	89.95	67.50	76.50
13830	59.60	44.70	50.70
13839	18.20	13.65	15.50
13842	54.80	41.10	46.60
13845	427.90	320.95	372.30
13848	103.65	77.75	88.15
13851	390.50	292.90	334.90
13854	90.80	68.10	77.20
13857	115.80	86.85	98.45
13870	241.30	181.00	205.15
13873	179.70	134.80	152.75
13876	54.80	41.10	46.60
13879	175.10	131.35	148.85
13882	59.60	44.70	50.70
13885	107.80	80.85	91.65
13888	56.15	42.15	47.75
13915	51.45	38.60	43.75
13918	77.40	58.05	65.80
13921	87.60	65.70	74.50
13924	51.65	38.75	43.95
13927	66.80	50.10	56.80
13930	93.15	69.90	79.20
13933	103.35	77.55	87.85
13936	67.30	50.50	57.25
13939	77.40	58.05	65.80
13942	51.65	38.75	43.95
13945	41.55	31.20	35.35
13948	51.65	38.75	43.95
14050	41.75	31.35	35.50
14053	41.75	31.35	35.50
14100	120.65	90.50	102.60
14103	148.15	111.15	125.95
14106	120.65	90.50	102.60
14109	148.15	111.15	125.95
14112	175.45	131.60	149.15
14115	202.85	152.15	172.45
14118	257.70	193.30	219.05
14120	120.65	90.50	102.60
14122	148.15	111.15	125.95
14124	120.65	90.50	102.60
14126	148.15	111.15	125.95
14128	175.45	131.60	149.15
14130	202.85	152.15	172.45
14132	257.70	193.30	219.05

14200	47.35	35.55	40.25
14203	40.45	30.35	34.40
14206	28.20	21.15	24.00
14209	70.20	52.65	59.70
14212	146.60	109.95	124.65
14215	77.40	58.05	65.80
14218	77.40	58.05	65.80
14221	41.55	31.20	35.35
14224	55.60	41.70	47.30
15000	33.70	25.30	28.65
15006	74.70	56.05	63.50
15012	42.25	31.70	35.95
15100	37.75	28.35	32.10
15106	44.55	33.45	37.90
15112	95.05	71.30	80.80
15203	47.20	35.40	40.15
15207	47.20	35.40	40.15
15211	43.25	32.45	36.80
15303	282.40	211.80	240.05
15304	282.40	211.80	240.05
15307	535.40	401.55	479.80
15308	535.40	401.55	479.80
15311	263.60	197.70	224.10
15312	261.70	196.30	222.45
15315	517.50	388.15	461.90
15316	517.50	388.15	461.90
15319	321.10	240.85	272.95
15320	321.10	240.85	272.95
15323	571.05	428.30	515.45
15324	571.05	428.30	515.45
15327	621.30	466.00	565.70
15328	621.30	466.00	565.70
15331	589.95	442.50	534.35
15332	589.95	442.50	534.35
15335	535.40	401.55	479.80
15336	535.40	401.55	479.80
15338	740.00	555.00	684.40
15339	60.25	45.20	51.25
15342	150.55	112.95	128.00
15345	401.70	301.30	346.10
15348	46.20	34.65	39.30
15351	92.25	69.20	78.45
15354	112.00	84.00	95.20
15357	31.60	23.70	26.90
15500	192.00	144.00	163.20
15503	246.50	184.90	209.55
15506	368.05	276.05	312.85
15509	166.45	124.85	141.50
15512	214.45	160.85	182.30
15513	242.60	181.95	206.25
15515	310.45	232.85	263.90
15518	60.90	45.70	51.80
15521	268.85	201.65	228.55
15524	504.15	378.15	448.55
15527	62.40	46.80	53.05
15530	278.50	208.90	236.75
15533	528.10	396.10	472.50
15536	211.05	158.30	179.40
15539	496.20	372.15	440.60
15600	1346.55	1009.95	1290.95
16003	514.60	385.95	459.00
16006	395.40	296.55	339.80
16009	269.85	202.40	229.40
16012	233.45	175.10	198.45
16015	3231.80	2423.85	3176.20
16018	1931.95	1449.00	1876.35
16500	28.75	21.60	24.45
16501	111.15	83.40	94.50
16502	28.75	21.60	24.45
16504	28.75	21.60	24.45
16505	28.75	21.60	24.45
16508	28.75	21.60	24.45
16509	28.75	21.60	24.45
16511	173.95	130.50	147.90
16512	50.20	37.65	42.70
16514	29.00	21.75	24.65
16515	274.15	205.65	233.05
16518	269.85	202.40	229.40
16519	422.25	316.70	366.65
16520	493.40	370.05	437.80
16522	991.40	743.55	935.80
16525	233.90	175.45	198.85
16564	172.45	129.35	146.60
16567	252.25	189.20	214.45
16570	329.05	246.80	279.70
16571	252.25	189.20	214.45
16573	205.55	154.20	174.75
16600	50.20	37.65	42.70
16603	96.45	72.35	82.00
16606	192.35	144.30	163.50
16609	392.35	294.30	336.75
16612	308.70	231.55	262.40
16615	164.35	123.30	139.70
16618	164.35	123.30	139.70
16621	164.35	123.30	139.70
16624	236.60	177.45	201.15
16627	481.65	361.25	426.05
17603	33.95	25.50	28.90
18213	70.15	52.65	59.65
18216	150.20	112.65	127.70
18222	29.75	22.35	25.30
18225	39.65	29.75	33.75
18228	49.45	37.10	42.05
18230	188.60	141.45	160.35
18232	150.20	112.65	127.70
18233	150.20	112.65	127.70
18234	98.75	74.10	83.95
18236	49.45	37.10	42.05
18238	29.75	22.35	25.30
18240	74.00	55.50	62.90
18242	29.75	22.35	25.30
18244	79.70	59.80	67.75
18246	79.70	59.80	67.75
18248	70.15	52.65	59.65
18250	49.45	37.10	42.05
18252	79.70	59.80	67.75
18254	79.70	59.80	67.75
18256	49.45	37.10	42.05
18258	49.45	37.10	42.05
18260	70.15	52.65	59.65

18262	49.45	37.10	42.05
18264	79.70	59.80	67.75
18266	49.45	37.10	42.05
18268	70.15	52.65	59.65
18270	70.15	52.65	59.65
18272	49.45	37.10	42.05
18274	70.15	52.65	59.65
18276	98.75	74.10	83.95
18278	70.15	52.65	59.65
18280	98.75	74.10	83.95
18282	79.70	59.80	67.75
18284	116.80	87.60	99.30
18286	116.80	87.60	99.30
18288	116.80	87.60	99.30
18290	197.55	148.20	167.95
18292	98.75	74.10	83.95
18294	139.20	104.40	118.35
18296	119.00	89.25	101.15
18298	139.20	104.40	118.35
20100	85.75	64.35	72.90
20102	102.90	77.20	87.50
20104	68.60	51.45	58.35
20120	85.75	64.35	72.90
20124	68.60	51.45	58.35
20140	85.75	64.35	72.90
20142	102.90	77.20	87.50
20143	102.90	77.20	87.50
20144	137.20	102.90	116.65
20145	137.20	102.90	116.65
20146	85.75	64.35	72.90
20148	68.60	51.45	58.35
20160	85.75	64.35	72.90
20162	120.05	90.05	102.05
20164	68.60	51.45	58.35
20170	85.75	64.35	72.90
20172	120.05	90.05	102.05
20174	154.35	115.80	131.20
20176	171.50	128.65	145.80
20190	85.75	64.35	72.90
20192	171.50	128.65	145.80
20210	257.25	192.95	218.70
20212	85.75	64.35	72.90
20214	154.35	115.80	131.20
20216	343.00	257.25	291.55
20220	171.50	128.65	145.80
20222	102.90	77.20	87.50
20225	205.80	154.35	174.95
20300	85.75	64.35	72.90
20305	257.25	192.95	218.70
20320	102.90	77.20	87.50
20321	171.50	128.65	145.80
20330	137.20	102.90	116.65
20350	171.50	128.65	145.80
20352	85.75	64.35	72.90
20400	51.45	38.60	43.75
20401	68.60	51.45	58.35
20402	85.75	64.35	72.90
20403	85.75	64.35	72.90
20404	102.90	77.20	87.50
20405	137.20	102.90	116.65
20406	222.95	167.25	189.55
20410	85.75	64.35	72.90
20420	85.75	64.35	72.90
20450	85.75	64.35	72.90
20452	102.90	77.20	87.50
20470	102.90	77.20	87.50
20472	171.50	128.65	145.80
20474	222.95	167.25	189.55
20500	257.25	192.95	218.70
20520	102.90	77.20	87.50
20522	68.60	51.45	58.35
20524	68.60	51.45	58.35
20526	171.50	128.65	145.80
20528	137.20	102.90	116.65
20540	222.95	167.25	189.55
20542	257.25	192.95	218.70
20546	257.25	192.95	218.70
20548	257.25	192.95	218.70
20560	343.00	257.25	291.55
20600	171.50	128.65	145.80
20604	222.95	167.25	189.55
20620	171.50	128.65	145.80
20622	222.95	167.25	189.55
20630	137.20	102.90	116.65
20632	120.05	90.05	102.05
20634	171.50	128.65	145.80
20670	222.95	167.25	189.55
20680	51.45	38.60	43.75
20690	85.75	64.35	72.90
20700	51.45	38.60	43.75
20702	68.60	51.45	58.35
20705	102.90	77.20	87.50
20706	120.05	90.05	102.05
20730	85.75	64.35	72.90
20740	85.75	64.35	72.90
20745	102.90	77.20	87.50
20750	68.60	51.45	58.35
20752	102.90	77.20	87.50
20754	120.05	90.05	102.05
20756	154.35	115.80	131.20
20770	257.25	192.95	218.70
20790	137.20	102.90	116.65
20791	171.50	128.65	145.80
20792	222.95	167.25	189.55
20793	257.25	192.95	218.70
20794	205.80	154.35	174.95
20798	171.50	128.65	145.80
20800	51.45	38.60	43.75
20802	85.75	64.35	72.90
20805	102.90	77.20	87.50
20806	120.05	90.05	102.05
20810	68.60	51.45	58.35
20815	102.90	77.20	87.50
20820	85.75	64.35	72.90
20830	68.60	51.45	58.35
20832	102.90	77.20	87.50
20840	102.90	77.20	87.50
20841	137.20	102.90	116.65
20842	68.60	51.45	58.35
20844	171.50	128.65	145.80

20845	171.50	128.65	145.80
20846	171.50	128.65	145.80
20848	171.50	128.65	145.80
20850	205.80	154.35	174.95
20855	257.25	192.95	218.70
20860	102.90	77.20	87.50
20862	120.05	90.05	102.05
20864	171.50	128.65	145.80
20866	171.50	128.65	145.80
20867	171.50	128.65	145.80
20868	171.50	128.65	145.80
20880	257.25	192.95	218.70
20882	171.50	128.65	145.80
20884	85.75	64.35	72.90
20900	51.45	38.60	43.75
20902	68.60	51.45	58.35
20904	120.05	90.05	102.05
20906	68.60	51.45	58.35
20910	68.60	51.45	58.35
20912	85.75	64.35	72.90
20914	120.05	90.05	102.05
20916	120.05	90.05	102.05
20920	51.45	38.60	43.75
20924	68.60	51.45	58.35
20926	68.60	51.45	58.35
20928	102.90	77.20	87.50
20930	68.60	51.45	58.35
20932	68.60	51.45	58.35
20934	102.90	77.20	87.50
20936	137.20	102.90	116.65
20938	68.60	51.45	58.35
20940	51.45	38.60	43.75
20942	68.60	51.45	58.35
20943	68.60	51.45	58.35
20944	102.90	77.20	87.50
20946	137.20	102.90	116.65
20948	68.60	51.45	58.35
20950	85.75	64.35	72.90
20952	68.60	51.45	58.35
20954	171.50	128.65	145.80
21100	51.45	38.60	43.75
21110	85.75	64.35	72.90
21120	102.90	77.20	87.50
21130	51.45	38.60	43.75
21140	257.25	192.95	218.70
21150	171.50	128.65	145.80
21160	68.60	51.45	58.35
21170	68.60	51.45	58.35
21195	51.45	38.60	43.75
21199	68.60	51.45	58.35
21200	68.60	51.45	58.35
21202	68.60	51.45	58.35
21210	102.90	77.20	87.50
21212	171.50	128.65	145.80
21214	171.50	128.65	145.80
21220	68.60	51.45	58.35
21230	102.90	77.20	87.50
21232	85.75	64.35	72.90
21234	137.20	102.90	116.65
21260	68.60	51.45	58.35
21270	137.20	102.90	116.65
21272	68.60	51.45	58.35
21274	102.90	77.20	87.50
21280	257.25	192.95	218.70
21300	51.45	38.60	43.75
21321	68.60	51.45	58.35
21340	68.60	51.45	58.35
21360	85.75	64.35	72.90
21380	51.45	38.60	43.75
21382	68.60	51.45	58.35
21390	51.45	38.60	43.75
21392	68.60	51.45	58.35
21400	68.60	51.45	58.35
21402	120.05	90.05	102.05
21403	171.50	128.65	145.80
21404	85.75	64.35	72.90
21420	51.45	38.60	43.75
21430	68.60	51.45	58.35
21432	85.75	64.35	72.90
21440	137.20	102.90	116.65
21460	51.45	38.60	43.75
21461	68.60	51.45	58.35
21462	51.45	38.60	43.75
21464	68.60	51.45	58.35
21472	85.75	64.35	72.90
21474	85.75	64.35	72.90
21480	68.60	51.45	58.35
21482	85.75	64.35	72.90
21484	85.75	64.35	72.90
21486	120.05	90.05	102.05
21490	51.45	38.60	43.75
21500	137.20	102.90	116.65
21502	102.90	77.20	87.50
21520	68.60	51.45	58.35
21522	85.75	64.35	72.90
21530	257.25	192.95	218.70
21532	137.20	102.90	116.65
21600	51.45	38.60	43.75
21610	85.75	64.35	72.90
21620	68.60	51.45	58.35
21622	85.75	64.35	72.90
21630	85.75	64.35	72.90
21632	102.90	77.20	87.50
21634	154.35	115.80	131.20
21636	257.25	192.95	218.70
21638	171.50	128.65	145.80
21650	137.20	102.90	116.65
21652	171.50	128.65	145.80
21654	137.20	102.90	116.65
21656	171.50	128.65	145.80
21670	68.60	51.45	58.35
21680	51.45	38.60	43.75
21682	68.60	51.45	58.35
21700	51.45	38.60	43.75
21710	68.60	51.45	58.35
21712	85.75	64.35	72.90
21714	85.75	64.35	72.90
21716	85.75	64.35	72.90
21730	51.45	38.60	43.75
21732	68.60	51.45	58.35

21740	85.75	64.35	72.90
21756	102.90	77.20	87.50
21760	120.05	90.05	102.05
21770	137.20	102.90	116.65
21772	102.90	77.20	87.50
21780	68.60	51.45	58.35
21790	257.25	192.95	218.70
21800	51.45	38.60	43.75
21810	68.60	51.45	58.35
21820	51.45	38.60	43.75
21830	68.60	51.45	58.35
21832	120.05	90.05	102.05
21834	68.60	51.45	58.35
21840	137.20	102.90	116.65
21842	102.90	77.20	87.50
21850	68.60	51.45	58.35
21860	51.45	38.60	43.75
21870	257.25	192.95	218.70
21872	137.20	102.90	116.65
21878	51.45	38.60	43.75
21879	85.75	64.35	72.90
21880	120.05	90.05	102.05
21881	154.35	115.80	131.20
21882	188.65	141.50	160.40
21883	222.95	167.25	189.55
21884	275.25	206.45	234.00
21885	291.55	218.70	247.85
21886	325.85	244.40	277.00
21887	360.15	270.15	306.15
21900	51.45	38.60	43.75
21906	85.75	64.35	72.90
21908	102.90	77.20	87.50
21910	154.35	115.80	131.20
21912	85.75	64.35	72.90
21914	102.90	77.20	87.50
21915	85.75	64.35	72.90
21916	85.75	64.35	72.90
21918	85.75	64.35	72.90
21922	120.05	90.05	102.05
21925	68.60	51.45	58.35
21926	85.75	64.35	72.90
21927	85.75	64.35	72.90
21930	102.90	77.20	87.50
21935	85.75	64.35	72.90
21936	102.90	77.20	87.50
21939	51.45	38.60	43.75
21941	120.05	90.05	102.05
21943	85.75	64.35	72.90
21945	85.75	64.35	72.90
21949	85.75	64.35	72.90
21952	171.50	128.65	145.80
21955	85.75	64.35	72.90
21959	85.75	64.35	72.90
21962	85.75	64.35	72.90
21965	85.75	64.35	72.90
21969	137.20	102.90	116.65
21970	257.25	192.95	218.70
21973	85.75	64.35	72.90
21976	85.75	64.35	72.90
21980	85.75	64.35	72.90
21990	51.45	38.60	43.75
21992	68.60	51.45	58.35
21997	68.60	51.45	58.35
22001	51.45	38.60	43.75
22002	68.60	51.45	58.35
22007	68.60	51.45	58.35
22008	68.60	51.45	58.35
22012	51.45	38.60	43.75
22014	51.45	38.60	43.75
22015	102.90	77.20	87.50
22020	68.60	51.45	58.35
22025	68.60	51.45	58.35
22030	34.30	25.75	29.20
22035	34.30	25.75	29.20
22040	34.30	25.75	29.20
22045	51.45	38.60	43.75
22050	34.30	25.75	29.20
22055	205.80	154.35	174.95
22065	85.75	64.35	72.90
22070	171.50	128.65	145.80
22075	257.25	192.95	218.70
22900	85.75	64.35	72.90
22905	85.75	64.35	72.90
23010	17.15	12.90	14.60
23021	34.30	25.75	29.20
23022	34.30	25.75	29.20
23023	34.30	25.75	29.20
23031	51.45	38.60	43.75
23032	51.45	38.60	43.75
23033	51.45	38.60	43.75
23041	68.60	51.45	58.35
23042	68.60	51.45	58.35
23043	68.60	51.45	58.35
23051	85.75	64.35	72.90
23052	85.75	64.35	72.90
23053	85.75	64.35	72.90
23061	102.90	77.20	87.50
23062	102.90	77.20	87.50
23063	102.90	77.20	87.50
23071	120.05	90.05	102.05
23072	120.05	90.05	102.05
23073	120.05	90.05	102.05
23081	137.20	102.90	116.65
23082	137.20	102.90	116.65
23083	137.20	102.90	116.65
23090	154.35	115.80	131.20
23100	171.50	128.65	145.80
23110	188.65	141.50	160.40
23120	205.80	154.35	174.95
23130	222.95	167.25	189.55
23140	240.10	180.10	204.10
23150	257.25	192.95	218.70
23160	274.40	205.80	233.25
23170	291.55	218.70	247.85
23180	308.70	231.55	262.40
23190	325.85	244.40	277.00
23200	343.00	257.25	291.55
23210	360.15	270.15	306.15
23220	377.30	283.00	321.70
23230	394.45	295.85	338.85

23240	411.60	308.70	356.00
23250	428.75	321.60	373.15
23260	445.90	334.45	390.30
23270	463.05	347.30	407.45
23280	480.20	360.15	424.60
23290	497.35	373.05	441.75
23300	514.50	385.90	458.90
23310	531.65	398.75	476.05
23320	548.80	411.60	493.20
23330	565.95	424.50	510.35
23340	583.10	437.35	527.50
23350	600.25	450.20	544.65
23360	617.40	463.05	561.80
23370	634.55	475.95	578.95
23380	651.70	488.80	596.10
23390	668.85	501.65	613.25
23400	686.00	514.50	630.40
23410	703.15	527.40	647.55
23420	720.30	540.25	664.70
23430	737.45	553.10	681.85
23440	754.60	565.95	699.00
23450	771.75	578.85	716.15
23460	788.90	591.70	733.30
23470	806.05	604.55	750.45
23480	823.20	617.40	767.60
23490	840.35	630.30	784.75
23500	857.50	643.15	801.90
23510	874.65	656.00	819.05
23520	891.80	668.85	836.20
23530	908.95	681.75	853.35
23540	926.10	694.60	870.50
23550	943.25	707.45	887.65
23560	960.40	720.30	904.80
23570	977.55	733.20	921.95
23580	994.70	746.05	939.10
23590	1011.85	758.90	956.25
23600	1029.00	771.75	973.40
23610	1046.15	784.65	990.55
23620	1063.30	797.50	1007.70
23630	1080.45	810.35	1024.85
23640	1097.60	823.20	1042.00
23650	1114.75	836.10	1059.15
23660	1131.90	848.95	1076.30
23670	1149.05	861.80	1093.45
23680	1166.20	874.65	1110.60
23690	1183.35	887.55	1127.75
23700	1200.50	900.40	1144.90
23710	1217.65	913.25	1162.05
23720	1234.80	926.10	1179.20
23730	1251.95	939.00	1196.35
23740	1269.10	951.85	1213.50
23750	1286.25	964.70	1230.65
23760	1303.40	977.55	1247.80
23770	1320.55	990.45	1264.95
23780	1337.70	1003.30	1282.10
23790	1354.85	1016.15	1299.25
23800	1372.00	1029.00	1316.40
23810	1389.15	1041.90	1333.55
23820	1406.30	1054.75	1350.70
23830	1423.45	1067.60	1367.85
23840	1440.60	1080.45	1385.00
23850	1457.75	1093.35	1402.15
23860	1474.90	1106.20	1419.30
23870	1492.05	1119.05	1436.45
23880	1509.20	1131.90	1453.60
23890	1526.35	1144.80	1470.75
23900	1543.50	1157.65	1487.90
23910	1560.65	1170.50	1505.05
23920	1577.80	1183.35	1522.20
23930	1594.95	1196.25	1539.35
23940	1612.10	1209.10	1556.50
23950	1629.25	1221.95	1573.65
23960	1646.40	1234.80	1590.80
23970	1663.55	1247.70	1607.95
23980	1680.70	1260.55	1625.10
23990	1697.85	1273.40	1642.25
24100	1715.00	1286.25	1659.40
24101	1732.15	1299.15	1676.55
24102	1749.30	1312.00	1693.70
24103	1766.45	1324.85	1710.85
24104	1783.60	1337.70	1728.00
24105	1800.75	1350.60	1745.15
24106	1817.90	1363.45	1762.30
24107	1835.05	1376.30	1779.45
24108	1852.20	1389.15	1796.60
24109	1869.35	1402.05	1813.75
24110	1886.50	1414.90	1830.90
24111	1903.65	1427.75	1848.05
24112	1920.80	1440.60	1865.20
24113	1937.95	1453.50	1882.35
24114	1955.10	1466.35	1899.50
24115	1972.25	1479.20	1916.65
24116	1989.40	1492.05	1933.80
24117	2006.55	1504.95	1950.95
24118	2023.70	1517.80	1968.10
24119	2040.85	1530.65	1985.25
24120	2058.00	1543.50	2002.40
24121	2075.15	1556.40	2019.55
24122	2092.30	1569.25	2036.70
24123	2109.45	1582.10	2053.85
24124	2126.60	1594.95	2071.00
24125	2143.75	1607.85	2088.15
24126	2160.90	1620.70	2105.30
24127	2178.05	1633.55	2122.45
24128	2195.20	1646.40	2139.60
24129	2212.35	1659.30	2156.75
24130	2229.50	1672.15	2173.90
24131	2246.65	1685.00	2191.05
24132	2263.80	1697.85	2208.20
24133	2280.95	1710.75	2225.35
24134	2298.10	1723.60	2242.50
24135	2315.25	1736.45	2259.65
24136	2332.40	1749.30	2276.80
25000	17.15	12.90	14.60
25005	34.30	25.75	29.20
25010	51.45	38.60	43.75
25015	17.15	12.90	14.60
25020	34.30	25.75	29.20
30003	28.75	21.60	24.45
30006	36.80	27.60	31.30

30009	48.00	36.00	40.80
30010	58.45	43.85	49.70
30013	103.50	77.65	88.00
30014	122.95	92.25	104.55
30017	257.85	193.40	219.20
30020	502.25	376.70	446.65
30023	257.85	193.40	219.20
30026	41.30	31.00	35.15
30029	71.15	53.40	60.50
30032	65.25	48.95	55.50
30035	92.95	69.75	79.05
30038	71.15	53.40	60.50
30041	113.95	85.50	96.90
30042	146.90	110.20	124.90
30045	92.95	69.75	79.05
30048	118.45	88.85	100.70
30049	146.90	110.20	124.90
30052	200.90	150.70	170.80
30055	58.45	43.85	49.70
30058	113.95	85.50	96.90
30061	18.55	13.95	15.80
30064	86.95	65.25	73.95
30067	176.90	132.70	150.40
30068	218.90	164.20	186.10
30071	41.30	31.00	35.15
30074	92.95	69.75	79.05
30075	118.45	88.85	100.70
30078	38.30	28.75	32.60
30081	86.95	65.25	73.95
30084	46.50	34.90	39.55
30087	23.30	17.50	19.85
30090	101.65	76.25	86.45
30093	135.70	101.80	115.35
30094	149.80	112.35	127.35
30096	145.45	109.10	123.65
30099	71.15	53.40	60.50
30102	118.45	88.85	100.70
30103	145.45	109.10	123.65
30104	100.45	75.35	85.40
30106	122.95	92.25	104.55
30107	173.95	130.50	147.90
30110	224.95	168.75	191.25
30111	293.85	220.40	249.80
30114	293.85	220.40	249.80
30165	359.80	269.85	305.85
30168	359.80	269.85	305.85
30171	547.25	410.45	491.65
30174	547.25	410.45	491.65
30177	779.70	584.80	724.10
30180	107.95	81.00	91.80
30183	194.95	146.25	165.75
30186	37.55	28.20	31.95
30187	203.25	152.45	172.80
30189	116.50	87.40	99.05
30190	314.65	236.00	267.50
30192	31.35	23.55	26.65
30195	50.20	37.65	42.70
30196	99.90	74.95	84.95
30197	348.10	261.10	295.90
30202	38.20	28.65	32.50
30203	134.70	101.05	114.50
30205	99.90	74.95	84.95
30207	35.25	26.45	30.00
30210	128.95	96.75	109.65
30213	86.85	65.15	73.85
30214	86.85	65.15	73.85
30216	21.60	16.20	18.40
30219	21.60	16.20	18.40
30223	128.95	96.75	109.65
30224	187.95	141.00	159.80
30225	211.70	158.80	179.95
30226	118.45	88.85	100.70
30229	215.90	161.95	183.55
30232	176.90	132.70	150.40
30235	233.90	175.45	198.85
30238	118.45	88.85	100.70
30241	281.90	211.45	239.65
30244	281.90	211.45	239.65
30246	545.60	409.20	490.00
30247	584.80	438.60	529.20
30250	989.55	742.20	933.95
30251	1520.05	1140.05	1464.45
30253	659.80	494.85	604.20
30255	878.55	658.95	822.95
30256	352.35	264.30	299.50
30259	155.90	116.95	132.55
30262	46.50	34.90	39.55
30265	92.95	69.75	79.05
30266	118.45	88.85	100.70
30269	118.45	88.85	100.70
30272	233.90	175.45	198.85
30275	1394.40	1045.80	1338.80
30278	36.80	27.60	31.30
30281	94.50	70.90	80.35
30282	122.95	92.25	104.55
30283	161.95	121.50	137.70
30286	314.75	236.10	267.55
30289	397.30	298.00	341.70
30293	352.35	264.30	299.50
30294	1394.40	1045.80	1338.80
30296	809.80	607.35	754.20
30297	809.80	607.35	754.20
30306	631.70	473.80	576.10
30308	631.70	473.80	576.10
30309	809.80	607.35	754.20
30310	361.80	271.35	307.55
30313	215.90	161.95	183.55
30314	361.80	271.35	307.55
30315	901.65	676.25	846.05
30317	1079.70	809.80	1024.10
30318	717.90	538.45	662.30
30320	1079.70	809.80	1024.10
30321	717.90	538.45	662.30
30323	1079.70	809.80	1024.10
30324	1079.70	809.80	1024.10
30329	195.30	146.50	166.05
30330	568.55	426.45	512.95
30332	274.30	205.75	233.20
30335	685.70	514.30	630.10
30336	822.90	617.20	767.30

30339	205.70	154.30	174.85
30340	274.30	205.75	233.20
30343	308.60	231.45	262.35
30344	274.30	205.75	233.20
30347	514.30	385.75	458.70
30348	345.00	258.75	293.25
30351	582.40	436.80	526.80
30352	342.90	257.20	291.50
30354	822.90	617.20	767.30
30355	411.45	308.60	355.85
30358	471.15	353.40	415.55
30360	109.05	81.80	92.70
30361	149.80	112.35	127.35
30363	109.05	81.80	92.70
30364	171.40	128.55	145.70
30366	342.90	257.20	291.50
30367	274.30	205.75	233.20
30369	274.30	205.75	233.20
30370	205.50	154.15	174.70
30372	102.85	77.15	87.45
30373	382.25	286.70	326.65
30375	412.30	309.25	356.70
30376	412.30	309.25	356.70
30378	414.20	310.65	358.60
30379	734.20	550.65	678.60
30382	1033.75	775.35	978.15
30384	869.60	652.20	814.00
30385	445.55	334.20	389.95
30387	502.25	376.70	446.65
30388	1263.55	947.70	1207.95
30390	173.95	130.50	147.90
30391	224.95	168.75	191.25
30392	533.55	400.20	477.95
30393	414.20	310.65	358.60
30394	389.80	292.35	334.20
30396	804.10	603.10	748.50
30397	183.80	137.85	156.25
30399	252.80	189.60	214.90
30400	500.30	375.25	444.70
30402	367.50	275.65	312.40
30403	412.30	309.25	356.70
30405	723.70	542.80	668.10
30406	41.30	31.00	35.15
30408	310.15	232.65	263.65
30409	138.05	103.55	117.35
30411	70.25	52.70	59.75
30412	41.40	31.05	35.20
30414	545.60	409.20	490.00
30415	1091.25	818.45	1035.65
30416	592.50	444.40	536.90
30417	888.70	666.55	833.10
30418	1263.55	947.70	1207.95
30419	646.40	484.80	590.80
30421	1579.30	1184.50	1523.70
30422	534.15	400.65	478.55
30425	1033.75	775.35	978.15
30427	1234.75	926.10	1179.15
30428	1320.95	990.75	1265.35
30430	1837.75	1378.35	1782.15
30431	412.30	309.25	356.70
30433	574.35	430.80	518.75
30434	465.25	348.95	409.65
30436	516.90	387.70	461.30
30437	643.25	482.45	587.65
30438	910.30	682.75	854.70
30439	146.90	110.20	124.90
30440	416.35	312.30	360.75
30441	107.75	80.85	91.60
30442	146.90	110.20	124.90
30443	584.80	438.60	529.20
30445	584.80	438.60	529.20
30446	584.80	438.60	529.20
30448	769.60	577.20	714.00
30449	855.75	641.85	800.15
30450	414.75	311.10	359.15
30451	211.70	158.80	179.95
30452	298.65	224.00	253.90
30454	682.20	511.65	626.60
30455	802.15	601.65	746.55
30457	1091.25	818.45	1035.65
30458	802.15	601.65	746.55
30460	682.20	511.65	626.60
30461	1169.45	877.10	1113.85
30463	1435.75	1076.85	1380.15
30464	1723.00	1292.25	1667.40
30466	993.60	745.20	938.00
30467	1229.00	921.75	1173.40
30469	1361.15	1020.90	1305.55
30472	735.10	551.35	679.50
30473	140.10	105.10	119.10
30475	253.30	190.00	215.35
30476	194.25	145.70	165.15
30478	194.25	145.70	165.15
30479	376.60	282.45	321.00
30481	282.40	211.80	240.05
30482	200.80	150.60	170.70
30483	140.05	105.05	119.05
30484	288.65	216.50	245.40
30485	445.55	334.20	389.95
30487	143.10	107.35	121.65
30488	71.15	53.40	60.50
30490	416.35	312.30	360.75
30491	439.25	329.45	383.65
30493	263.60	197.70	224.10
30494	332.60	249.45	282.75
30496	465.25	348.95	409.65
30497	554.70	416.05	499.10
30499	659.80	494.85	604.20
30500	706.40	529.80	650.80
30502	779.70	584.80	724.10
30503	873.05	654.80	817.45
30505	436.45	327.35	380.85
30506	763.90	572.95	708.30
30508	804.10	603.10	748.50
30509	804.10	603.10	748.50
30511	672.00	504.00	616.40
30512	826.95	620.25	771.35
30514	1217.50	913.15	1161.90
30515	557.05	417.80	501.45
30517	729.40	547.05	673.80

30518	781.10	585.85	725.50
30520	534.15	400.65	478.55
30521	1142.95	857.25	1087.35
30523	1194.50	895.90	1138.90
30524	1315.15	986.40	1259.55
30526	1705.65	1279.25	1650.05
30527	689.20	516.90	633.60
30529	1033.75	775.35	978.15
30530	620.30	465.25	564.70
30532	712.25	534.20	656.65
30533	847.20	635.40	791.60
30535	1342.00	1006.50	1286.40
30536	1361.15	1020.90	1305.55
30538	941.90	706.45	886.30
30539	689.20	516.90	633.60
30541	1200.35	900.30	1144.75
30542	815.50	611.65	759.90
30544	597.30	448.00	541.70
30545	1453.10	1089.85	1397.50
30547	999.30	749.50	943.70
30548	746.60	559.95	691.00
30550	1631.10	1223.35	1575.50
30551	1125.70	844.30	1070.10
30553	832.70	624.55	777.10
30554	1814.90	1361.20	1759.30
30556	1252.00	939.00	1196.40
30557	924.65	693.50	869.05
30559	672.00	504.00	616.40
30560	746.60	559.95	691.00
30562	470.70	353.05	415.10
30563	470.70	353.05	415.10
30564	610.90	458.20	555.30
30565	689.20	516.90	633.60
30566	765.60	574.20	710.00
30568	574.35	430.80	518.75
30569	292.85	219.65	248.95
30571	352.35	264.30	299.50
30572	352.35	264.30	299.50
30574	97.50	73.15	82.90
30575	405.60	304.20	350.00
30577	861.50	646.15	805.90
30578	907.45	680.60	851.85
30580	826.95	620.25	771.35
30581	603.05	452.30	547.45
30583	944.70	708.55	889.10
30584	1394.40	1045.80	1338.80
30586	554.70	416.05	499.10
30587	574.35	430.80	518.75
30589	989.55	742.20	933.95
30590	1091.25	818.45	1035.65
30593	1493.25	1119.95	1437.65
30594	1723.00	1292.25	1667.40
30596	709.75	532.35	654.15
30597	569.70	427.30	514.10
30599	1033.75	775.35	978.15
30600	614.75	461.10	559.15
30601	757.20	567.90	701.60
30602	1229.00	921.75	1173.40
30603	1298.00	973.50	1242.40
30605	1476.05	1107.05	1420.45
30606	878.70	659.05	823.10
30609	367.40	275.55	312.30
30612	281.90	211.45	239.65
30614	367.40	275.55	312.30
30615	412.30	309.25	356.70
30616	209.85	157.40	178.40
30617	281.90	211.45	239.65
30620	236.90	177.70	201.40
30621	322.40	241.80	274.05
30628	28.20	21.15	24.00
30631	187.15	140.40	159.10
30634	185.95	139.50	158.10
30635	230.90	173.20	196.30
30638	236.90	177.70	201.40
30641	322.40	241.80	274.05
30644	412.30	309.25	356.70
30653	36.80	27.60	31.30
30656	85.50	64.15	72.70
30659	118.45	88.85	100.70
30660	146.90	110.20	124.90
30663	114.20	85.65	97.10
30666	37.55	28.20	31.95
30672	352.35	264.30	299.50
30675	236.90	177.70	201.40
30676	299.85	224.90	254.90
30679	76.15	57.15	64.75
31000	459.45	344.60	403.85
31001	574.35	430.80	518.75
31002	689.20	516.90	633.60
31200	26.90	20.20	22.90
31205	75.45	56.60	64.15
31210	97.35	73.05	82.75
31215	113.50	85.15	96.50
31220	169.70	127.30	144.25
31225	301.60	226.20	256.40
31230	132.95	99.75	113.05
31235	113.50	85.15	96.50
31240	132.95	99.75	113.05
31245	291.85	218.90	248.10
31250	291.85	218.90	248.10
31255	175.10	131.35	148.85
31260	249.70	187.30	212.25
31265	145.90	109.45	124.05
31270	204.30	153.25	173.70
31275	236.75	177.60	201.25
31280	123.25	92.45	104.80
31285	168.55	126.45	143.30
31290	194.50	145.90	165.35
31295	231.65	173.75	196.95
31300	253.00	189.75	215.05
31305	311.25	233.45	264.60
31310	220.45	165.35	187.40
31315	278.85	209.15	237.05
31320	311.25	233.45	264.60
31325	214.05	160.55	181.95
31330	253.00	189.75	215.05
31335	291.85	218.90	248.10
31345	166.80	125.10	141.80
31350	342.80	257.10	291.40
31355	565.10	423.85	509.50

31400	206.50	154.90	175.55
31403	238.35	178.80	202.60
31406	397.20	297.90	341.60
31409	1234.05	925.55	1178.45
31412	1520.05	1140.05	1464.45
31420	145.45	109.10	123.65
31423	317.75	238.35	270.10
31426	635.55	476.70	579.95
31429	990.40	742.80	934.80
31432	1059.25	794.45	1003.65
31435	778.55	583.95	722.95
31438	1234.05	925.55	1178.45
31441	199.05	149.30	169.20
31450	321.65	241.25	273.45
31452	562.85	422.15	507.25
31454	445.55	334.20	389.95
31456	194.25	145.70	165.15
31458	233.10	174.85	198.15
31460	282.40	211.80	240.05
31462	412.30	309.25	356.70
31464	689.20	516.90	633.60
31466	1033.80	775.35	978.20
31468	1135.80	851.85	1080.20
31470	569.70	427.30	514.10
31472	925.35	694.05	869.75
32000	815.80	611.85	760.20
32003	853.40	640.05	797.80
32004	909.95	682.50	854.35
32005	1027.95	771.00	972.35
32006	909.95	682.50	854.35
32009	1079.40	809.55	1023.80
32012	1192.35	894.30	1136.75
32015	1465.30	1099.00	1409.70
32018	1242.50	931.90	1186.90
32021	445.55	334.20	389.95
32024	1079.40	809.55	1023.80
32025	1443.80	1082.85	1388.20
32026	1554.85	1166.15	1499.25
32028	1665.95	1249.50	1610.35
32029	333.15	249.90	283.20
32030	815.80	611.85	760.20
32033	1192.35	894.30	1136.75
32036	1512.30	1134.25	1456.70
32039	1214.25	910.70	1158.65
32042	1022.90	767.20	967.30
32045	382.85	287.15	327.25
32046	591.55	443.70	535.95
32047	689.20	516.90	633.60
32051	1832.45	1374.35	1776.85
32054	1681.80	1261.35	1626.20
32057	445.55	334.20	389.95
32060	1832.45	1374.35	1776.85
32063	1681.80	1261.35	1626.20
32066	445.55	334.20	389.95
32069	1355.50	1016.65	1299.90
32072	37.90	28.45	32.25
32075	59.40	44.55	50.50
32078	133.30	100.00	113.35
32081	183.05	137.30	155.60
32084	88.10	66.10	74.90
32087	161.95	121.50	137.70
32090	264.40	198.30	224.75
32093	371.10	278.35	315.50
32094	436.45	327.35	380.85
32095	101.10	75.85	85.95
32096	203.25	152.45	172.80
32099	263.60	197.70	224.10
32102	502.00	376.50	446.40
32105	382.85	287.15	327.25
32108	790.75	593.10	735.15
32111	502.00	376.50	446.40
32112	610.90	458.20	555.30
32114	138.05	103.55	117.35
32115	100.40	75.30	85.35
32117	790.75	593.10	735.15
32120	203.25	152.45	172.80
32123	263.60	197.70	224.10
32126	382.85	287.15	327.25
32129	502.00	376.50	446.40
32131	422.10	316.60	366.50
32132	35.70	26.80	30.35
32135	53.35	40.05	45.35
32138	290.90	218.20	247.30
32139	290.90	218.20	247.30
32142	53.35	40.05	45.35
32145	106.85	80.15	90.85
32147	35.70	26.80	30.35
32150	203.25	152.45	172.80
32153	55.50	41.65	47.20
32156	104.20	78.15	88.60
32159	263.60	197.70	224.10
32162	382.85	287.15	327.25
32165	502.00	376.50	446.40
32166	163.05	122.30	138.60
32168	104.20	78.15	88.60
32171	70.25	52.70	59.75
32174	70.25	52.70	59.75
32175	128.65	96.50	109.40
32177	137.85	103.40	117.20
32180	203.25	152.45	172.80
32183	444.30	333.25	388.70
32186	444.30	333.25	388.70
32200	233.90	175.45	198.85
32203	502.25	376.70	446.65
32206	453.75	340.35	398.15
32209	729.20	546.90	673.60
32210	202.05	151.55	171.75
32212	107.75	80.85	91.60
32500	86.85	65.15	73.85
32501	86.85	65.15	73.85
32504	211.70	158.80	179.95
32507	422.10	316.60	366.50
32508	422.10	316.60	366.50
32511	627.50	470.65	571.90
32514	733.05	549.80	677.45
32517	943.95	708.00	888.35
32700	1136.15	852.15	1080.55
32703	939.85	704.90	884.25
32708	1124.30	843.25	1068.70
32710	1249.25	936.95	1193.65

32711	1374.20	1030.65	1318.60
32712	993.40	745.05	937.80
32715	993.40	745.05	937.80
32718	939.85	704.90	884.25
32721	1492.90	1119.70	1437.30
32724	1695.20	1271.40	1639.60
32730	1284.85	963.65	1229.25
32733	1492.90	1119.70	1437.30
32736	327.10	245.35	278.05
32739	1023.10	767.35	967.50
32742	1171.85	878.90	1116.25
32745	1338.30	1003.75	1282.70
32748	1451.35	1088.55	1395.75
32751	939.85	704.90	884.25
32754	1171.85	878.90	1116.25
32757	327.10	245.35	278.05
32760	321.10	240.85	272.95
32763	939.85	704.90	884.25
32766	624.60	468.45	569.00
32769	216.50	162.40	184.05
33050	1151.10	863.35	1095.50
33055	923.15	692.40	867.55
33070	666.05	499.55	610.45
33075	847.25	635.45	791.65
33080	1034.20	775.65	978.60
33100	1136.15	852.15	1080.55
33103	1594.05	1195.55	1538.45
33109	1927.25	1445.45	1871.65
33112	1671.40	1253.55	1615.80
33115	1124.30	843.25	1068.70
33118	1249.25	936.95	1193.65
33121	1374.20	1030.65	1318.60
33124	957.65	718.25	902.05
33127	1255.05	941.30	1199.45
33130	1094.45	820.85	1038.85
33133	820.85	615.65	765.25
33136	2069.90	1552.45	2014.30
33139	1255.05	941.30	1199.45
33142	1171.85	878.90	1116.25
33145	2016.45	1512.35	1960.85
33148	2504.20	1878.15	2448.60
33151	2379.25	1784.45	2323.65
33154	1760.75	1320.60	1705.15
33157	1962.90	1472.20	1907.30
33160	1962.90	1472.20	1907.30
33163	1665.60	1249.20	1610.00
33166	1665.60	1249.20	1610.00
33169	1296.75	972.60	1241.15
33172	1011.15	758.40	955.55
33175	931.90	698.95	876.30
33178	1185.05	888.80	1129.45
33181	1448.90	1086.70	1393.30
33500	898.15	673.65	842.55
33506	1005.30	754.00	949.70
33509	1124.30	843.25	1068.70
33512	1249.25	936.95	1193.65
33515	1374.20	1030.65	1318.60
33518	1005.30	754.00	949.70
33521	1088.50	816.40	1032.90
33524	1284.85	963.65	1229.25
33527	1492.90	1119.70	1437.30
33530	1284.85	963.65	1229.25
33533	1492.90	1119.70	1437.30
33536	1064.80	798.60	1009.20
33539	767.30	575.50	711.70
33542	1094.45	820.85	1038.85
33545	216.50	162.40	184.05
33548	440.30	330.25	384.70
33551	216.50	162.40	184.05
33554	215.45	161.60	183.15
33800	933.85	700.40	878.25
33803	892.25	669.20	836.65
33806	642.45	481.85	586.85
33810	468.65	351.50	413.05
33811	1395.05	1046.30	1339.45
33812	737.60	553.20	682.00
33815	678.10	508.60	622.50
33818	791.15	593.40	735.55
33821	904.15	678.15	848.55
33824	862.45	646.85	806.85
33827	1011.15	758.40	955.55
33830	1159.85	869.90	1104.25
33833	1052.90	789.70	997.30
33836	1255.05	941.30	1199.45
33839	1469.20	1101.90	1413.60
33842	725.70	544.30	670.10
33845	505.60	379.20	450.00
33848	505.60	379.20	450.00
34100	559.15	419.40	503.55
34103	327.10	245.35	278.05
34106	230.80	173.10	196.20
34109	267.60	200.70	227.50
34112	678.10	508.60	622.50
34115	767.30	575.50	711.70
34118	1094.45	820.85	1038.85
34121	874.35	655.80	818.75
34124	957.65	718.25	902.05
34127	1255.05	941.30	1199.45
34130	392.65	294.50	337.05
34133	440.30	330.25	384.70
34136	707.75	530.85	652.15
34139	707.75	530.85	652.15
34142	874.35	655.80	818.75
34145	636.50	477.40	580.90
34148	1136.15	852.15	1080.55
34151	1552.50	1164.40	1496.90
34154	1849.95	1387.50	1794.35
34157	939.85	704.90	884.25
34160	1760.75	1320.60	1705.15
34163	2260.35	1695.30	2204.75
34166	2260.35	1695.30	2204.75
34169	1255.05	941.30	1199.45
34172	1023.10	767.35	967.50
34175	939.85	704.90	884.25
34500	243.90	182.95	207.35
34503	327.10	245.35	278.05
34506	166.55	124.95	141.60
34509	773.25	579.95	717.65
34512	850.65	638.00	795.05
34515	606.70	455.05	551.10

34518	1017.10	762.85	961.50
34521	624.85	468.65	569.25
34524	327.10	245.35	278.05
34527	436.30	327.25	380.70
34528	215.45	161.60	183.15
34530	161.60	121.20	137.40
34533	981.40	736.05	925.80
34800	642.45	481.85	586.85
34803	1415.70	1061.80	1360.10
34806	767.30	575.50	711.70
34809	767.30	575.50	711.70
34812	927.95	696.00	872.35
34815	767.30	575.50	711.70
34818	844.65	633.50	789.05
34821	1148.05	861.05	1092.45
34824	392.65	294.50	337.05
34827	475.85	356.90	420.25
34830	559.15	419.40	503.55
34833	725.70	544.30	670.10
35000	559.15	419.40	503.55
35003	725.70	544.30	670.10
35006	910.10	682.60	854.50
35009	707.75	530.85	652.15
35012	559.15	419.40	503.55
35100	291.55	218.70	247.85
35103	185.55	139.20	157.75
35200	135.65	101.75	115.35
35202	646.40	484.80	590.80
35300	407.70	305.80	352.10
35303	522.70	392.05	467.10
35304	407.70	305.80	352.10
35305	522.70	392.05	467.10
35306	482.45	361.85	426.85
35309	603.05	452.30	547.45
35310	603.05	452.30	547.45
35312	683.45	512.60	627.85
35315	683.45	512.60	627.85
35317	281.45	211.10	239.25
35319	504.50	378.40	448.90
35320	677.70	508.30	622.10
35321	643.25	482.45	587.65
35324	241.15	180.90	205.00
35327	323.20	242.40	274.75
35330	407.70	305.80	352.10
35500	64.25	48.20	54.65
35503	42.35	31.80	36.00
35506	42.45	31.85	36.10
35507	138.05	103.55	117.35
35508	203.25	152.45	172.80
35509	70.85	53.15	60.25
35512	141.85	106.40	120.60
35513	175.40	131.55	149.10
35516	92.05	69.05	78.25
35517	115.45	86.60	98.15
35518	164.35	123.30	139.70
35520	46.10	34.60	39.20
35523	46.10	34.60	39.20
35526	92.05	69.05	78.25
35527	115.45	86.60	98.15
35530	213.40	160.05	181.40
35533	276.75	207.60	235.25
35536	275.60	206.70	234.30
35539	215.90	161.95	183.55
35542	252.80	189.60	214.90
35545	145.30	109.00	123.55
35548	659.80	494.85	604.20
35551	540.95	405.75	485.35
35554	34.40	25.80	29.25
35557	169.65	127.25	144.25
35560	540.95	405.75	485.35
35561	1091.25	818.45	1035.65
35562	895.95	672.00	840.35
35564	413.60	310.20	358.00
35565	540.95	405.75	485.35
35566	314.25	235.70	267.15
35567	555.30	416.50	499.70
35569	127.20	95.40	108.15
35572	97.95	73.50	83.30
35576	336.20	252.15	285.80
35580	424.00	318.00	368.40
35584	533.55	400.20	477.95
35587	138.90	104.20	118.10
35590	424.00	318.00	368.40
35593	424.00	318.00	368.40
35596	540.95	405.75	485.35
35599	533.55	400.20	477.95
35600	414.20	310.65	358.60
35602	533.55	400.20	477.95
35605	289.45	217.10	246.05
35608	50.60	37.95	43.05
35611	50.60	37.95	43.05
35612	400.20	300.15	344.60
35613	320.25	240.20	272.25
35614	50.50	37.90	42.95
35615	42.45	31.85	36.10
35616	355.60	266.70	302.30
35617	137.35	103.05	116.75
35618	172.45	129.35	146.60
35620	42.15	31.65	35.85
35622	476.60	357.45	421.00
35623	648.00	486.00	592.40
35626	65.50	49.15	55.70
35627	84.80	63.60	72.10
35630	144.80	108.60	123.10
35633	172.45	129.35	146.60
35634	542.40	406.80	486.80
35635	236.90	177.70	201.40
35636	342.55	256.95	291.20
35637	321.65	241.25	273.45
35638	562.85	422.15	507.25
35639	106.75	80.10	90.75
35640	144.80	108.60	123.10
35641	982.95	737.25	927.35
35643	172.45	129.35	146.60
35644	161.05	120.80	136.90
35645	252.15	189.15	214.35
35646	161.05	120.80	136.90
35647	161.05	120.80	136.90
35648	252.15	189.15	214.35
35649	424.00	318.00	368.40

35653	533.65	400.25	478.05
35657	533.65	400.25	478.05
35658	329.05	246.80	279.70
35661	689.20	516.90	633.60
35664	1148.65	861.50	1093.05
35667	976.25	732.20	920.65
35670	803.90	602.95	748.30
35673	599.40	449.55	543.80
35674	164.35	123.30	139.70
35676	336.20	252.15	285.80
35677	424.00	318.00	368.40
35678	511.15	383.40	455.55
35680	460.40	345.30	404.80
35683	277.85	208.40	236.20
35684	372.75	279.60	317.15
35687	257.25	192.95	218.70
35688	314.25	235.70	267.15
35691	125.55	94.20	106.75
35694	504.40	378.30	448.80
35697	748.45	561.35	692.85
35700	577.50	433.15	521.90
35703	53.35	40.05	45.35
35706	53.35	40.05	45.35
35709	34.40	25.80	29.25
35710	366.50	274.90	311.55
35712	286.50	214.90	243.55
35713	358.20	268.65	304.50
35716	343.55	257.70	292.05
35717	431.30	323.50	375.70
35720	533.55	400.20	477.95
35723	382.10	286.60	326.50
35726	382.10	286.60	326.50
35729	172.30	129.25	146.50
35750	620.65	465.50	565.05
35753	686.30	514.75	630.70
35754	863.60	647.70	808.00
35756	620.65	465.50	565.05
35759	445.55	334.20	389.95
36500	731.35	548.55	675.75
36502	540.95	405.75	485.35
36503	1100.40	825.30	1044.80
36506	731.35	548.55	675.75
36509	619.35	464.55	563.75
36516	731.35	548.55	675.75
36519	1021.30	766.00	965.70
36522	876.40	657.30	820.80
36525	1245.40	934.05	1189.80
36528	1021.30	766.00	965.70
36529	1260.40	945.30	1204.80
36531	915.85	686.90	860.25
36532	1314.55	985.95	1258.95
36533	1553.60	1165.20	1498.00
36537	546.95	410.25	491.35
36540	876.40	657.30	820.80
36543	1021.30	766.00	965.70
36546	546.95	410.25	491.35
36549	658.95	494.25	603.35
36552	586.50	439.90	530.90
36558	514.00	385.50	458.40
36561	136.45	102.35	116.00
36564	731.35	548.55	675.75
36567	803.90	602.95	748.30
36570	1021.30	766.00	965.70
36573	731.35	548.55	675.75
36576	915.85	686.90	860.25
36579	586.50	439.90	530.90
36585	586.50	439.90	530.90
36588	731.35	548.55	675.75
36591	876.40	657.30	820.80
36594	731.35	548.55	675.75
36597	731.35	548.55	675.75
36600	876.40	657.30	820.80
36603	1021.30	766.00	965.70
36604	211.70	158.80	179.95
36606	1831.80	1373.85	1776.20
36609	586.50	439.90	530.90
36612	514.00	385.50	458.40
36615	586.50	439.90	530.90
36618	514.00	385.50	458.40
36621	367.40	275.55	312.30
36624	441.45	331.10	385.85
36627	546.95	410.25	491.35
36630	270.20	202.65	229.70
36633	586.50	439.90	530.90
36636	316.35	237.30	268.90
36639	658.95	494.25	603.35
36642	329.45	247.10	280.05
36645	843.40	632.55	787.80
36648	751.20	563.40	695.60
36649	211.70	158.80	179.95
36652	514.00	385.50	458.40
36654	658.95	494.25	603.35
36656	843.40	632.55	787.80
36800	21.85	16.40	18.60
36803	368.90	276.70	313.60
36806	514.00	385.50	458.40
36809	658.95	494.25	603.35
36811	255.80	191.85	217.45
36812	131.80	98.85	112.05
36815	188.20	141.15	160.00
36818	218.75	164.10	185.95
36821	255.65	191.75	217.35
36824	168.65	126.50	143.40
36825	459.80	344.85	404.20
36827	181.85	136.40	154.60
36830	160.85	120.65	136.75
36833	218.75	164.10	185.95
36836	181.85	136.40	154.60
36839	255.65	191.75	217.35
36842	257.25	192.95	218.70
36845	546.95	410.25	491.35
36848	181.85	136.40	154.60
36851	181.85	136.40	154.60
36854	368.90	276.70	313.60
36857	289.85	217.40	246.40
36860	131.80	98.85	112.05
36863	368.90	276.70	313.60
37000	586.50	439.90	530.90
37004	514.00	385.50	458.40
37008	329.45	247.10	280.05

37011	73.75	55.35	62.70
37014	843.40	632.55	787.80
37020	586.50	439.90	530.90
37023	329.45	247.10	280.05
37026	329.45	247.10	280.05
37029	731.35	548.55	675.75
37038	547.25	410.45	491.65
37041	36.90	27.70	31.40
37042	720.90	540.70	665.30
37043	533.55	400.20	477.95
37044	547.25	410.45	491.65
37045	1130.15	847.65	1074.55
37047	1317.85	988.40	1262.25
37050	586.50	439.90	530.90
37053	677.70	508.30	622.10
37200	803.90	602.95	748.30
37203	824.30	618.25	768.70
37206	441.45	331.10	385.85
37207	685.40	514.05	629.80
37208	329.05	246.80	279.70
37209	1021.30	766.00	965.70
37210	1260.40	945.30	1204.80
37211	1530.80	1148.10	1475.20
37212	218.75	164.10	185.95
37215	329.45	247.10	280.05
37218	109.40	82.05	93.00
37219	222.15	166.65	188.85
37220	826.00	619.50	770.40
37221	368.90	276.70	313.60
37223	163.10	122.35	138.65
37300	36.90	27.70	31.40
37303	58.60	43.95	49.85
37306	514.00	385.50	458.40
37309	731.35	548.55	675.75
37315	109.40	82.05	93.00
37318	218.75	164.10	185.95
37321	73.75	55.35	62.70
37324	181.85	136.40	154.60
37327	255.65	191.75	217.35
37330	514.00	385.50	458.40
37333	441.45	331.10	385.85
37336	586.50	439.90	530.90
37339	189.75	142.35	161.30
37340	336.20	252.15	285.80
37341	720.90	540.70	665.30
37342	658.95	494.25	603.35
37343	1100.40	825.30	1044.80
37345	546.95	410.25	491.35
37348	546.95	410.25	491.35
37351	218.75	164.10	185.95
37354	255.65	191.75	217.35
37369	147.55	110.70	125.45
37372	368.90	276.70	313.60
37375	915.85	686.90	860.25
37381	586.50	439.90	530.90
37384	915.85	686.90	860.25
37387	255.65	191.75	217.35
37390	731.35	548.55	675.75
37393	181.85	136.40	154.60
37396	586.50	439.90	530.90
37402	368.90	276.70	313.60
37405	731.35	548.55	675.75
37408	368.90	276.70	313.60
37411	731.35	548.55	675.75
37415	36.90	27.70	31.40
37417	441.45	331.10	385.85
37418	586.50	439.90	530.90
37420	289.85	217.40	246.40
37423	731.35	548.55	675.75
37426	770.90	578.20	715.30
37429	255.65	191.75	217.35
37432	731.35	548.55	675.75
37435	73.75	55.35	62.70
37438	218.75	164.10	185.95
37444	790.75	593.10	735.15
37601	218.75	164.10	185.95
37604	218.75	164.10	185.95
37607	731.35	548.55	675.75
37610	1100.40	825.30	1044.80
37613	218.75	164.10	185.95
37616	546.95	410.25	491.35
37619	218.75	164.10	185.95
37622	152.90	114.70	130.00
37623	181.85	136.40	154.60
37800	412.30	309.25	356.70
37803	412.30	309.25	356.70
37806	476.40	357.30	420.80
37809	476.40	357.30	420.80
37812	439.85	329.90	384.25
37815	73.30	55.00	62.35
37818	388.75	291.60	333.15
37821	658.95	494.25	603.35
37824	916.25	687.20	860.65
37827	422.10	316.60	366.50
37830	546.95	410.25	491.35
37833	261.00	195.75	221.85
37836	549.75	412.35	494.15
37839	623.00	467.25	567.40
37842	1209.50	907.15	1153.90
37845	549.75	412.35	494.15
37848	989.50	742.15	933.90
37851	733.05	549.80	677.45
37854	289.85	217.40	246.40
38200	352.35	264.30	299.50
38203	420.45	315.35	364.85
38206	508.30	381.25	452.70
38209	652.65	489.50	597.05
38212	1085.60	814.20	1030.00
38213	323.20	242.40	274.75
38215	350.90	263.20	298.30
38218	526.30	394.75	470.70
38220	175.45	131.60	149.15
38222	350.90	263.20	298.30
38256	211.35	158.55	179.65
38270	721.60	541.20	666.00
38275	235.90	176.95	200.55
38278	505.20	378.90	449.60
38281	202.05	151.55	171.75
38284	662.40	496.80	606.80
38287	1659.80	1244.85	1604.20

38290	2113.50	1585.15	2057.90
38293	2268.60	1701.45	2213.00
38400	30.50	22.90	25.95
38403	60.80	45.60	51.70
38406	105.65	79.25	89.85
38409	105.65	79.25	89.85
38410	130.20	97.65	110.70
38412	165.45	124.10	140.65
38415	315.85	236.90	268.50
38418	758.10	568.60	702.50
38421	1211.80	908.85	1156.20
38424	758.10	568.60	702.50
38427	936.05	702.05	880.45
38430	482.45	361.85	426.85
38436	197.55	148.20	167.95
38438	1211.80	908.85	1156.20
38440	907.45	680.60	851.85
38441	1435.75	1076.85	1380.15
38446	936.05	702.05	880.45
38447	1211.80	908.85	1156.20
38448	287.15	215.40	244.10
38449	1695.30	1271.50	1639.70
38450	677.65	508.25	622.05
38452	453.75	340.35	398.15
38453	1361.15	1020.90	1305.55
38455	1841.20	1380.90	1785.60
38456	1211.80	908.85	1156.20
38457	1131.35	848.55	1075.75
38458	603.05	452.30	547.45
38460	217.85	163.40	185.20
38462	258.15	193.65	219.45
38464	280.65	210.50	238.60
38466	757.85	568.40	702.25
38468	1167.70	875.80	1112.10
38469	1361.15	1020.90	1305.55
38470	758.10	568.60	702.50
38473	453.75	340.35	398.15
38475	658.00	493.50	602.40
38477	1584.70	1188.55	1529.10
38478	767.65	575.75	712.05
38480	1584.70	1188.55	1529.10
38481	1804.00	1353.00	1748.40
38483	1361.15	1020.90	1305.55
38485	646.40	484.80	590.80
38487	1361.15	1020.90	1305.55
38488	1510.50	1132.90	1454.90
38489	1796.35	1347.30	1740.75
38490	438.60	328.95	383.00
38493	1548.50	1161.40	1492.90
38496	493.50	370.15	437.90
38497	1619.60	1214.70	1564.00
38500	1740.15	1305.15	1684.55
38503	1889.45	1417.10	1833.85
38505	219.30	164.50	186.45
38506	1286.40	964.80	1230.80
38507	1510.20	1132.65	1454.60
38508	1889.45	1417.10	1833.85
38509	1889.45	1417.10	1833.85
38512	1659.80	1244.85	1604.20
38515	2113.50	1585.15	2057.90
38518	2268.60	1701.45	2213.00
38521	832.70	624.55	777.10
38524	227.65	170.75	193.55
38550	1697.65	1273.25	1642.05
38553	2151.30	1613.50	2095.70
38556	2455.75	1841.85	2400.15
38559	2002.05	1501.55	1946.45
38562	2455.75	1841.85	2400.15
38565	2754.40	2065.80	2698.80
38568	1473.60	1105.20	1418.00
38571	1622.95	1217.25	1567.35
38572	1571.75	1178.85	1516.15
38577	438.60	328.95	383.00
38588	329.05	246.80	279.70
38600	1211.80	908.85	1156.20
38603	758.10	568.60	702.50
38606	304.45	228.35	258.80
38609	379.00	284.25	323.40
38612	424.90	318.70	369.30
38613	533.25	399.95	477.65
38615	1211.80	908.85	1156.20
38618	1510.50	1132.90	1454.90
38621	603.05	452.30	547.45
38624	677.65	508.25	622.05
38627	529.65	397.25	474.05
38637	438.60	328.95	383.00
38640	758.10	568.60	702.50
38643	844.25	633.20	788.65
38647	1688.45	1266.35	1632.85
38650	1510.50	1132.90	1454.90
38653	1510.50	1132.90	1454.90
38656	758.10	568.60	702.50
38670	1510.20	1132.65	1454.60
38673	1699.80	1274.85	1644.20
38677	1590.15	1192.65	1534.55
38680	1886.20	1414.65	1830.60
38700	844.25	633.20	788.65
38703	1521.95	1141.50	1466.35
38706	1441.50	1081.15	1385.90
38709	1688.45	1266.35	1632.85
38712	2027.40	1520.55	1971.80
38715	1349.65	1012.25	1294.05
38718	1688.45	1266.35	1632.85
38721	1183.10	887.35	1127.50
38724	1688.45	1266.35	1632.85
38727	1183.10	887.35	1127.50
38730	1688.45	1266.35	1632.85
38733	1183.10	887.35	1127.50
38736	1688.45	1266.35	1632.85
38739	1521.95	1141.50	1466.35
38742	1521.95	1141.50	1466.35
38745	1688.45	1266.35	1632.85
38748	1688.45	1266.35	1632.85
38751	1688.45	1266.35	1632.85
38754	2113.50	1585.15	2057.90
38757	1688.45	1266.35	1632.85
38760	1688.45	1266.35	1632.85
38763	1688.45	1266.35	1632.85
38766	1688.45	1266.35	1632.85
39000	59.55	44.70	50.65

39003	67.75	50.85	57.60
39006	126.10	94.60	107.20
39009	46.95	35.25	39.95
39012	187.95	141.00	159.80
39013	86.40	64.80	73.45
39015	297.40	223.05	252.80
39018	297.40	223.05	252.80
39100	187.95	141.00	159.80
39106	939.85	704.90	884.25
39109	350.95	263.25	298.35
39112	1219.40	914.55	1163.80
39115	59.55	44.70	50.65
39118	235.55	176.70	200.25
39121	499.70	374.80	444.10
39124	1278.90	959.20	1223.30
39125	235.75	176.85	200.40
39126	286.25	214.70	243.35
39127	374.70	281.05	319.10
39128	522.00	391.50	466.40
39130	482.75	362.10	427.15
39131	101.10	75.85	85.95
39133	126.10	94.60	107.20
39134	269.40	202.05	229.00
39136	126.10	94.60	107.20
39139	850.65	638.00	795.05
39140	231.65	173.75	196.95
39300	279.55	209.70	237.65
39303	368.70	276.55	313.40
39306	535.40	401.55	479.80
39309	565.00	423.75	509.40
39312	315.20	236.40	267.95
39315	814.85	611.15	759.25
39318	505.60	379.20	450.00
39321	374.70	281.05	319.10
39323	218.90	164.20	186.10
39324	218.90	164.20	186.10
39327	374.70	281.05	319.10
39330	218.90	164.20	186.10
39331	218.90	164.20	186.10
39333	315.20	236.40	267.95
39500	1005.30	754.00	949.70
39503	755.40	566.55	699.80
39600	374.70	281.05	319.10
39603	945.75	709.35	890.15
39606	630.50	472.90	574.90
39609	755.40	566.55	699.80
39612	886.35	664.80	830.75
39615	945.75	709.35	890.15
39640	2398.05	1798.55	2342.45
39642	2521.10	1890.85	2465.50
39646	2890.00	2167.50	2834.40
39650	2090.60	1567.95	2035.00
39653	3720.10	2790.10	3664.50
39654	2705.55	2029.20	2649.95
39656	2029.15	1521.90	1973.55
39658	2398.05	1798.55	2342.45
39660	2398.05	1798.55	2342.45
39662	2398.05	1798.55	2342.45
39700	440.30	330.25	384.70
39703	410.45	307.85	354.85
39706	880.25	660.20	824.65
39709	1255.05	941.30	1199.45
39712	2266.25	1699.70	2210.65
39715	1570.35	1177.80	1514.75
39718	690.00	517.50	634.40
39721	630.50	472.90	574.90
39800	2260.35	1695.30	2204.75
39803	2260.35	1695.30	2204.75
39806	1017.10	762.85	961.50
39812	499.70	374.80	444.10
39815	1445.35	1084.05	1389.75
39818	1445.35	1084.05	1389.75
39821	1716.30	1287.25	1660.70
39900	410.45	307.85	354.85
39903	1255.05	941.30	1199.45
39906	630.50	472.90	574.90
40000	725.70	544.30	670.10
40003	725.70	544.30	670.10
40006	571.00	428.25	515.40
40009	416.35	312.30	360.75
40012	814.85	611.15	759.25
40015	505.20	378.90	449.60
40018	126.10	94.60	107.20
40100	547.25	410.45	491.65
40103	803.00	602.25	747.40
40106	814.85	611.15	759.25
40109	880.25	660.20	824.65
40112	1130.15	847.65	1074.55
40115	571.00	428.25	515.40
40118	755.40	566.55	699.80
40300	755.40	566.55	699.80
40301	757.85	568.40	702.25
40303	862.45	646.85	806.85
40306	1136.15	852.15	1080.55
40309	862.45	646.85	806.85
40312	1159.85	869.90	1104.25
40315	1255.05	941.30	1199.45
40316	1645.00	1233.75	1589.40
40318	1570.35	1177.80	1514.75
40321	862.45	646.85	806.85
40324	505.60	379.20	450.00
40327	505.60	379.20	450.00
40330	755.40	566.55	699.80
40331	755.40	566.55	699.80
40332	1232.65	924.50	1177.05
40333	630.50	472.90	574.90
40334	833.55	625.20	777.95
40335	1530.95	1148.25	1475.35
40336	249.90	187.45	212.45
40339	1255.05	941.30	1199.45
40342	1159.85	869.90	1104.25
40345	1079.80	809.85	1024.20
40348	1370.85	1028.15	1315.25
40351	1370.85	1028.15	1315.25
40600	755.40	566.55	699.80
40700	1380.05	1035.05	1324.45
40703	1159.85	869.90	1104.25
40706	1695.20	1271.40	1639.60
40709	410.45	307.85	354.85
40712	826.75	620.10	771.15

40800	505.20	378.90	449.60
40801	1380.90	1035.70	1325.30
40803	945.75	709.35	890.15
40903	438.60	328.95	383.00
41500	65.25	48.95	55.50
41503	188.95	141.75	160.65
41506	113.95	85.50	96.90
41509	128.95	96.75	109.65
41512	463.45	347.60	407.85
41515	304.15	228.15	258.55
41518	734.65	551.00	679.05
41521	782.20	586.65	726.60
41524	225.95	169.50	192.10
41527	464.85	348.65	409.25
41530	757.20	567.90	701.60
41533	905.20	678.90	849.60
41536	1013.85	760.40	958.25
41539	862.15	646.65	806.55
41542	944.70	708.55	889.10
41545	412.30	309.25	356.70
41548	547.25	410.45	491.65
41551	1260.10	945.10	1204.50
41554	1484.65	1113.50	1429.05
41557	862.15	646.65	806.55
41560	944.70	708.55	889.10
41563	1169.45	877.10	1113.85
41564	1512.30	1134.25	1456.70
41566	862.15	646.65	806.55
41569	944.70	708.55	889.10
41572	817.15	612.90	761.55
41575	1926.70	1445.05	1871.10
41576	2890.00	2167.50	2834.40
41578	1926.70	1445.05	1871.10
41579	1444.95	1083.75	1389.35
41581	2216.00	1662.00	2160.40
41584	1520.80	1140.60	1465.20
41587	2071.20	1553.40	2015.60
41590	944.70	708.55	889.10
41593	1231.20	923.40	1175.60
41596	1376.00	1032.00	1320.40
41599	1376.00	1032.00	1320.40
41602	944.70	708.55	889.10
41605	464.85	348.65	409.25
41608	862.15	646.65	806.55
41611	554.70	416.05	499.10
41614	862.15	646.65	806.55
41615	862.15	646.65	806.55
41617	1499.10	1124.35	1443.50
41620	652.20	489.15	596.60
41623	944.70	708.55	889.10
41626	113.95	85.50	96.90
41629	412.30	309.25	356.70
41632	188.95	141.75	160.65
41635	905.20	678.90	849.60
41638	1129.80	847.35	1074.20
41641	37.55	28.20	31.95
41644	112.95	84.75	96.05
41647	86.95	65.25	73.95
41650	86.95	65.25	73.95
41653	56.95	42.75	48.45
41656	97.10	72.85	82.55
41659	61.40	46.05	52.20
41662	65.25	48.95	55.50
41665	136.45	102.35	116.00
41668	173.95	130.50	147.90
41671	382.25	286.70	326.65
41672	476.95	357.75	421.35
41674	79.45	59.60	67.55
41677	71.15	53.40	60.50
41680	128.95	96.75	109.65
41683	92.65	69.50	78.80
41686	56.95	42.75	48.45
41689	107.95	81.00	91.80
41692	140.85	105.65	119.75
41695	79.05	59.30	67.20
41698	25.70	19.30	21.85
41701	72.80	54.60	61.90
41704	28.75	21.60	24.45
41707	354.80	266.10	301.60
41710	412.30	309.25	356.70
41713	479.75	359.85	424.15
41716	233.90	175.45	198.85
41719	92.95	69.75	79.05
41722	464.85	348.65	409.25
41725	354.80	266.10	301.60
41728	709.75	532.35	654.15
41729	449.80	337.35	394.20
41731	614.75	461.10	559.15
41734	802.15	601.65	746.55
41737	382.25	286.70	326.65
41740	46.50	34.90	39.55
41743	266.90	200.20	226.90
41746	614.75	461.10	559.15
41749	479.75	359.85	424.15
41752	233.90	175.45	198.85
41755	36.80	27.60	31.30
41758	92.95	69.75	79.05
41761	97.10	72.85	82.55
41764	97.10	72.85	82.55
41767	582.95	437.25	527.35
41770	554.70	416.05	499.10
41773	464.85	348.65	409.25
41776	463.45	347.60	407.85
41779	554.70	416.05	499.10
41782	753.10	564.85	697.50
41785	934.30	700.75	878.70
41786	582.95	437.25	527.35
41787	449.80	337.35	394.20
41788	173.95	130.50	147.90
41789	233.90	175.45	198.85
41792	218.90	164.20	186.10
41793	293.85	220.40	249.80
41796	89.95	67.50	76.50
41797	113.95	85.50	96.90
41800	92.95	69.75	79.05
41801	128.95	96.75	109.65
41804	71.15	53.40	60.50
41807	55.50	41.65	47.20
41810	28.20	21.15	24.00
41813	281.90	211.45	239.65

41816	146.90	110.20	124.90
41819	276.05	207.05	234.65
41820	331.25	248.45	281.60
41822	188.95	141.75	160.65
41825	281.90	211.45	239.65
41828	41.30	31.00	35.15
41831	282.40	211.80	240.05
41832	180.70	135.55	153.60
41834	1019.60	764.70	964.00
41837	977.70	733.30	922.10
41840	1202.20	901.65	1146.60
41843	1057.10	792.85	1001.50
41846	146.90	110.20	124.90
41849	215.85	161.90	183.50
41852	233.90	175.45	198.85
41855	227.95	171.00	193.80
41858	390.95	293.25	335.35
41861	477.95	358.50	422.35
41864	322.40	241.80	274.05
41867	485.15	363.90	429.55
41868	307.45	230.60	261.35
41869	211.20	158.40	179.55
41870	359.80	269.85	305.85
41873	464.85	348.65	409.25
41876	464.85	348.65	409.25
41879	753.10	564.85	697.50
41880	201.00	150.75	170.85
41881	317.75	238.35	270.10
41884	72.00	54.00	61.20
41885	227.70	170.80	193.55
41886	140.85	105.65	119.75
41889	140.85	105.65	119.75
41892	185.95	139.50	158.10
41895	290.90	218.20	247.30
41898	203.25	152.45	172.80
41901	477.95	358.50	422.35
41904	194.95	146.25	165.75
41905	358.65	269.00	304.90
41907	97.10	72.85	82.55
41910	308.70	231.55	262.40
42503	81.00	60.75	68.85
42506	380.70	285.55	325.10
42509	481.75	361.35	426.15
42510	555.30	416.50	499.70
42512	380.70	285.55	325.10
42515	481.75	361.35	426.15
42518	279.55	209.70	237.65
42521	951.75	713.85	896.15
42524	161.85	121.40	137.60
42527	321.10	240.85	272.95
42530	499.70	374.80	444.10
42533	321.10	240.85	272.95
42536	660.25	495.20	604.65
42539	939.85	704.90	884.25
42542	398.60	298.95	343.00
42543	699.10	524.35	643.50
42545	1011.15	758.40	955.55
42548	600.75	450.60	545.15
42551	499.70	374.80	444.10
42554	582.95	437.25	527.35
42557	814.85	611.15	759.25
42560	321.10	240.85	272.95
42563	410.45	307.85	354.85
42566	582.95	437.25	527.35
42569	814.85	611.15	759.25
42572	92.75	69.60	78.85
42573	179.95	135.00	153.00
42574	382.25	286.70	326.65
42575	65.45	49.10	55.65
42578	368.70	276.55	313.40
42581	92.75	69.60	78.85
42584	218.90	164.20	186.10
42587	41.05	30.80	34.90
42590	267.60	200.70	227.50
42593	161.85	121.40	137.60
42596	398.60	298.95	343.00
42599	499.70	374.80	444.10
42602	499.70	374.80	444.10
42605	368.70	276.55	313.40
42608	237.90	178.45	202.25
42610	76.10	57.10	64.70
42611	114.20	85.65	97.10
42614	38.15	28.65	32.45
42615	57.10	42.85	48.55
42617	108.30	81.25	92.10
42620	41.70	31.30	35.45
42621	41.70	31.30	35.45
42622	65.45	49.10	55.65
42623	553.25	414.95	497.65
42626	892.25	669.20	836.65
42629	672.15	504.15	616.55
42632	92.75	69.60	78.85
42635	237.90	178.45	202.25
42638	297.40	223.05	252.80
42641	386.60	289.95	331.00
42644	57.05	42.80	48.50
42647	161.85	121.40	137.60
42650	57.05	42.80	48.50
42651	127.15	95.40	108.10
42653	1058.75	794.10	1003.15
42656	1320.50	990.40	1264.90
42659	713.75	535.35	658.15
42662	713.75	535.35	658.15
42665	475.85	356.90	420.25
42667	112.25	84.20	95.45
42668	59.55	44.70	50.65
42671	713.75	535.35	658.15
42674	356.90	267.70	303.40
42676	91.55	68.70	77.85
42677	48.20	36.15	41.00
42680	237.90	178.45	202.25
42683	95.15	71.40	80.90
42686	216.50	162.40	184.05
42689	92.75	69.60	78.85
42692	218.90	164.20	186.10
42695	356.90	267.70	303.40
42698	556.75	417.60	501.15
42701	310.45	232.85	263.90
42702	712.00	534.00	656.40
42703	452.50	339.40	396.90

42704	368.70	276.55	313.40
42707	630.50	472.90	574.90
42710	713.75	535.35	658.15
42713	297.40	223.05	252.80
42716	945.75	709.35	890.15
42719	410.45	307.85	354.85
42722	449.00	336.75	393.40
42725	1058.75	794.10	1003.15
42728	178.50	133.90	151.75
42731	1201.45	901.10	1145.85
42734	237.90	178.45	202.25
42737	237.90	178.45	202.25
42740	237.90	178.45	202.25
42743	499.70	374.80	444.10
42746	755.40	566.55	699.80
42749	945.75	709.35	890.15
42752	1058.75	794.10	1003.15
42755	130.90	98.20	111.30
42758	553.25	414.95	497.65
42761	410.45	307.85	354.85
42764	410.45	307.85	354.85
42767	862.45	646.85	806.85
42770	233.20	174.90	198.25
42771	229.55	172.20	195.15
42773	713.75	535.35	658.15
42776	1058.75	794.10	1003.15
42779	1320.50	990.40	1264.90
42782	356.90	267.70	303.40
42783	356.90	267.70	303.40
42785	279.55	209.70	237.65
42786	279.55	209.70	237.65
42788	279.55	209.70	237.65
42789	279.55	209.70	237.65
42791	279.55	209.70	237.65
42792	279.55	209.70	237.65
42794	53.50	40.15	45.50
42797	53.50	40.15	45.50
42806	279.55	209.70	237.65
42807	281.45	211.10	239.25
42808	281.45	211.10	239.25
42809	356.90	267.70	303.40
42810	449.05	336.80	393.45
42812	130.90	98.20	111.30
42815	499.70	374.80	444.10
42818	463.85	347.90	408.25
42821	71.35	53.55	60.65
42824	55.30	41.50	47.05
42827	35.65	26.75	30.35
42830	123.75	92.85	105.20
42833	463.85	347.90	408.25
42836	576.95	432.75	521.35
42839	553.25	414.95	497.65
42842	690.00	517.50	634.40
42845	149.80	112.35	127.35
42848	553.25	414.95	497.65
42851	690.00	517.50	634.40
42854	321.10	240.85	272.95
42857	321.10	240.85	272.95
42860	713.75	535.35	658.15
42863	612.65	459.50	557.05
42866	594.80	446.10	539.20
42869	434.25	325.70	378.65
42872	190.35	142.80	161.80
43500	97.60	73.20	83.00
43503	161.95	121.50	137.70
43506	281.90	211.45	239.65
43509	281.90	211.45	239.65
43512	281.90	211.45	239.65
43515	281.90	211.45	239.65
43518	464.85	348.65	409.25
43521	367.40	275.55	312.30
43524	464.85	348.65	409.25
43801	757.20	567.90	701.60
43804	806.25	604.70	750.65
43807	879.60	659.70	824.00
43810	1026.25	769.70	970.65
43813	1026.25	769.70	970.65
43816	952.90	714.70	897.30
43819	769.65	577.25	714.05
43822	769.65	577.25	714.05
43825	879.60	659.70	824.00
43828	971.75	728.85	916.15
43831	757.20	567.90	701.60
43834	879.60	659.70	824.00
43837	1099.45	824.60	1043.85
43840	952.90	714.70	897.30
43843	1465.95	1099.50	1410.35
43846	1575.85	1181.90	1520.25
43849	403.10	302.35	347.50
43852	1282.70	962.05	1227.10
43855	1356.05	1017.05	1300.45
43858	476.40	357.30	420.80
43861	1319.40	989.55	1263.80
43864	989.50	742.15	933.90
43867	549.75	412.35	494.15
43870	769.65	577.25	714.05
43873	1026.25	769.70	970.65
43876	879.60	659.70	824.00
43879	1026.25	769.70	970.65
43882	1319.40	989.55	1263.80
43900	879.60	659.70	824.00
43903	1465.95	1099.50	1410.35
43906	1282.70	962.05	1227.10
43909	1282.70	962.05	1227.10
43912	1211.80	908.85	1156.20
43915	916.25	687.20	860.65
43930	352.35	264.30	299.50
43933	412.40	309.30	356.80
43936	769.65	577.25	714.05
43939	586.40	439.80	530.80
43942	183.30	137.50	155.85
43945	769.65	577.25	714.05
43948	110.00	82.50	93.50
43951	689.20	516.90	633.60
43954	843.00	632.25	787.40
43957	916.25	687.20	860.65
43960	322.40	241.80	274.05
43963	1282.70	962.05	1227.10
43966	1465.95	1099.50	1410.35
43969	2015.75	1511.85	1960.15

43972	1465.95	1099.50	1410.35
43975	1722.55	1291.95	1666.95
43978	1465.95	1099.50	1410.35
43981	403.10	302.35	347.50
43984	1026.25	769.70	970.65
43987	1136.20	852.15	1080.60
43990	1392.70	1044.55	1337.10
43993	1502.65	1127.00	1447.05
43996	1685.90	1264.45	1630.30
43999	210.85	158.15	179.25
44102	203.25	152.45	172.80
44105	35.70	26.80	30.35
44108	388.75	291.60	333.15
44111	455.30	341.50	399.70
44114	455.30	341.50	399.70
44130	366.50	274.90	311.55
44133	290.90	218.20	247.30
44136	134.05	100.55	113.95
44325	233.90	175.45	198.85
44328	281.90	211.45	239.65
44331	464.85	348.65	409.25
44334	944.70	708.55	889.10
44338	113.95	85.50	96.90
44342	173.95	130.50	147.90
44346	200.90	150.70	170.80
44350	227.95	171.00	193.80
44354	260.90	195.70	221.80
44358	145.45	109.10	123.65
44359	208.75	156.60	177.45
44361	281.90	211.45	239.65
44364	233.90	175.45	198.85
44367	412.80	309.60	357.20
44370	569.70	427.30	514.10
44373	1169.45	877.10	1113.85
45000	428.25	321.20	372.65
45003	475.85	356.90	420.25
45006	820.85	615.65	765.25
45009	299.85	224.90	254.90
45012	502.25	376.70	446.65
45015	237.90	178.45	202.25
45018	374.70	281.05	319.10
45019	313.75	235.35	266.70
45020	313.75	235.35	266.70
45021	140.35	105.30	119.30
45024	315.20	236.40	267.95
45025	140.35	105.30	119.30
45026	315.20	236.40	267.95
45027	95.15	71.40	80.90
45030	102.25	76.70	86.95
45033	190.35	142.80	161.80
45035	555.30	416.50	499.70
45036	892.25	669.20	836.65
45039	190.35	142.80	161.80
45042	243.90	182.95	207.35
45045	243.90	182.95	207.35
45048	612.65	459.50	557.05
45051	374.80	281.10	319.20
45054	194.60	145.95	165.45
45200	224.95	168.75	191.25
45203	321.10	240.85	272.95
45206	303.40	227.55	257.90
45209	374.80	281.10	319.20
45212	185.95	139.50	158.10
45215	802.15	601.65	746.55
45218	359.80	269.85	305.85
45221	206.85	155.15	175.85
45224	92.95	69.75	79.05
45227	352.35	264.30	299.50
45230	176.10	132.10	149.70
45233	374.80	281.10	319.20
45236	293.85	220.40	249.80
45239	206.85	155.15	175.85
45400	161.95	121.50	137.70
45403	322.40	241.80	274.05
45406	356.90	267.70	303.40
45409	475.85	356.90	420.25
45412	654.35	490.80	598.75
45415	713.75	535.35	658.15
45418	773.25	579.95	717.65
45439	224.95	168.75	191.25
45442	463.85	347.90	408.25
45445	440.30	330.25	384.70
45448	297.40	223.05	252.80
45451	374.80	281.10	319.20
45460	991.40	743.55	935.80
45461	706.55	529.95	650.95
45462	533.25	399.95	477.65
45464	1513.25	1134.95	1457.65
45465	1078.10	808.60	1022.50
45466	813.00	609.75	757.40
45468	1449.60	1087.20	1394.00
45469	1093.65	820.25	1038.05
45471	1822.15	1366.65	1766.55
45472	1374.45	1030.85	1318.85
45474	2193.70	1645.30	2138.10
45475	1655.15	1241.40	1599.55
45477	2565.20	1923.90	2509.60
45478	1934.85	1451.15	1879.25
45480	2936.70	2202.55	2881.10
45481	2215.60	1661.70	2160.00
45483	3345.85	2509.40	3290.25
45484	2524.50	1893.40	2468.90
45485	417.40	313.05	361.80
45486	356.90	267.70	303.40
45487	321.10	240.85	272.95
45488	356.90	267.70	303.40
45489	535.40	401.55	479.80
45490	713.85	535.40	658.25
45491	892.25	669.20	836.65
45492	1070.75	803.10	1015.15
45493	321.10	240.85	272.95
45494	1296.20	972.15	1240.60
45496	329.05	246.80	279.70
45497	257.05	192.80	218.50
45498	206.85	155.15	175.85
45499	154.25	115.70	131.15
45500	862.45	646.85	806.85
45501	1403.85	1052.90	1348.25
45502	1403.85	1052.90	1348.25
45503	1606.05	1204.55	1550.45

45504	1403.85	1052.90	1348.25
45505	1403.85	1052.90	1348.25
45506	173.95	130.50	147.90
45512	233.90	175.45	198.85
45515	147.50	110.65	125.40
45518	178.50	133.90	151.75
45519	339.35	254.55	288.45
45520	712.25	534.20	656.65
45522	499.70	374.80	444.10
45524	586.65	440.00	531.05
45527	586.65	440.00	531.05
45528	879.90	659.95	824.30
45530	869.60	652.20	814.00
45533	984.85	738.65	929.25
45536	362.15	271.65	307.85
45539	847.35	635.55	791.75
45542	485.15	363.90	429.55
45545	492.45	369.35	436.85
45546	156.55	117.45	133.10
45548	218.90	164.20	186.10
45551	350.95	263.25	298.35
45552	505.20	378.90	449.60
45554	553.25	414.95	497.65
45555	505.20	378.90	449.60
45556	605.90	454.45	550.30
45557	605.90	454.45	550.30
45558	908.85	681.65	853.25
45560	374.70	281.05	319.10
45562	869.60	652.20	814.00
45563	869.60	652.20	814.00
45564	2014.10	1510.60	1958.50
45565	1510.65	1133.00	1455.05
45566	847.35	635.55	791.75
45572	230.80	173.10	196.20
45575	569.70	427.30	514.10
45578	659.80	494.85	604.20
45581	218.90	164.20	186.10
45584	499.70	374.80	444.10
45585	499.70	374.80	444.10
45587	704.70	528.55	649.10
45588	1057.05	792.80	1001.45
45590	382.25	286.70	326.65
45593	449.00	336.75	393.40
45596	712.25	534.20	656.65
45597	953.40	715.05	897.80
45599	740.85	555.65	685.25
45602	553.25	414.95	497.65
45605	464.85	348.65	409.25
45608	654.35	490.80	598.75
45611	374.80	281.10	319.20
45614	464.85	348.65	409.25
45617	185.95	139.50	158.10
45620	257.85	193.40	219.20
45623	572.00	429.00	516.40
45624	741.50	556.15	685.90
45625	148.35	111.30	126.10
45626	257.85	193.40	219.20
45629	374.80	281.10	319.20
45632	404.90	303.70	349.30
45635	464.85	348.65	409.25
45638	802.15	601.65	746.55
45639	802.15	601.65	746.55
45641	856.55	642.45	800.95
45644	1012.05	759.05	956.45
45645	176.90	132.70	150.40
45646	712.25	534.20	656.65
45647	1012.05	759.05	956.45
45650	116.95	87.75	99.45
45652	281.90	211.45	239.65
45653	281.90	211.45	239.65
45656	397.30	298.00	341.70
45659	412.30	309.25	356.70
45660	2277.10	1707.85	2221.50
45661	1012.05	759.05	956.45
45662	554.70	416.05	499.10
45665	257.85	193.40	219.20
45668	257.85	193.40	219.20
45669	257.85	193.40	219.20
45671	659.80	494.85	604.20
45674	191.90	143.95	163.15
45675	382.25	286.70	326.65
45676	455.05	341.30	399.45
45677	428.25	321.20	372.65
45680	535.40	401.55	479.80
45683	594.80	446.10	539.20
45686	701.95	526.50	646.35
45689	207.00	155.25	175.95
45692	237.90	178.45	202.25
45695	386.60	289.95	331.00
45698	362.85	272.15	308.45
45701	654.35	490.80	598.75
45704	237.90	178.45	202.25
45707	618.55	463.95	562.95
45710	386.60	289.95	331.00
45713	440.30	330.25	384.70
45714	618.55	463.95	562.95
45716	618.55	463.95	562.95
45720	764.75	573.60	709.15
45723	862.45	646.85	806.85
45726	974.60	730.95	919.00
45729	1094.45	820.85	1038.85
45731	1109.50	832.15	1053.90
45732	1249.15	936.90	1193.55
45735	1274.35	955.80	1218.75
45738	1433.55	1075.20	1377.95
45741	1401.90	1051.45	1346.30
45744	1576.20	1182.15	1520.60
45747	1529.40	1147.05	1473.80
45752	1713.10	1284.85	1657.50
45753	1723.35	1292.55	1667.75
45754	2065.75	1549.35	2010.15
45755	290.90	218.20	247.30
45758	520.55	390.45	464.95
45761	592.20	444.15	536.60
45767	1986.70	1490.05	1931.10
45770	1521.80	1141.35	1466.20
45773	1386.95	1040.25	1331.35
45776	1386.95	1040.25	1331.35
45779	1019.60	764.70	964.00
45782	779.70	584.80	724.10

45785	1319.45	989.60	1263.85
45788	1304.40	978.30	1248.80
45791	704.70	528.55	649.10
45794	398.60	298.95	343.00
45797	147.50	110.65	125.40
46300	267.65	200.75	227.55
46303	297.50	223.15	252.90
46306	416.45	312.35	360.85
46307	416.45	312.35	360.85
46309	416.45	312.35	360.85
46312	535.50	401.65	479.90
46315	713.90	535.45	658.30
46318	892.45	669.35	836.85
46321	1070.95	803.25	1015.35
46324	638.65	479.00	583.05
46325	666.40	499.80	610.80
46327	160.75	120.60	136.65
46330	273.75	205.35	232.70
46333	446.20	334.65	390.60
46336	208.30	156.25	177.10
46339	368.80	276.60	313.50
46342	368.80	276.60	313.50
46345	446.20	334.65	390.60
46348	193.35	145.05	164.35
46351	288.55	216.45	245.30
46354	386.70	290.05	331.10
46357	481.90	361.45	426.30
46360	580.05	435.05	524.45
46363	166.60	124.95	141.65
46366	101.15	75.90	86.00
46369	166.60	124.95	141.65
46372	338.50	253.90	287.75
46375	401.60	301.20	346.00
46378	535.50	401.65	479.90
46381	237.95	178.50	202.30
46384	237.95	178.50	202.30
46387	490.85	368.15	435.25
46390	654.50	490.90	598.90
46393	758.55	568.95	702.95
46396	260.70	195.55	221.60
46399	409.60	307.20	354.00
46402	409.60	307.20	354.00
46405	499.80	374.85	444.20
46408	547.35	410.55	491.75
46411	321.20	240.90	273.05
46414	416.35	312.30	360.75
46417	386.70	290.05	331.10
46420	161.85	121.40	137.60
46423	258.80	194.10	220.00
46426	267.65	200.75	227.55
46429	327.20	245.40	278.15
46432	357.00	267.75	303.45
46435	416.45	312.35	360.85
46438	107.10	80.35	91.05
46441	258.80	194.10	220.00
46442	222.15	166.65	188.85
46444	386.70	290.05	331.10
46447	481.90	361.45	426.30
46450	178.50	133.90	151.75
46453	297.50	223.15	252.90
46456	77.30	58.00	65.75
46459	148.80	111.60	126.50
46462	237.95	178.50	202.30
46464	178.50	133.90	151.75
46465	178.50	133.90	151.75
46468	312.35	234.30	265.50
46471	446.20	334.65	390.60
46474	580.05	435.05	524.45
46477	713.90	535.45	658.30
46480	297.50	223.15	252.90
46483	237.95	178.50	202.30
46486	178.50	133.90	151.75
46489	208.30	156.25	177.10
46492	285.60	214.20	242.80
46494	173.95	130.50	147.90
46495	160.75	120.60	136.65
46498	173.95	130.50	147.90
46500	208.30	156.25	177.10
46501	260.35	195.30	221.30
46502	239.55	179.70	203.65
46503	299.30	224.50	254.45
46504	874.55	655.95	818.95
46507	1017.30	763.00	961.70
46510	277.65	208.25	236.05
46513	44.70	33.55	38.00
46516	89.30	67.00	75.95
46519	111.75	83.85	95.00
46522	333.15	249.90	283.20
46525	44.70	33.55	38.00
46528	134.05	100.55	113.95
46531	67.30	50.50	57.25
46534	186.25	139.70	158.35
47000	55.90	41.95	47.55
47003	67.00	50.25	56.95
47006	134.70	101.05	114.50
47009	134.05	100.55	113.95
47012	268.10	201.10	227.90
47015	67.00	50.25	56.95
47018	156.30	117.25	132.90
47021	208.55	156.45	177.30
47024	156.30	117.25	132.90
47027	208.55	156.45	177.30
47030	156.30	117.25	132.90
47033	208.55	156.45	177.30
47036	67.00	50.25	56.95
47039	89.30	67.00	75.95
47042	89.30	67.00	75.95
47045	119.20	89.40	101.35
47048	256.95	192.75	218.45
47051	342.50	256.90	291.15
47054	256.95	192.75	218.45
47057	100.50	75.40	85.45
47060	134.05	100.55	113.95
47063	201.05	150.80	170.90
47066	268.10	201.10	227.90
47069	55.90	41.95	47.55
47072	74.35	55.80	63.20
47300	67.00	50.25	56.95
47303	78.20	58.65	66.50
47306	89.30	67.00	75.95

47309	111.75	83.85	95.00
47312	100.50	75.40	85.45
47315	115.40	86.55	98.10
47318	134.05	100.55	113.95
47321	167.50	125.65	142.40
47324	134.05	100.55	113.95
47327	156.30	117.25	132.90
47330	178.75	134.10	151.95
47333	223.30	167.50	189.85
47336	134.05	100.55	113.95
47339	156.30	117.25	132.90
47342	178.75	134.10	151.95
47345	223.30	167.50	189.85
47348	74.35	55.80	63.20
47351	186.25	139.70	158.35
47354	134.05	100.55	113.95
47357	297.90	223.45	253.25
47360	104.30	78.25	88.70
47363	156.30	117.25	132.90
47366	208.55	156.45	177.30
47369	134.05	100.55	113.95
47372	223.30	167.50	189.85
47375	297.90	223.45	253.25
47378	134.05	100.55	113.95
47381	201.05	150.80	170.90
47384	268.10	201.10	227.90
47385	230.85	173.15	196.25
47386	372.30	279.25	316.70
47387	215.90	161.95	183.55
47390	323.95	243.00	275.40
47393	431.90	323.95	376.30
47396	148.95	111.75	126.65
47399	297.90	223.45	253.25
47402	223.30	167.50	189.85
47405	148.95	111.75	126.65
47408	297.90	223.45	253.25
47411	89.30	67.00	75.95
47414	178.75	134.10	151.95
47417	208.55	156.45	177.30
47420	409.60	307.20	354.00
47423	171.20	128.40	145.55
47426	256.95	192.75	218.45
47429	342.50	256.90	291.15
47432	428.20	321.15	372.60
47435	327.65	245.75	278.55
47438	521.35	391.05	465.75
47441	651.60	488.70	596.00
47444	178.75	134.10	151.95
47447	268.10	201.10	227.90
47450	357.45	268.10	303.85
47451	430.95	323.25	375.35
47453	208.55	156.45	177.30
47456	312.90	234.70	266.00
47459	417.00	312.75	361.40
47462	89.30	67.00	75.95
47465	178.75	134.10	151.95
47466	89.30	67.00	75.95
47467	178.75	134.10	151.95
47468	342.50	256.90	291.15
47471	33.95	25.50	28.90
47474	148.95	111.75	126.65
47477	186.25	139.70	158.35
47480	372.30	279.25	316.70
47483	446.80	335.10	391.20
47486	744.70	558.55	689.10
47489	1117.05	837.80	1061.45
47492	186.25	139.70	158.35
47495	372.30	279.25	316.70
47498	558.50	418.90	502.90
47501	744.70	558.55	689.10
47504	1117.05	837.80	1061.45
47507	1117.05	837.80	1061.45
47510	1117.05	837.80	1061.45
47513	297.90	223.45	253.25
47516	342.50	256.90	291.15
47519	685.15	513.90	629.55
47522	595.80	446.85	540.20
47525	685.15	513.90	629.55
47528	595.80	446.85	540.20
47531	759.55	569.70	703.95
47534	856.40	642.30	800.80
47537	342.50	256.90	291.15
47540	171.20	128.40	145.55
47543	178.75	134.10	151.95
47546	268.10	201.10	227.90
47549	357.45	268.10	303.85
47552	297.90	223.45	253.25
47555	446.80	335.10	391.20
47558	595.80	446.85	540.20
47561	215.90	161.95	183.55
47564	323.95	243.00	275.40
47565	563.45	422.60	507.85
47566	718.30	538.75	662.70
47567	376.00	282.00	320.40
47570	431.90	323.95	376.30
47573	539.85	404.90	484.25
47576	89.30	67.00	75.95
47579	126.65	95.00	107.70
47582	260.70	195.55	221.60
47585	335.15	251.40	284.90
47588	1042.50	781.90	986.90
47591	1266.10	949.60	1210.50
47594	171.20	128.40	145.55
47597	256.95	192.75	218.45
47600	342.50	256.90	291.15
47603	446.80	335.10	391.20
47606	186.25	139.70	158.35
47609	279.25	209.45	237.40
47612	323.95	243.00	275.40
47615	372.30	279.25	316.70
47618	465.50	349.15	409.90
47621	323.95	243.00	275.40
47624	446.80	335.10	391.20
47627	126.65	95.00	107.70
47630	268.10	201.10	227.90
47633	89.30	67.00	75.95
47636	134.05	100.55	113.95
47639	178.75	134.10	151.95
47642	119.20	89.40	101.35
47645	178.75	134.10	151.95

47648	238.20	178.65	202.50
47651	186.25	139.70	158.35
47654	279.25	209.45	237.40
47657	372.30	279.25	316.70
47663	111.75	83.85	95.00
47666	186.25	139.70	158.35
47672	89.30	67.00	75.95
47678	134.05	100.55	113.95
47681	33.95	25.50	28.90
47684	595.80	446.85	540.20
47687	1042.50	781.90	986.90
47690	819.15	614.40	763.55
47693	1042.50	781.90	986.90
47696	297.90	223.45	253.25
47699	1191.50	893.65	1135.90
47702	1489.45	1117.10	1433.85
47703	33.95	25.50	28.90
47705	223.30	167.50	189.85
47708	171.20	128.40	145.55
47711	253.25	189.95	215.30
47714	189.90	142.45	161.45
47717	335.15	251.40	284.90
47720	335.15	251.40	284.90
47723	335.15	251.40	284.90
47726	111.75	83.85	95.00
47729	186.25	139.70	158.35
47732	297.90	223.45	253.25
47735	33.95	25.50	28.90
47738	186.25	139.70	158.35
47741	379.90	284.95	324.30
47753	321.65	241.25	273.45
47756	321.65	241.25	273.45
47762	188.95	141.75	160.65
47765	310.15	232.65	263.65
47768	379.90	284.95	324.30
47771	436.45	327.35	380.85
47774	344.65	258.50	293.00
47777	344.65	258.50	293.00
47780	447.95	336.00	392.35
47783	447.95	336.00	392.35
47786	568.55	426.45	512.95
47789	568.55	426.45	512.95
47900	134.05	100.55	113.95
47903	186.25	139.70	158.35
47904	44.70	33.55	38.00
47906	89.30	67.00	75.95
47912	44.70	33.55	38.00
47915	134.05	100.55	113.95
47916	67.30	50.50	57.25
47918	186.25	139.70	158.35
47920	301.20	225.90	256.05
47921	89.30	67.00	75.95
47924	29.75	22.35	25.30
47927	111.75	83.85	95.00
47930	208.55	156.45	177.30
47933	163.80	122.85	139.25
47936	201.05	150.80	170.90
47948	126.65	95.00	107.70
47951	148.95	111.75	126.65
47954	297.90	223.45	253.25
47957	223.30	167.50	189.85
47960	104.30	78.25	88.70
47963	171.20	128.40	145.55
47966	342.50	256.90	291.15
47969	208.55	156.45	177.30
47972	166.60	124.95	141.65
47975	291.95	219.00	248.20
47978	177.35	133.05	150.75
47981	119.00	89.25	101.15
47982	288.65	216.50	245.40
48200	595.80	446.85	540.20
48203	722.40	541.80	666.80
48206	447.25	335.45	391.65
48209	573.40	430.05	517.80
48212	447.25	335.45	391.65
48215	573.40	430.05	517.80
48218	447.25	335.45	391.65
48221	595.80	446.85	540.20
48224	297.90	223.45	253.25
48227	387.25	290.45	331.65
48230	335.15	251.40	284.90
48233	484.05	363.05	428.45
48236	633.00	474.75	577.40
48239	350.00	262.50	297.50
48242	484.05	363.05	428.45
48400	260.70	195.55	221.60
48403	409.60	307.20	354.00
48406	260.70	195.55	221.60
48409	409.60	307.20	354.00
48412	498.85	374.15	443.25
48415	633.00	474.75	577.40
48418	498.85	374.15	443.25
48421	633.00	474.75	577.40
48424	595.80	446.85	540.20
48427	722.40	541.80	666.80
48500	260.70	195.55	221.60
48503	260.70	195.55	221.60
48506	387.25	290.45	331.65
48509	186.25	139.70	158.35
48512	707.40	530.55	651.80
48600	74.35	55.80	63.20
48603	111.75	83.85	95.00
48606	1042.50	781.90	986.90
48609	1303.20	977.40	1247.60
48612	1936.25	1452.20	1880.65
48613	2754.10	2065.60	2698.50
48615	350.00	262.50	297.50
48618	1936.25	1452.20	1880.65
48621	1266.10	949.60	1210.50
48624	1563.95	1173.00	1508.35
48627	2010.65	1508.00	1955.05
48630	2234.05	1675.55	2178.45
48632	1234.95	926.25	1179.35
48636	640.35	480.30	584.75
48639	1079.80	809.85	1024.20
48640	2754.10	2065.60	2698.50
48642	633.00	474.75	577.40
48645	856.40	642.30	800.80
48648	856.40	642.30	800.80
48651	1191.50	893.65	1135.90

48654	856.40	642.30	800.80
48657	1191.50	893.65	1135.90
48660	856.40	642.30	800.80
48663	640.35	480.30	584.75
48666	387.25	290.45	331.65
48669	1154.30	865.75	1098.70
48672	863.95	648.00	808.35
48675	521.35	391.05	465.75
48678	447.25	335.45	391.65
48681	744.70	558.55	689.10
48684	744.70	558.55	689.10
48687	1042.50	781.90	986.90
48690	1191.50	893.65	1135.90
48900	223.30	167.50	189.85
48903	446.80	335.10	391.20
48906	446.80	335.10	391.20
48909	595.80	446.85	540.20
48912	260.70	195.55	221.60
48915	595.80	446.85	540.20
48918	1191.50	893.65	1135.90
48921	1228.75	921.60	1173.15
48924	1415.00	1061.25	1359.40
48927	290.35	217.80	246.80
48930	595.80	446.85	540.20
48933	781.95	586.50	726.35
48936	595.80	446.85	540.20
48939	856.40	642.30	800.80
48942	1117.05	837.80	1061.45
48945	215.90	161.95	183.55
48948	484.05	363.05	428.45
48951	707.40	530.55	651.80
48954	744.70	558.55	689.10
48957	856.40	642.30	800.80
48960	744.70	558.55	689.10
49100	260.70	195.55	221.60
49103	558.50	418.90	502.90
49106	744.70	558.55	689.10
49109	558.50	418.90	502.90
49112	558.50	418.90	502.90
49115	893.60	670.20	838.00
49118	215.90	161.95	183.55
49121	484.05	363.05	428.45
49200	647.80	485.85	592.20
49203	484.05	363.05	428.45
49206	446.80	335.10	391.20
49209	595.80	446.85	540.20
49212	186.25	139.70	158.35
49215	513.90	385.45	458.30
49218	215.90	161.95	183.55
49221	484.05	363.05	428.45
49224	558.50	418.90	502.90
49227	558.50	418.90	502.90
49300	412.30	309.25	356.70
49303	431.90	323.95	376.30
49306	856.40	642.30	800.80
49309	595.80	446.85	540.20
49312	744.70	558.55	689.10
49315	670.25	502.70	614.65
49318	1042.50	781.90	986.90
49319	1831.35	1373.55	1775.75
49321	1266.10	949.60	1210.50
49324	1489.45	1117.10	1433.85
49327	1712.80	1284.60	1657.20
49330	1712.80	1284.60	1657.20
49333	1936.25	1452.20	1880.65
49336	282.95	212.25	240.55
49339	2196.80	1647.60	2141.20
49342	2196.80	1647.60	2141.20
49345	2606.45	1954.85	2550.85
49346	670.25	502.70	614.65
49360	272.10	204.10	231.30
49363	327.60	245.70	278.50
49366	484.05	363.05	428.45
49500	297.90	223.45	253.25
49503	387.25	290.45	331.65
49506	580.90	435.70	525.30
49509	595.80	446.85	540.20
49512	856.40	642.30	800.80
49515	670.25	502.70	614.65
49517	954.25	715.70	898.65
49518	1042.50	781.90	986.90
49519	1831.35	1373.55	1775.75
49521	1266.10	949.60	1210.50
49524	1489.45	1117.10	1433.85
49527	1266.10	949.60	1210.50
49530	1563.95	1173.00	1508.35
49533	1787.30	1340.50	1731.70
49534	355.50	266.65	302.20
49536	744.70	558.55	689.10
49539	744.70	558.55	689.10
49542	1042.50	781.90	986.90
49545	595.80	446.85	540.20
49548	744.70	558.55	689.10
49551	1042.50	781.90	986.90
49554	1489.45	1117.10	1433.85
49557	215.90	161.95	183.55
49558	215.90	161.95	183.55
49559	323.20	242.40	274.75
49560	436.30	327.25	380.70
49561	533.20	399.90	477.60
49562	581.75	436.35	526.15
49563	630.15	472.65	574.55
49564	726.90	545.20	671.30
49566	595.80	446.85	540.20
49569	595.80	446.85	540.20
49700	215.90	161.95	183.55
49703	484.05	363.05	428.45
49706	260.70	195.55	221.60
49709	558.50	418.90	502.90
49712	595.80	446.85	540.20
49715	893.60	670.20	838.00
49718	297.90	223.45	253.25
49721	186.25	139.70	158.35
49724	521.35	391.05	465.75
49727	223.30	167.50	189.85
49800	104.30	78.25	88.70
49803	134.05	100.55	113.95
49806	104.30	78.25	88.70
49809	171.20	128.40	145.55
49812	342.50	256.90	291.15

49815	595.80	446.85	540.20
49818	215.90	161.95	183.55
49821	342.50	256.90	291.15
49824	599.50	449.65	543.90
49827	372.30	279.25	316.70
49830	651.60	488.70	596.00
49833	409.60	307.20	354.00
49836	707.40	530.55	651.80
49837	512.00	384.00	456.40
49838	884.20	663.15	828.60
49839	409.60	307.20	354.00
49842	707.40	530.55	651.80
49845	372.30	279.25	316.70
49848	126.65	95.00	107.70
49851	163.80	122.85	139.25
49854	297.90	223.45	253.25
49857	275.50	206.65	234.20
49860	223.30	167.50	189.85
49863	335.15	251.40	284.90
49866	238.20	178.65	202.50
49878	44.70	33.55	38.00
50100	215.90	161.95	183.55
50102	484.05	363.05	428.45
50103	260.70	195.55	221.60
50104	247.00	185.25	209.95
50106	372.30	279.25	316.70
50109	372.30	279.25	316.70
50112	285.60	214.20	242.80
50115	111.75	83.85	95.00
50118	342.50	256.90	291.15
50121	670.25	502.70	614.65
50124	23.40	17.55	19.90
50125	23.40	17.55	19.90
50127	555.70	416.80	500.10
50130	247.00	185.25	209.95
50200	148.95	111.75	126.65
50203	327.65	245.75	278.55
50206	484.05	363.05	428.45
50209	595.80	446.85	540.20
50212	1303.20	977.40	1247.60
50215	1638.35	1228.80	1582.75
50218	2159.65	1619.75	2104.05
50221	2010.65	1508.00	1955.05
50224	2234.05	1675.55	2178.45
50227	2606.45	1954.85	2550.85
50230	1340.45	1005.35	1284.85
50233	1712.80	1284.60	1657.20
50236	1340.45	1005.35	1284.85
50239	893.60	670.20	838.00
50300	915.70	686.80	860.10
50303	1250.20	937.65	1194.60
50306	1952.10	1464.10	1896.50
50309	241.20	180.90	205.05
50312	553.80	415.35	498.20
50315	548.35	411.30	492.75
50318	548.35	411.30	492.75
50321	734.75	551.10	679.15
50324	1047.35	785.55	991.75
50327	1277.55	958.20	1221.95
50330	180.90	135.70	153.80
50333	488.00	366.00	432.40
50336	729.30	547.00	673.70
50339	444.20	333.15	388.60
50342	515.40	386.55	459.80
50345	274.20	205.65	233.10
50348	180.90	135.70	153.80
50349	126.65	95.00	107.70
50350	670.25	502.70	614.65
50351	789.60	592.20	734.00
50352	44.70	33.55	38.00
50353	280.65	210.50	238.60
50354	1036.35	777.30	980.75
50357	444.20	333.15	388.60
50360	515.40	386.55	459.80
50363	394.85	296.15	339.25
50366	690.95	518.25	635.35
50369	515.40	386.55	459.80
50372	904.75	678.60	849.15
50375	394.85	296.15	339.25
50378	690.95	518.25	635.35
50381	515.40	386.55	459.80
50384	904.75	678.60	849.15
50387	515.40	386.55	459.80
50390	180.90	135.70	153.80
50393	668.95	501.75	613.35
50394	2196.80	1647.60	2141.20
50396	367.45	275.60	312.35
50399	729.30	547.00	673.70
50402	334.50	250.90	284.35
50405	455.10	341.35	399.50
50408	789.60	592.20	734.00
50411	1036.35	777.30	980.75
50414	1398.20	1048.65	1342.60
50417	1036.35	777.30	980.75
50420	855.40	641.55	799.80
50423	789.60	592.20	734.00
50426	367.45	275.60	312.35
51300	68.30	51.25	58.10
51306	98.65	74.00	83.90
51315	215.45	161.60	183.15
51318	142.20	106.65	120.90
51700	67.65	50.75	57.55
51703	33.95	25.50	28.90
51800	68.30	51.25	58.10
51900	257.85	193.40	219.20
51902	58.45	43.85	49.70
51904	359.80	269.85	305.85
51906	547.25	410.45	491.65
52000	65.25	48.95	55.50
52003	92.95	69.75	79.05
52006	92.95	69.75	79.05
52009	146.90	110.20	124.90
52010	200.90	150.70	170.80
52012	18.55	13.95	15.80
52015	86.95	65.25	73.95
52018	218.90	164.20	186.10
52021	23.30	17.50	19.85
52024	41.30	31.00	35.15
52025	145.45	109.10	123.65
52027	118.45	88.85	100.70

52030	71.15	53.40	60.50
52033	145.45	109.10	123.65
52034	33.95	25.50	28.90
52035	376.60	282.45	321.00
52036	100.45	75.35	85.40
52039	257.85	193.40	219.20
52042	136.45	102.35	116.00
52045	194.95	146.25	165.75
52048	293.85	220.40	249.80
52051	397.30	298.00	341.70
52054	464.85	348.65	409.25
52055	21.60	16.20	18.40
52056	21.60	16.20	18.40
52057	128.95	96.75	109.65
52058	187.95	141.00	159.80
52059	211.70	158.80	179.95
52060	149.80	112.35	127.35
52061	176.90	132.70	150.40
52062	233.90	175.45	198.85
52063	281.90	211.45	239.65
52064	134.05	100.55	113.95
52066	352.35	264.30	299.50
52069	157.05	117.80	133.50
52072	46.50	34.90	39.55
52073	118.45	88.85	100.70
52075	118.45	88.85	100.70
52078	233.90	175.45	198.85
52081	36.80	27.60	31.30
52084	94.50	70.90	80.35
52087	161.95	121.50	137.70
52090	281.90	211.45	239.65
52092	367.40	275.55	312.30
52094	464.80	348.60	409.20
52095	301.20	225.90	256.05
52096	89.30	67.00	75.95
52097	126.65	95.00	107.70
52098	148.95	111.75	126.65
52099	111.75	83.85	95.00
52102	111.75	83.85	95.00
52105	208.55	156.45	177.30
52106	86.15	64.65	73.25
52108	257.85	193.40	219.20
52111	257.85	193.40	219.20
52114	464.85	348.65	409.25
52117	553.25	414.95	497.65
52120	652.20	489.15	596.60
52122	654.35	490.80	598.75
52123	740.85	555.65	685.25
52126	712.25	534.20	656.65
52129	953.40	715.05	897.80
52130	350.00	262.50	297.50
52131	484.05	363.05	428.45
52132	188.95	141.75	160.65
52133	72.00	54.00	61.20
52135	114.20	85.65	97.10
52138	352.35	264.30	299.50
52141	350.95	263.25	298.35
52144	327.10	245.35	278.05
52147	308.70	231.55	262.40
52148	545.60	409.20	490.00
52158	878.55	658.95	822.95
52180	148.95	111.75	126.65
52182	327.65	245.75	278.55
52184	484.05	363.05	428.45
52186	595.80	446.85	540.20
52300	224.95	168.75	191.25
52303	321.10	240.85	272.95
52306	476.60	357.45	421.00
52309	161.95	121.50	137.70
52312	224.95	168.75	191.25
52315	374.80	281.10	319.20
52318	111.75	83.85	95.00
52319	185.95	139.50	158.10
52321	374.80	281.10	319.20
52324	374.80	281.10	319.20
52327	185.95	139.50	158.10
52330	618.55	463.95	562.95
52333	618.55	463.95	562.95
52336	386.60	289.95	331.00
52337	845.65	634.25	790.05
52339	440.30	330.25	384.70
52342	764.75	573.60	709.15
52345	862.45	646.85	806.85
52348	974.60	730.95	919.00
52351	1094.45	820.85	1038.85
52354	1109.50	832.15	1053.90
52357	1249.15	936.90	1193.55
52360	1274.35	955.80	1218.75
52363	1433.55	1075.20	1377.95
52366	1401.90	1051.45	1346.30
52369	1576.20	1182.15	1520.60
52372	1529.40	1147.05	1473.80
52375	1713.10	1284.85	1657.50
52378	592.20	444.15	536.60
52379	1011.15	758.40	955.55
52380	1723.35	1292.55	1667.75
52382	2065.75	1549.35	2010.15
52420	190.75	143.10	162.15
52424	374.70	281.05	319.10
52430	862.45	646.85	806.85
52440	428.25	321.20	372.65
52442	535.40	401.55	479.80
52444	594.80	446.10	539.20
52446	701.95	526.50	646.35
52450	237.90	178.45	202.25
52452	386.60	289.95	331.00
52456	654.35	490.80	598.75
52458	237.90	178.45	202.25
52460	618.55	463.95	562.95
52480	397.30	298.00	341.70
52482	382.25	286.70	326.65
52484	455.05	341.30	399.45
52600	267.60	200.70	227.50
52603	255.80	191.85	217.45
52606	195.10	146.35	165.85
52609	255.80	191.85	217.45
52612	321.10	240.85	272.95
52615	398.60	298.95	343.00
52618	463.85	347.90	408.25
52621	463.85	347.90	408.25

52624	374.70	281.05	319.10
52626	229.75	172.35	195.30
52627	398.60	298.95	343.00
52630	147.50	110.65	125.40
52633	398.60	298.95	343.00
52636	147.50	110.65	125.40
52800	218.90	164.20	186.10
52803	315.20	236.40	267.95
52806	218.90	164.20	186.10
52809	374.80	281.10	319.20
52812	535.40	401.55	479.80
52815	565.00	423.75	509.40
52818	374.80	281.10	319.20
52821	814.85	611.15	759.25
52824	350.95	263.25	298.35
52826	187.95	141.00	159.80
52828	279.55	209.70	237.65
52830	368.70	276.55	313.40
52832	505.60	379.20	450.00
53000	25.70	19.30	21.85
53003	72.80	54.60	61.90
53004	26.55	19.95	22.60
53006	412.30	309.25	356.70
53009	233.90	175.45	198.85
53012	92.95	69.75	79.05
53015	464.85	348.65	409.25
53016	382.25	286.70	326.65
53017	476.95	357.75	421.35
53019	459.45	344.60	403.85
53052	97.10	72.85	82.55
53054	97.05	72.80	82.50
53056	56.95	42.75	48.45
53058	97.05	72.80	82.50
53060	79.45	59.60	67.55
53062	71.15	53.40	60.50
53064	128.95	96.75	109.65
53068	106.70	80.05	90.70
53070	140.85	105.65	119.75
53200	55.90	41.95	47.55
53203	94.00	70.50	79.90
53206	113.00	84.75	96.05
53209	1304.40	978.30	1248.80
53212	704.70	528.55	649.10
53215	323.20	242.40	274.75
53218	517.10	387.85	461.50
53220	260.70	195.55	221.60
53221	690.00	517.50	634.40
53224	764.90	573.70	709.30
53225	229.75	172.35	195.30
53226	247.00	185.25	209.95
53227	939.85	704.90	884.25
53230	1058.75	794.10	1003.15
53233	1189.65	892.25	1134.05
53236	372.30	279.25	316.70
53239	372.30	279.25	316.70
53242	247.00	185.25	209.95
53400	102.20	76.65	86.90
53403	124.85	93.65	106.15
53406	321.65	241.25	273.45
53409	321.65	241.25	273.45
53410	67.75	50.85	57.60
53411	188.95	141.75	160.65
53412	310.15	232.65	263.65
53413	379.00	284.25	323.40
53414	436.45	327.35	380.85
53415	344.65	258.50	293.00
53416	344.65	258.50	293.00
53418	447.95	336.00	392.35
53419	447.95	336.00	392.35
53422	568.55	426.45	512.95
53423	568.55	426.45	512.95
53424	487.80	365.85	432.20
53425	487.80	365.85	432.20
53427	666.25	499.70	610.65
53429	666.25	499.70	610.65
53439	188.95	141.75	160.65
53453	382.25	286.70	326.65
53455	449.00	336.75	393.40
53458	34.00	25.50	28.90
53459	186.25	139.70	158.35
53460	379.90	284.95	324.30
53600	30.80	23.10	26.20
53700	98.75	74.10	83.95
53702	49.45	37.10	42.05
53704	29.75	22.35	25.30
53706	98.75	74.10	83.95
55028	99.90	74.95	84.95
55029	34.65	26.00	29.50
55030	99.90	74.95	84.95
55031	34.65	26.00	29.50
55032	99.90	74.95	84.95
55033	34.65	26.00	29.50
55036	101.95	76.50	86.70
55037	34.65	26.00	29.50
55038	99.90	74.95	84.95
55039	34.65	26.00	29.50
55044	101.95	76.50	86.70
55045	34.65	26.00	29.50
55048	100.30	75.25	85.30
55049	34.65	26.00	29.50
55054	99.90	74.95	84.95
55070	90.00	67.50	76.50
55073	31.20	23.40	26.55
55076	99.90	74.95	84.95
55079	34.65	26.00	29.50
55113	244.75	183.60	208.05
55114	244.75	183.60	208.05
55115	244.75	183.60	208.05
55116	244.75	183.60	208.05
55117	244.75	183.60	208.05
55118	244.20	183.15	207.60
55130	353.60	265.20	300.60
55238	169.45	127.10	144.05
55244	169.45	127.10	144.05
55246	169.45	127.10	144.05
55248	169.45	127.10	144.05
55252	169.45	127.10	144.05
55256	169.45	127.10	144.05
55262	169.45	127.10	144.05
55264	169.45	127.10	144.05

55266	169.45	127.10	144.05
55270	169.45	127.10	144.05
55274	169.45	127.10	144.05
55276	169.45	127.10	144.05
55277	109.40	82.05	93.00
55278	169.45	127.10	144.05
55279	109.40	82.05	93.00
55280	169.45	127.10	144.05
55282	169.45	127.10	144.05
55284	169.45	127.10	144.05
55288	298.65	224.00	253.90
55290	298.65	224.00	253.90
55292	169.45	127.10	144.05
55294	169.45	127.10	144.05
55296	101.70	76.30	86.45
55600	99.90	74.95	84.95
55603	99.90	74.95	84.95
55700	60.00	45.00	51.00
55703	35.00	26.25	29.75
55704	70.00	52.50	59.50
55705	35.00	26.25	29.75
55706	100.00	75.00	85.00
55709	38.00	28.50	32.30
55712	115.00	86.25	97.75
55715	40.00	30.00	34.00
55718	100.00	75.00	85.00
55721	115.00	86.25	97.75
55723	38.00	28.50	32.30
55725	40.00	30.00	34.00
55728	100.00	75.00	85.00
55729	27.25	20.45	23.20
55731	98.00	73.50	83.30
55733	35.00	26.25	29.75
55736	127.00	95.25	107.95
55739	57.00	42.75	48.45
55759	150.00	112.50	127.50
55762	60.00	45.00	51.00
55764	160.00	120.00	136.00
55766	65.00	48.75	55.25
55768	150.00	112.50	127.50
55770	60.00	45.00	51.00
55772	160.00	120.00	136.00
55774	65.00	48.75	55.25
55800	99.90	74.95	84.95
55802	34.65	26.00	29.50
55804	99.90	74.95	84.95
55806	34.65	26.00	29.50
55808	99.90	74.95	84.95
55810	34.65	26.00	29.50
55812	99.90	74.95	84.95
55814	34.65	26.00	29.50
55816	99.90	74.95	84.95
55818	34.65	26.00	29.50
55820	99.90	74.95	84.95
55822	34.65	26.00	29.50
55824	99.90	74.95	84.95
55826	34.65	26.00	29.50
55828	99.90	74.95	84.95
55830	34.65	26.00	29.50
55832	99.90	74.95	84.95
55834	34.65	26.00	29.50
55836	99.90	74.95	84.95
55838	34.65	26.00	29.50
55840	99.90	74.95	84.95
55842	34.65	26.00	29.50
55844	80.00	60.00	68.00
55846	34.65	26.00	29.50
55848	99.90	74.95	84.95
55850	140.00	105.00	119.00
55852	99.90	74.95	84.95
55854	34.65	26.00	29.50
56001	185.25	138.95	157.50
56007	237.50	178.15	201.90
56010	239.50	179.65	203.60
56013	237.50	178.15	201.90
56016	275.50	206.65	234.20
56022	213.75	160.35	181.70
56028	319.95	240.00	272.00
56030	213.75	160.35	181.70
56036	319.95	240.00	272.00
56041	93.80	70.35	79.75
56047	119.80	89.85	101.85
56050	121.75	91.35	103.50
56053	121.75	91.35	103.50
56056	147.65	110.75	125.55
56062	107.50	80.65	91.40
56068	160.00	120.00	136.00
56070	107.50	80.65	91.40
56076	160.00	120.00	136.00
56101	218.50	163.90	185.75
56107	323.00	242.25	274.55
56141	110.60	82.95	94.05
56147	163.00	122.25	138.55
56219	309.90	232.45	263.45
56220	228.00	171.00	193.80
56221	228.00	171.00	193.80
56223	228.00	171.00	193.80
56224	333.80	250.35	283.75
56225	333.80	250.35	283.75
56226	333.80	250.35	283.75
56227	116.40	87.30	98.95
56228	116.40	87.30	98.95
56229	116.40	87.30	98.95
56230	168.60	126.45	143.35
56231	168.60	126.45	143.35
56232	168.60	126.45	143.35
56233	228.00	171.00	193.80
56234	333.80	250.35	283.75
56235	116.35	87.30	98.90
56236	168.60	126.45	143.35
56237	228.00	171.00	193.80
56238	333.80	250.35	283.75
56239	116.35	87.30	98.90
56240	168.60	126.45	143.35
56259	156.55	117.45	133.10
56301	280.25	210.20	238.25
56307	380.00	285.00	324.40
56341	142.00	106.50	120.70
56347	191.90	143.95	163.15
56401	237.50	178.15	201.90

56407	342.00	256.50	290.70
56409	237.50	178.15	201.90
56412	342.00	256.50	290.70
56441	120.45	90.35	102.40
56447	172.40	129.30	146.55
56449	120.45	90.35	102.40
56452	172.40	129.30	146.55
56501	365.75	274.35	310.90
56507	456.00	342.00	400.40
56541	183.45	137.60	155.95
56547	231.55	173.70	196.85
56619	209.00	156.75	177.65
56625	317.90	238.45	270.25
56659	106.50	79.90	90.55
56665	159.00	119.25	135.15
56801	443.20	332.40	387.60
56807	532.00	399.00	476.40
56841	221.65	166.25	188.45
56847	269.65	202.25	229.25
57001	443.30	332.50	387.70
57007	539.35	404.55	483.75
57041	221.70	166.30	188.45
57047	269.70	202.30	229.25
57201	147.45	110.60	125.35
57247	73.70	55.30	62.65
57341	446.50	334.90	390.90
57345	229.50	172.15	195.10
57350	484.50	363.40	428.90
57351	484.50	363.40	428.90
57355	250.95	188.25	213.35
57356	250.95	188.25	213.35
57506	28.05	21.05	23.85
57509	37.50	28.15	31.90
57512	38.15	28.65	32.45
57515	50.90	38.20	43.30
57518	30.65	23.00	26.10
57521	40.90	30.70	34.80
57524	46.55	34.95	39.60
57527	62.00	46.50	52.70
57700	38.15	28.65	32.45
57703	50.90	38.20	43.30
57706	30.65	23.00	26.10
57709	40.90	30.70	34.80
57712	44.45	33.35	37.80
57715	57.45	43.10	48.85
57721	93.55	70.20	79.55
57901	60.80	45.60	51.70
57902	60.80	45.60	51.70
57903	44.55	33.45	37.90
57906	60.80	45.60	51.70
57909	60.80	45.60	51.70
57912	44.45	33.35	37.80
57915	44.45	33.35	37.80
57918	44.45	33.35	37.80
57921	44.45	33.35	37.80
57924	44.45	33.35	37.80
57927	46.80	35.10	39.80
57930	31.00	23.25	26.35
57933	73.75	55.35	62.70
57939	60.80	45.60	51.70
57942	46.80	35.10	39.80
57945	40.90	30.70	34.80
57948	44.65	33.50	38.00
57951	44.65	33.50	38.00
57954	44.65	33.50	38.00
57957	44.65	33.50	38.00
58100	63.30	47.50	53.85
58103	51.95	39.00	44.20
58106	72.55	54.45	61.70
58108	125.30	94.00	106.55
58109	44.30	33.25	37.70
58112	91.65	68.75	77.95
58115	125.30	94.00	106.55
58300	37.80	28.35	32.15
58306	84.25	63.20	71.65
58500	33.30	25.00	28.35
58503	44.45	33.35	37.80
58506	57.30	43.00	48.75
58509	37.50	28.15	31.90
58521	40.90	30.70	34.80
58524	53.25	39.95	45.30
58527	65.45	49.10	55.65
58700	43.40	32.55	36.90
58706	148.85	111.65	126.55
58715	142.85	107.15	121.45
58718	118.90	89.20	101.10
58721	130.30	97.75	110.80
58900	33.65	25.25	28.65
58903	44.85	33.65	38.15
58909	84.80	63.60	72.10
58912	103.95	78.00	88.40
58915	74.40	55.80	63.25
58916	130.55	97.95	111.00
58921	127.50	95.65	108.40
58924	79.20	59.40	67.35
58927	72.05	54.05	61.25
58933	193.80	145.35	164.75
58936	184.70	138.55	157.00
58939	131.30	98.50	111.65
59300	82.00	61.50	69.70
59303	49.45	37.10	42.05
59306	94.55	70.95	80.40
59309	189.10	141.85	160.75
59312	82.00	61.50	69.70
59314	49.45	37.10	42.05
59318	44.35	33.30	37.70
59503	84.25	63.20	71.65
59700	91.00	68.25	77.35
59703	71.55	53.70	60.85
59712	107.20	80.40	91.15
59715	135.30	101.50	115.05
59718	126.95	95.25	107.95
59724	213.45	160.10	181.45
59733	101.50	76.15	86.30
59736	58.45	43.85	49.70
59739	69.50	52.15	59.10
59751	131.15	98.40	111.50
59754	206.75	155.10	175.75
59760	108.55	81.45	92.30
59763	126.20	94.65	107.30

59903	120.60	90.45	102.55
59912	321.25	240.95	273.10
59925	381.55	286.20	325.95
59970	158.65	119.00	134.90
59971	60.30	45.25	51.30
59972	160.65	120.50	136.60
59973	190.80	143.10	162.20
59974	79.35	59.55	67.45
60000	531.60	398.70	476.00
60003	779.60	584.70	724.00
60006	1108.60	831.45	1053.00
60009	1297.30	973.00	1241.70
60012	531.60	398.70	476.00
60015	779.60	584.70	724.00
60018	1108.60	831.45	1053.00
60021	1297.30	973.00	1241.70
60024	531.60	398.70	476.00
60027	779.60	584.70	724.00
60030	1108.60	831.45	1053.00
60033	1297.30	973.00	1241.70
60036	531.60	398.70	476.00
60039	779.60	584.70	724.00
60042	1108.60	831.45	1053.00
60045	1297.30	973.00	1241.70
60048	531.60	398.70	476.00
60051	779.60	584.70	724.00
60054	1108.60	831.45	1053.00
60057	1297.30	973.00	1241.70
60060	531.60	398.70	476.00
60063	779.60	584.70	724.00
60066	1108.60	831.45	1053.00
60069	1297.30	973.00	1241.70
60072	45.35	34.05	38.55
60075	90.60	67.95	77.05
60078	135.95	102.00	115.60
60100	57.30	43.00	48.75
60500	40.90	30.70	34.80
60503	28.05	21.05	23.85
60506	60.10	45.10	51.10
60509	93.20	69.90	79.25
60918	49.65	37.25	42.25
60927	40.05	30.05	34.05
61109	244.05	183.05	207.45
61302	397.10	297.85	341.50
61303	500.15	375.15	444.55
61306	627.90	470.95	572.30
61307	738.65	554.00	683.05
61310	324.95	243.75	276.25
61313	268.40	201.30	228.15
61314	371.60	278.70	316.00
61316	337.20	252.90	286.65
61317	435.60	326.70	380.00
61320	202.55	151.95	172.20
61328	201.40	151.05	171.20
61340	223.85	167.90	190.30
61348	392.25	294.20	336.65
61352	229.45	172.10	195.05
61353	342.00	256.50	290.70
61356	347.50	260.65	295.40
61360	356.85	267.65	303.35
61361	408.25	306.20	352.65
61364	439.65	329.75	384.05
61368	197.35	148.05	167.75
61372	197.35	148.05	167.75
61373	433.25	324.95	377.65
61376	126.85	95.15	107.85
61381	508.15	381.15	452.55
61383	552.95	414.75	497.35
61384	608.45	456.35	552.85
61386	294.15	220.65	250.05
61387	381.10	285.85	325.50
61389	327.85	245.90	278.70
61390	362.75	272.10	308.35
61393	535.70	401.80	480.10
61397	218.40	163.80	185.65
61401	143.55	107.70	122.05
61402	535.30	401.50	479.70
61405	306.10	229.60	260.20
61409	772.80	579.60	717.20
61413	199.90	149.95	169.95
61417	105.10	78.85	89.35
61421	424.50	318.40	368.90
61425	531.45	398.60	475.85
61426	490.85	368.15	435.25
61429	480.40	360.30	424.80
61430	583.40	437.55	527.80
61433	439.65	329.75	384.05
61434	544.45	408.35	488.85
61437	480.20	360.15	424.60
61438	595.40	446.55	539.80
61441	433.25	324.95	377.65
61442	665.60	499.20	610.00
61445	253.75	190.35	215.70
61446	295.10	221.35	250.85
61449	403.65	302.75	348.05
61450	351.70	263.80	298.95
61453	455.35	341.55	399.75
61454	307.95	231.00	261.80
61457	416.25	312.20	360.65
61458	351.15	263.40	298.50
61461	467.00	350.25	411.40
61465	234.90	176.20	199.70
61469	307.95	231.00	261.80
61473	155.15	116.40	131.90
61480	342.25	256.70	290.95
61484	779.30	584.50	723.70
61485	884.05	663.05	828.45
61495	197.35	148.05	167.75
61499	223.85	167.90	190.30
63000	475.00	356.25	419.40
63003	475.00	356.25	419.40
63006	475.00	356.25	419.40
63009	475.00	356.25	419.40
63012	475.00	356.25	419.40
63015	475.00	356.25	419.40
63018	475.00	356.25	419.40
63021	475.00	356.25	419.40
63024	475.00	356.25	419.40
63050	475.00	356.25	419.40
63053	475.00	356.25	419.40

63056	475.00	356.25	419.40	63450	475.00	356.25	419.40
63059	475.00	356.25	419.40	63453	475.00	356.25	419.40
63062	475.00	356.25	419.40	63456	475.00	356.25	419.40
63100	475.00	356.25	419.40	63459	475.00	356.25	419.40
63103	475.00	356.25	419.40	63462	475.00	356.25	419.40
63106	475.00	356.25	419.40	63465	475.00	356.25	419.40
63109	475.00	356.25	419.40	63468	475.00	356.25	419.40
63112	475.00	356.25	419.40	63471	475.00	356.25	419.40
63115	475.00	356.25	419.40	63474	475.00	356.25	419.40
63118	475.00	356.25	419.40	63477	475.00	356.25	419.40
63121	475.00	356.25	419.40	63480	475.00	356.25	419.40
63124	475.00	356.25	419.40	63500	475.00	356.25	419.40
63127	475.00	356.25	419.40	63503	475.00	356.25	419.40
63130	475.00	356.25	419.40	63506	475.00	356.25	419.40
63133	475.00	356.25	419.40	63509	475.00	356.25	419.40
63150	475.00	356.25	419.40	63512	475.00	356.25	419.40
63153	475.00	356.25	419.40	63515	475.00	356.25	419.40
63156	475.00	356.25	419.40	63518	475.00	356.25	419.40
63159	475.00	356.25	419.40	63521	475.00	356.25	419.40
63162	475.00	356.25	419.40	63524	475.00	356.25	419.40
63200	475.00	356.25	419.40	63550	475.00	356.25	419.40
63203	475.00	356.25	419.40	63553	475.00	356.25	419.40
63206	475.00	356.25	419.40	63556	475.00	356.25	419.40
63209	475.00	356.25	419.40	63559	475.00	356.25	419.40
63212	475.00	356.25	419.40	63562	475.00	356.25	419.40
63215	475.00	356.25	419.40	63565	475.00	356.25	419.40
63218	475.00	356.25	419.40	63568	475.00	356.25	419.40
63221	475.00	356.25	419.40	63571	475.00	356.25	419.40
63250	475.00	356.25	419.40	63574	475.00	356.25	419.40
63253	475.00	356.25	419.40	63580	475.00	356.25	419.40
63256	475.00	356.25	419.40	63583	475.00	356.25	419.40
63270	475.00	356.25	419.40	63590	475.00	356.25	419.40
63273	475.00	356.25	419.40	63593	475.00	356.25	419.40
63276	475.00	356.25	419.40	63600	475.00	356.25	419.40
63279	475.00	356.25	419.40	63603	475.00	356.25	419.40
63290	475.00	356.25	419.40	63606	475.00	356.25	419.40
63293	475.00	356.25	419.40	63609	475.00	356.25	419.40
63300	475.00	356.25	419.40	63612	475.00	356.25	419.40
63303	475.00	356.25	419.40	63615	475.00	356.25	419.40
63306	475.00	356.25	419.40	63618	475.00	356.25	419.40
63309	475.00	356.25	419.40	63621	475.00	356.25	419.40
63312	475.00	356.25	419.40	63624	475.00	356.25	419.40
63315	475.00	356.25	419.40	63627	475.00	356.25	419.40
63350	475.00	356.25	419.40	63650	475.00	356.25	419.40
63353	475.00	356.25	419.40	63653	475.00	356.25	419.40
63356	475.00	356.25	419.40	63656	475.00	356.25	419.40
63359	475.00	356.25	419.40	63659	475.00	356.25	419.40
63362	475.00	356.25	419.40	63662	475.00	356.25	419.40
63365	475.00	356.25	419.40	63665	475.00	356.25	419.40
63400	475.00	356.25	419.40	63668	475.00	356.25	419.40
63403	475.00	356.25	419.40	63671	475.00	356.25	419.40
63406	475.00	356.25	419.40	63674	475.00	356.25	419.40
63409	475.00	356.25	419.40	63677	475.00	356.25	419.40
63412	475.00	356.25	419.40	63680	475.00	356.25	419.40
63415	475.00	356.25	419.40	63700	475.00	356.25	419.40
63418	475.00	356.25	419.40	63703	475.00	356.25	419.40
63421	475.00	356.25	419.40	63706	475.00	356.25	419.40
63424	475.00	356.25	419.40	63709	475.00	356.25	419.40
63427	475.00	356.25	419.40	63712	475.00	356.25	419.40
63430	475.00	356.25	419.40	63715	475.00	356.25	419.40

63718	475.00	356.25	419.40
63721	475.00	356.25	419.40
63736	475.00	356.25	419.40
63739	475.00	356.25	419.40
63742	475.00	356.25	419.40
63745	475.00	356.25	419.40
63750	475.00	356.25	419.40
63753	475.00	356.25	419.40
63756	475.00	356.25	419.40
63800	475.00	356.25	419.40
63803	475.00	356.25	419.40
63806	475.00	356.25	419.40
63850	475.00	356.25	419.40
63853	475.00	356.25	419.40
63856	475.00	356.25	419.40
63859	475.00	356.25	419.40
63862	475.00	356.25	419.40
63865	475.00	356.25	419.40
63868	475.00	356.25	419.40
63870	475.00	356.25	419.40
63880	475.00	356.25	419.40
63883	475.00	356.25	419.40
63900	475.00	356.25	419.40
63903	475.00	356.25	419.40
63906	475.00	356.25	419.40
63909	475.00	356.25	419.40
63920	475.00	356.25	419.40
63930	475.00	356.25	419.40
63940	475.00	356.25	419.40
63943	475.00	356.25	419.40
63946	475.00	356.25	419.40
65060	7.70	5.80	6.55
65066	10.25	7.70	8.75
65070	16.70	12.55	14.20
65072	10.00	7.50	8.50
65075	51.30	38.50	43.65
65078	89.00	66.75	75.65
65081	95.30	71.50	81.05
65084	163.70	122.80	139.15
65087	82.00	61.50	69.70
65090	10.90	8.20	9.30
65093	21.70	16.30	18.45
65096	40.40	30.30	34.35
65099	110.00	82.50	93.50
65102	165.00	123.75	140.25
65105	110.00	82.50	93.50
65108	165.00	123.75	140.25
65111	22.90	17.20	19.50
65114	8.95	6.75	7.65
65117	20.00	15.00	17.00
65120	13.65	10.25	11.65
65123	20.00	15.00	17.00
65126	27.50	20.65	23.40
65129	35.00	26.25	29.75
65132	25.00	18.75	21.25
65133	48.00	36.00	40.80
65134	71.00	53.25	60.35
65135	94.00	70.50	79.90
65136	117.00	87.75	99.45
65137	25.00	18.75	21.25
65139	25.00	18.75	21.25
65140	25.00	18.75	21.25
65142	25.00	18.75	21.25
65144	55.80	41.85	47.45
65147	37.40	28.05	31.80
65150	70.00	52.50	59.50
65153	140.00	105.00	119.00
65156	210.00	157.50	178.50
65159	70.00	52.50	59.50
65162	10.25	7.70	8.75
65165	34.00	25.50	28.90
65168	36.00	27.00	30.60
65171	25.00	18.75	21.25
65174	36.00	27.00	30.60
66500	9.45	7.10	8.05
66503	11.40	8.55	9.70
66506	13.35	10.05	11.35
66509	15.30	11.50	13.05
66512	17.25	12.95	14.70
66515	19.20	14.40	16.35
66518	19.80	14.85	16.85
66519	39.60	29.70	33.70
66536	10.90	8.20	9.30
66539	30.20	22.65	25.70
66542	18.70	14.05	15.90
66545	15.60	11.70	13.30
66548	19.70	14.80	16.75
66551	16.60	12.45	14.15
66554	16.60	12.45	14.15
66557	9.55	7.20	8.15
66560	19.90	14.95	16.95
66563	24.35	18.30	20.70
66566	33.25	24.95	28.30
66569	42.05	31.55	35.75
66572	50.85	38.15	43.25
66575	59.65	44.75	50.75
66578	68.45	51.35	58.20
66581	77.25	57.95	65.70
66584	9.55	7.20	8.15
66587	46.90	35.20	39.90
66590	30.20	22.65	25.70
66593	17.80	13.35	15.15
66596	32.10	24.10	27.30
66599	23.35	17.55	19.85
66602	42.45	31.85	36.10
66605	30.20	22.65	25.70
66608	41.70	31.30	35.45
66611	20.45	15.35	17.40
66614	32.60	24.45	27.75
66617	44.80	33.60	38.10
66620	12.20	9.15	10.40
66623	41.00	30.75	34.85
66626	23.80	17.85	20.25
66629	19.90	14.95	16.95
66632	19.90	14.95	16.95
66635	19.90	14.95	16.95
66638	28.80	21.60	24.50
66641	28.80	21.60	24.50
66644	19.90	14.95	16.95
66647	44.50	33.40	37.85

66650	24.00	18.00	20.40
66653	44.00	33.00	37.40
66655	19.90	14.95	16.95
66656	19.90	14.95	16.95
66659	36.65	27.50	31.20
66662	78.90	59.20	67.10
66665	30.20	22.65	25.70
66667	30.20	22.65	25.70
66669	30.20	22.65	25.70
66670	51.75	38.85	44.00
66671	36.40	27.30	30.95
66672	30.20	22.65	25.70
66673	51.75	38.85	44.00
66674	39.45	29.60	33.55
66677	11.00	8.25	9.35
66680	73.45	55.10	62.45
66683	73.45	55.10	62.45
66686	50.00	37.50	42.50
66689	80.00	60.00	68.00
66692	140.00	105.00	119.00
66695	29.80	22.35	25.35
66698	42.50	31.90	36.15
66701	55.50	41.65	47.20
66704	68.50	51.40	58.25
66707	81.50	61.15	69.30
66710	94.50	70.90	80.35
66713	13.00	9.75	11.05
66716	24.70	18.55	21.00
66719	34.40	25.80	29.25
66722	37.40	28.05	31.80
66725	50.40	37.80	42.85
66728	63.40	47.55	53.90
66731	76.40	57.30	64.95
66734	89.40	67.05	76.00
66737	13.00	9.75	11.05
66740	54.50	40.90	46.35
66743	19.90	14.95	16.95
66746	31.55	23.70	26.85
66749	32.50	24.40	27.65
66752	24.35	18.30	20.70
66755	38.30	28.75	32.60
66758	24.35	18.30	20.70
66761	13.00	9.75	11.05
66764	8.80	6.60	7.50
66767	17.60	13.20	15.00
66770	26.40	19.80	22.45
66773	24.35	18.30	20.70
66776	24.35	18.30	20.70
66779	39.45	29.60	33.55
66782	13.00	9.75	11.05
66785	39.45	29.60	33.55
66788	65.00	48.75	55.25
66791	73.45	55.10	62.45
66794	36.00	27.00	30.60
69300	12.20	9.15	10.40
69303	21.50	16.15	18.30
69306	33.00	24.75	28.05
69309	47.00	35.25	39.95
69312	33.00	24.75	28.05
69315	64.00	48.00	54.40
69318	33.00	24.75	28.05
69321	47.00	35.25	39.95
69324	42.00	31.50	35.70
69327	83.00	62.25	70.55
69330	125.00	93.75	106.25
69333	20.10	15.10	17.10
69336	18.65	14.00	15.90
69339	37.25	27.95	31.70
69342	55.90	41.95	47.55
69345	51.65	38.75	43.95
69348	103.30	77.50	87.85
69351	154.95	116.25	131.75
69354	30.00	22.50	25.50
69357	60.00	45.00	51.00
69360	90.00	67.50	76.50
69363	25.00	18.75	21.25
69366	34.10	25.60	29.00
69369	27.80	20.85	23.65
69370	32.80	24.60	27.90
69372	25.00	18.75	21.25
69375	28.20	21.15	24.00
69378	176.00	132.00	149.60
69381	176.00	132.00	149.60
69382	176.00	132.00	149.60
69384	15.30	11.50	13.05
69387	28.00	21.00	23.80
69390	42.00	31.50	35.70
69393	56.00	42.00	47.60
69396	70.00	52.50	59.50
69399	84.00	63.00	71.40
69402	14.00	10.50	11.90
69405	15.30	11.50	13.05
69408	27.15	20.40	23.10
69411	38.15	28.65	32.45
69414	15.30	11.50	13.05
69417	15.30	11.50	13.05
69420	27.15	20.40	23.10
69423	38.15	28.65	32.45
69426	15.30	11.50	13.05
69429	15.30	11.50	13.05
69432	15.30	11.50	13.05
69435	27.15	20.40	23.10
69438	16.70	12.55	14.20
69441	16.70	12.55	14.20
69442	176.00	132.00	149.60
69443	200.00	150.00	170.00
69444	90.00	67.50	76.50
69445	90.00	67.50	76.50
69447	15.30	11.50	13.05
69450	27.15	20.40	23.10
69453	28.55	21.45	24.30
69456	39.55	29.70	33.65
69459	50.55	37.95	43.00
69462	39.55	29.70	33.65
69465	38.15	28.65	32.45
69468	30.20	22.65	25.70
69471	34.10	25.60	29.00
69472	15.30	11.50	13.05
69474	28.00	21.00	23.80
71057	35.20	26.40	29.95

71058	49.85	37.40	42.40
71059	28.80	21.60	24.50
71060	43.45	32.60	36.95
71062	43.45	32.60	36.95
71064	20.45	15.35	17.40
71067	14.35	10.80	12.20
71069	22.45	16.85	19.10
71071	30.55	22.95	26.00
71073	104.75	78.60	89.05
71075	22.70	17.05	19.30
71077	26.70	20.05	22.70
71079	26.50	19.90	22.55
71081	40.00	30.00	34.00
71083	19.90	14.95	16.95
71085	28.55	21.45	24.30
71087	37.20	27.90	31.65
71089	28.75	21.60	24.45
71091	52.10	39.10	44.30
71093	75.45	56.60	64.15
71095	40.00	30.00	34.00
71097	24.10	18.10	20.50
71099	26.20	19.65	22.30
71101	17.15	12.90	14.60
71103	51.35	38.55	43.65
71106	11.15	8.40	9.50
71109	34.10	25.60	29.00
71113	46.80	35.10	39.80
71115	59.50	44.65	50.60
71117	72.20	54.15	61.40
71119	17.10	12.85	14.55
71121	20.50	15.40	17.45
71123	23.90	17.95	20.35
71125	27.30	20.50	23.25
71127	174.05	130.55	147.95
71129	215.00	161.25	182.75
71131	255.95	192.00	217.60
71135	205.25	153.95	174.50
71137	29.85	22.40	25.40
71139	102.65	77.00	87.30
71141	194.80	146.10	165.60
71143	256.60	192.45	218.15
71145	418.95	314.25	363.35
71147	40.00	30.00	34.00
71149	106.85	80.15	90.85
71151	117.30	88.00	99.75
71153	34.10	25.60	29.00
71155	46.80	35.10	39.80
71157	59.50	44.65	50.60
71159	72.20	54.15	61.40
72813	70.00	52.50	59.50
72816	84.50	63.40	71.85
72817	94.50	70.90	80.35
72823	95.00	71.25	80.75
72824	138.00	103.50	117.30
72825	176.00	132.00	149.60
72830	165.00	123.75	140.25
72836	205.00	153.75	174.25
72844	30.00	22.50	25.50
72846	42.00	31.50	35.70
72847	56.00	42.00	47.60
72851	180.00	135.00	153.00
72852	240.00	180.00	204.00
72855	180.00	135.00	153.00
72856	240.00	180.00	204.00
73043	22.30	16.75	19.00
73045	47.50	35.65	40.40
73047	92.50	69.40	78.65
73049	67.50	50.65	57.40
73051	166.35	124.80	141.40
73053	19.00	14.25	16.15
73055	19.00	14.25	16.15
73057	19.00	14.25	16.15
73059	42.00	31.50	35.70
73060	56.00	42.00	47.60
73287	354.00	265.50	300.90
73289	322.00	241.50	273.70
73521	9.50	7.15	8.10
73523	41.20	30.90	35.05
73525	28.00	21.00	23.80
73527	9.90	7.45	8.45
73529	28.25	21.20	24.05
73801	6.75	5.10	5.75
73802	4.45	3.35	3.80
73803	6.20	4.65	5.30
73804	7.95	6.00	6.80
73805	4.45	3.35	3.80
73806	9.90	7.45	8.45
73807	6.75	5.10	5.75
73808	8.45	6.35	7.20
73809	2.30	1.75	2.00
73810	6.75	5.10	5.75
73811	10.95	8.25	9.35
73901	8.00	6.00	6.80
73903	14.30	10.75	12.20
73905	8.00	6.00	6.80
73907	16.90	12.70	14.40
73909	17.15	12.90	14.60
73910	10.00	7.50	8.50
73912	17.15	12.90	14.60
73913	9.50	7.15	8.10
73915	9.50	7.15	8.10
73921	10.00	7.50	8.50
75001	67.65	50.75	57.55
75004	33.95	25.50	28.90
75006	60.30	45.25	51.30
75009	53.90	40.45	45.85
75012	85.40	64.05	72.60
75015	117.50	88.15	99.90
75018	149.65	112.25	127.25
75021	183.55	137.70	156.05
75023	36.75	27.60	31.25
75024	474.75	356.10	419.15
75027	650.90	488.20	595.30
75030	579.60	434.70	524.00
75033	949.90	712.45	894.30
75034	483.50	362.65	427.90
75036	1312.10	984.10	1256.50
75037	1652.55	1239.45	1596.95
75039	439.15	329.40	383.55
75042	164.25	123.20	139.65

75045	879.20	659.40	823.60
75048	225.45	169.10	191.65
75049	263.90	197.95	224.35
75050	509.40	382.05	453.80
75051	782.05	586.55	726.45
75150	67.65	50.75	57.55
75153	33.95	25.50	28.90
75156	60.30	45.25	51.30
75200	43.45	32.60	36.95
75203	65.20	48.90	55.45
75206	21.60	16.20	18.40
75400	130.35	97.80	110.80
75403	149.65	112.25	127.25
75406	170.65	128.00	145.10
75409	193.20	144.90	164.25
75412	107.90	80.95	91.75
75415	130.35	97.80	110.80
75600	183.55	137.70	156.05
75603	215.70	161.80	183.35
75606	215.70	161.80	183.35
75609	322.05	241.55	273.75
75612	398.60	298.95	343.00
75615	147.50	110.65	125.40
75618	183.20	137.40	155.75
75621	183.20	137.40	155.75
75800	65.20	48.90	55.45
75803	260.85	195.65	221.75
75806	305.90	229.45	260.05
75809	362.25	271.70	307.95
75812	402.50	301.90	346.90
75815	491.05	368.30	435.45
75818	579.60	434.70	524.00
75821	466.85	350.15	411.25
75824	539.35	404.55	483.75
75827	619.85	464.90	564.25
75830	684.30	513.25	628.70
75833	837.15	627.90	781.55
75836	957.90	718.45	902.30
75839	21.60	16.20	18.40
75842	32.20	24.15	27.40
75845	161.05	120.80	136.90
75848	193.20	144.90	164.25
75851	96.60	72.45	82.15
75854	96.60	72.45	82.15

Derived FeeDescriptions Commencing 1 November 2001

Item 4	The fee for item 3, plus $20.05 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 $1.40 per patient
Item 13	The fee for item 3, plus $20.05 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 $1.40 per patient
Item 19	The fee for item 3, plus $20.05 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 $1.40 per patient
Item 20	The fee for item 3, plus $20.05 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 $1.40 per patient
Item 24	The fee for item 23, plus $20.05 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 $1.40 per patient
Item 25	The fee for item 23, plus $20.05 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 $1.40 per patient
Item 33	The fee for item 23, plus $20.05 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 $1.40 per patient
Item 35	The fee for item 23, plus $20.05 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 $1.40 per patient
Item 37	The fee for item 36, plus $20.05 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 $1.40 per patient
Item 38	The fee for item 36, plus $20.05 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 $1.40 per patient
Item 40	The fee for item 36, plus $20.05 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 $1.40 per patient
Item 43	The fee for item 36, plus $20.05 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 $1.40 per patient
Item 47	The fee for item 44, plus $20.05 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 $1.40 per patient
Item 48	The fee for item 44, plus $20.05 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 $1.40 per patient
Item 50	The fee for item 44, plus $20.05 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 $1.40 per patient
Item 51	The fee for item 44, plus $20.05 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 $1.40 per patient
Item 58	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
Item 59	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
Item 60	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

Item 65	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
Item 81	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
Item 83	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
Item 84	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
Item 86	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
Item 87	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
Item 89	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
Item 90	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
Item 91	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
Item 92	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
Item 93	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
Item 95	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
Item 96	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
Item 195	The fee for item 193, plus $20.05 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 $1.40 per patient
Item 414	The fee for item 410, plus $20.05 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 $1.40 per patient
Item 415	The fee for item 411, plus $20.05 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 $1.40 per patient
Item 416	The fee for item 412, plus $20.05 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 $1.40 per patient
Item 417	The fee for item 413, plus $20.05 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 $1.40 per patient
Item 2503	The fee for item 2501, plus $20.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2501 plus $1.40 per patient.
Item 2506	The fee for item 2504, plus $20.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2504 plus $1.40 per patient.

Item 2509 The fee for item 2507, plus $20.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2507 plus $1.40 per patient.

Item 2518 The fee for item 2517, plus $20.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2517 plus $1.40 per patient.

Item 2522 The fee for item 2521, plus $20.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2521 plus $1.40 per patient.

Item 2526 The fee for item 2525, plus $20.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2525 plus $1.40 per patient.

Item 2547 The fee for item 2546, plus $20.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2546 plus $1.40 per patient.

Item 2553 The fee for item 2552, plus $20.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2552 plus $1.40 per patient.

Item 2559 The fee for item 2558, plus $20.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2558 plus $1.40 per patient.

Item 2610 An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients – an amount equal to $16.00 plus $0.70 per patient.

Item 2613 An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients – an amount equal to $35.50 plus $0.70 per patient.

Item 2616 An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients – an amount equal to $57.50 plus $0.70 per patient.

Item 2631 An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients – an amount equal to $16.00 plus $0.70 per patient.

Item 2633 An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients – an amount equal to $35.50 plus $0.70 per patient.

Item 2635 An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients – an amount equal to $57.50 plus $0.70 per patient.

Item 2673 An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients – an amount equal to $16.00 plus $0.70 per patient.

Item 2675 An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients – an amount equal to $35.50 plus $0.70 per patient.

Item 2677 An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients – an amount equal to $57.50 plus $0.70 per patient.

Item 15003 The fee for item 15000 plus for each field in excess of 1, an amount of $13.50

Item 15009 The fee for item 15006 plus for each field in excess of 1, an amount of $14.70

Item 15103 The fee for item 15100 plus for each field in excess of 1, an amount of $14.90

Item 15109 The fee for item 15106 plus for each field in excess of 1, an amount of $17.95

Item 15115 The fee for item 15112 plus for each field in excess of 1, an amount of $37.40

Item 15204 The fee for item 15203 plus for each field in excess of 1, an amount of $30.00

Item 15208 The fee for item 15207 plus for each field in excess of 1, an amount of $30.00

Item 15214 The fee for item 15211 plus for each field in excess of 1, an amount of $25.20

Item 16633 50% of the fee for the first foetus for any additional foetus tested

Item 16636 50% of the fee for the first foetus for any additional foetus tested

Item 18219 The fee for item 18216 plus $15.05 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner

Item 22060 – An amount of $343.00 (3 Basic units), plus the fee for perfusion time (an item in the range 23010-24136), plus where applicable, the fee for patient modifiers (an item in the range 25000-25020)

Item 25025 – An additional amount of 50% of the fee for the anaesthetic service. That is:
a) an item in the range 20100 – 21997 or 22900 plus,
b) an item in the range 23010 – 24136, plus,
c) where applicable, an item in the range 25000-25015, plus
d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22050.

Item 25030 – An additional amount of 50% of the fee for the anaesthetic service. That is:
a) an assistant anaesthesia item in the range 20200-25205, plus
b) an item in the range 23010 – 24136, plus
c) where applicable, an item in the range 25000-25015, plus
d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22050.

Item 25050 – An additional amount of 50% of the fee for perfusion service. That is:
a) item 22060, plus
b) an item in the range 23010 – 24136, plus
c) where applicable, an item in the range 25000-25015, plus
d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22050.

Item 25200 – An amount of $85.75 (5 Basic units), plus an item in the range 23010 – 24136 plus, where applicable, an item in the range 25000 – 25020.

Item 25205 – An amount of $85.75 (5 Basic units), plus an item in the range 23010 – 24136 plus, where applicable, an item in the range 25000 – 25020.

Item 30001 50% of the fee which would have applied had the procedure not been discontinued

Item 31340 75% of the fee for excision of malignant tumour

Item 44376 75% of the original amputation fee

Item 51303 one fifth of the established fee for the operation or combination of operations

Item 51309 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)

Item 51312 one fifth of the established fee for the procedure or combination of procedures

Item 51803 one fifth of the established fee for the operation or combination of operations

Ready reckoner here.

Service	Item

A

Abbe flap, reconstruction of cleft lip	45701
flap, reconstruction of lip or eyelid	45671
Abdomen, burst, repair of	30403
Abdominal apron, wedge excision	30165,30168,30171
musculature transfer to greater trochanter	50387
paracentesis	30406
viscera, operations involving laparotomy	30387
wall vitello intestinal remnant, excision of	43942
Abdomino-perineal resection, rectum and anus	32039-32046
Abdomino-vaginal op for stress incontinence	35602,35605
Abdominoplasty, Pitanguy type	30177
Abortion, threatened, treatment of	16505
Abrasive therapy	45021,45024
Abscess, anal, drainage of	32174,32175
Bartholin's, incision of	35520
appendiceal, laparotomy for drainage	30394
breast, exploration and drainage	30364
deep, percutaneous drainage	30224
drainage tube, exchange of	30225
extradural, laminectomy for	40309
intra-orbital, drainage of	42572
intracranial, excision of	39903
ischio-rectal, drainage of	32174,32175
laparotomy for drainage of	30394
large, incision and drainage, with GA	30223
liver, open abdominal drainage of	30431
middle ear, operation for	41626
pancreatic, laparotomy, external drainage	30575
pelvic, laparotomy for drainage of	30394
peritonsillar, incision of	41807
prostate, drainage of	37212,37221
retroperitoneal, drainage of	30402
small, incision without drainage	*
small, incision, drainage, without GA	30219
subperiosteal	43500-43524
subphrenic, laparotomy for drainage	30394
Accessory bone, osteotomy or osteectomy of	48400
Acetabular dysplasia, pelvis, bone graft/shelf procedure	50393
Acetabulum, treatment of fracture of	47492-47510
Achilles' tendon, operation for lengthening	49727
tendon, repair of	49718,49721,49724
Acoustic neuroma, removal of	41575-41579
Acupuncture, by a medical practitioner	173
Adductors to ischium transfer	50387
Adenoids and tonsils, removal of	41788-41793
removal of	41800,41801
Adhesions, division of, via laparoscope	35637,31450,31452
division of, with laparoscopy	30393
division of, with laparotomy	30376,30378,30379
labial, separation of	*
liver, destruction of by cryotherapy	30419
nasal, division of	41683
pharyngeal, division of	41758
preputial, breakdown of	*
Adrenal gland, excision of	36500
gland tumour, excision of	30324
hyperplasia, congenital, vaginoplasty for	37851
Alcohol, injection of trigeminal nerve/s	39100
local infiltration, nerve or muscle	*
retrobulbar injection of	42824
Alimentary continuity, primary restoration	41843
obstruction, neonatal, laparotomy for	43825
Allergens, epicutaneous patch testing	12012-12021
skin sensitivity testing	12000,12003
Alopecia, hair transplantation for	45560
Amnio-infusion	16621
Amniocentesis, diagnostic	16600
therapeutic	16618
Amputation, limb, digit etc.	44325-44376
stump, reamputation of	44376
stump, revision of	46483
stump, trimming of	*
Anaesthesia, for therapeutic purposes	17974
nerve block	(see nerve)
separate examination in preparation for	17603
Anaesthetic, Relative Value Guide	20100-25205
in connection with	
- forceps delivery	17968
- hyperbaric oxygen therapy	18026,18027
- incision of lesion causing airway obstruction	18019
- magnetic resonance imaging services	18013
- manipulative correction of inversion of uterus	18004
- manual removal of products of conception	18001
- multiple procedures	(see Note T6.2)
- muscle biopsy for malignant hyperpyrexia	18021
- nerve blocks	18016
- percutaneous central venous cannulation	17995
- peripheral venous cannula, insertion of	17989
- peripheral venous cannulation, open exposure	17992
- phaeochromocytoma, removal of	17986
- postpartum haemorrhage, treatment of	18001
- procedure not allocated anaesthetic units	
- procedure on person under 10 years	18030,18031,18032
- prolonged	17800
- radiotherapy	17965
- reamputation of amputation stump	17977
- third degree tear, repair of	18001
- unusual length	17800,17805,17810
- vacuum extraction delivery	17968
Anal canal, laser therapy (restriction)	35539,35542,35545
fissure, operation for, including excision	32150
fistula, excision/repair	32156-32165
fistula, readjustment of Seton	32166
graciloplasty	32203
graciloplasty, insertion of stimulator & electrode	32209
incontinence, Parks' procedure	32126
manometry, pelvic floor abnormalities	11830
skin tags or polyps, excision of	32142,32145
sphincter, direct repair of	32129

*** Payable on attendance basis**

Service	Item
sphincterotomy, independent, Hirschsprung's	43999
stricture, anoplasty for	32123
warts, removal under GA or nerve block	32177,32180
Anastomosis, aorta, congenital heart disease	38706,38709
arterial/venous, independent	32766
arterial/venous, with other operation	32769
arteriovenous, upper or lower limb	34503,34509
facio-hypoglossal/accessory nerve	39503
ileo-rectal, with total colectomy	32012
intrathoracic, congenital heart disease	38727,38730
microvascular, in plastic surgery	45502
oesophageal atresia, neonatal	43855
saphenous vein, for femoral vein bypass	34809
vena cava, for congenital heart disease	38721,38724
Aneurysm, cerebrovascular, clipping/reinforcement	39800
intracranial proximal artery clipping	39806
intracranial, ligation cervical vessels	39812
left ventricular, plication of	38506
left ventricular, resection	38507,38508
major artery, replacement/repair	33050-33181
Angiofibroma, face/neck, removal by laser excision	30190
nasopharyngeal, removal	41767
Angioma, cauterisation/injection into	45027
excision of	45030-45036
Angioplasty, peripheral laser	35315
transluminal balloon	35300-35305
Angioscopy	35324,35327
Ankle, achilles tendon, operation for lengthening	49727
achilles tendon, repair of	49718,49721,49724
and foot, tibialis tendon transfer	50339,50342
arthrodesis of	49712
arthroscopic surgery of	49703
arthroscopy of, diagnostic	49700
arthrotomy of	49706
dislocation, treatment of	47063,47066
fracture, treatment of	47594-47603
jerk test for half relaxation time	*
ligamentous stabilisation of	49709
major tendon repair	49718
synovectomy of	50312
tibialis tendon transfer	50339,50342
total joint replacement	49715
Annuloplasty, heart valve	38475,38477,38478
Anophthalmic orbit, insertion cartilage/implant	42518
orbit, placement of motility integrating peg	42518
orbit, removal of implant from socket	42518
socket, treatment as secondary procedure	42521
Anoplasty for anal stricture	32123
Anorectal carcinoma, excision of	32105
application of formalin	32212
examination, under GA	32171
malformation, neonatal, laparotomy and colostomy	43822
malformation, paediatric, operations	43960,43963,43966
sensation, measurement of	11830
Anorectoplasty of anorectal malformation	43963,43966
Antenatal cardiotocography (restriction)	16514
care, independent of confinement	16500
Antepartum haemorrhage, treatment of	16509
Anterior chamber, irrigation of blood from	42743
resection of rectum	32024,32025
section of corpus callosum for epilepsy	40700
synechiae, division of	42761
vaginal repair	35575-35580
Antireflux operations	30527,30529,30530
operation by fundoplasty	31464,31466
Antrectomy and/or vagotomy	30497,30503
Antrobuccal fistula operation	41722
Antrostomy, radical	41710,41713
Antrum, drainage of, through tooth socket	41719
intranasal, operation on	41716
maxillary, lavage of	41704
maxillary, proof puncture, lavage	41698,41701
removal of foreign body from	41716
Anus, dilatation of (Lord's procedure)	32153
Aorta, anastomosis, congenital heart disease	38706,38709
thoracic, management of rupture/dissection	38572
thoracic, repair/replacement procedures	38550-38571
Aortic bypass	32708,32710,32711
endarterectomy	33509
interruption, repair of	38712
valve leaflet/s, decalcification of	38483
Aorto-duodenal fistula, repair of	34160,34163,34166
Aorto-femoral endarterectomy	33515
Aorto-iliac endarterectomy	33512
Aortopexy for tracheomalacia	43909
Appendiceal abscess, laparotomy for drainage	30394
Appendicectomy	30571,30572,30574
Appendicostomy	30375
Appendix, ruptured, laparotomy for drainage	30394
Arachnoidal cyst, craniotomy for	39718
Areola, reconstruction of	45545,45546
Arm, amputation or disarticulation of	44328
Arnold Chiari malformation, decompression of	40106
Arrhythmia ablation	38287,38290,38293
surgery	38512-38524
Arterial anastomosis, not otherwise covered	32766,32769
atherectomy, peripheral	35312
cannulation for infusion chemotherapy, open	34524
catheterisation, peripheral	35317-35321
line for blood pressure monitoring	11600,11601,13876
puncture and blood collection, diagnostic	13839
Arteries, major, access as part of re-operation	35202
Arteriography, operative	35200
Arteriovenous access device, insertion of	34512
access device, prosthetic, correction of	34518
access device, thrombectomy of	34515
anastomosis of upper or lower limb	34503,34509
fistula extremity, surgically created, closure	34130
fistula, dissection and ligation/repair	34112-34127
fistula, ligation of cervical vessel/s	39812
fistula, stenosis of, correction of	34518
malformation, excision of	45039,45042,45045

*** Payable on attendance basis**

Service	Item
malformation, intracranial artery clipping of	39806
malformation, intracranial, excision of	39803
malformation, laminectomy, radical excision of	40318
shunt, declotting of	13106
shunt, external, insertion/removal	34500,34506
Artery, anastomosis of, microvascular	45502
bypass grafting, occlusive arterial disease	32700-32763
coeliac, decompression of	34142
coronary, bypass operations	38497,38500,38503
embolectomy of	33800,33803,33806
endarterectomy of	33500-33542
ethmoidal, transorbital ligation of	41725
great, ligation/exploration, other	34103
harvesting for coronary bypass	38496
ligation/exploration not otherwise covered	34106
major, of neck, ligation/exploration, other	34100
major, repair of wound of	33815-33839
maxillary, transantral ligation of	41707
neck, reoperation for bleeding/thrombosis	33842
patch grafting to	33545,33548
popliteal, exploration for popliteal entrapment	34145
temporal, biopsy of	34109
thrombectomy of	33803,33806
Arthrectomy, hip	49309,49312
Arthrodesis, ankle	49712
elbow	49106
finger/hand	46300,46303
foot	49815,49845
hip	49306
joint, other	50109
knee	49509,49512,49545
sacro-iliac joint	49300
shoulder	48939,48942
subtalar joint	50118
wrist	49200,49203
Arthroplasty, ankle	49715
carpal bone	46324,46325
finger/hand	46306-46321
foot	49839,49842
hip	49309-49333,49346
joint, other	50127
knee	49518-49534
shoulder	48915-48924
temporo-mandibular joint	45758
wrist	49209
Arthroscopy, ankle	49700,49703
elbow	49118,49121
hip	49360,49363,49366
joint, other	50100,50102
knee	49557-49566
shoulder	48945-48960
wrist	49218-49227
Arthrotomy, ankle	49706
elbow	49100
finger/hand	46327,46330
hip	49303
joint, other	50103
knee	49500
shoulder	48912
wrist	49212
Artificial erection device, insertion of	37426,37429
erection device, revision or removal of	37432
insemination services	13203,13209,13221
lens, insertion of	42701
lens, removal of	42704
lens, removal, replacement different lens	42707
lens, repositioning of, open operation	42704
urinary sphincter, insertion	37381,37384,37387
urinary sphincter, revision/removal	37390
Arytenoidectomy with microlaryngoscopy	41867
Aspiration biopsy, bone marrow	30087
biopsy, deep organ, imaging guided	30094
of bladder, needle	37041
of breast cyst	*
of haematoma	30216
of joint, other synovial cavity (restriction)	50124,50125
of thoracic cavity	38400,38403
Assistance at operations	51300-51318
Assisted reproductive technologies	13200-13221
Atherectomy, peripheral arterial	35312
Atresia, choanal, repair/correction	45645,45646
external auditory canal, reconstruction	45662
Atrial chamber/s, operations for arrhythmia	38512,38515
septal defect closure	38742
septectomy	38739
Attendance, acupuncture	173
anaesthetist, prior to anaesthesia	17603
antenatal	16500
care planning	720-728
case conferencing	740-773
consultant occupational physician	385-388
consultant physician (not psychiatry)	110-131
consultant psychiatrist	300-352
consultant public health medicine	410-417
contact lenses	10801-10816
emergency - after hours	1,2,97, 98
emergency - after hours (11pm to 7am)	601, 602,697,698
family group therapy	170, 171,172
general practitioner	1-51
general practitioner, emergency, after hours	1,2
health assessments	700-706
incentive items - PIP - general practitioner	2501-2559
incentive items - PIP - other non-preferred	2600-2677
intensive care unit (specialist)	13870,13873
other non-specialist	52-98
other non-specialist, emergency, after hours	97, 98
post-operative	(see note T8.7)
prolonged, lifesaving treatment	160-164
public health physicians	410-417
specialist	104-108
sports physicians	444-449
Atticotomy	41533,41536

*** Payable on attendance basis**

Service	Item
Audiogram	11309-11318
impedance	11324,11327,11330
Audiometry, brain stem evoked response	11300
non-determinate	11306
oto-acoustic emission audiometry	11332
Auditory canal, external	41524
- reconstruction of	
- reconstruction, congenital atresia	45662
- removal of foreign body, incision	41503
canal external, blind sac closure	41564
canal stenosis, correction of, with meatoplasty	41521
meatus, external, removal of exostoses in	41518
meatus, internal, exploration	41599
Augmentation mammaplasty	45524,45527,45528
Aural polyp, removal of	41506
Autoconjunctival transplant	42641
Avulsion, penis, repair of	37411
Axilla, lymph glands, excision of	30332
lymph nodes, excision of	30336,30335
Axillary hyperhidrosis, excision for	30180,30183
to femoral bypass grafting	32715
vessel, ligation/exploration, other	34103
Axillofemoral graft, infected, excision of	34172

B

Baker's cyst, excision of	30114
Balloon catheter, right heart, insertion of	13818
intubation, gastro-oesophageal	13506
valvuloplasty or septostomy	38270
Bartholin's abscess, incision of	35520
cyst or gland, marsupialisation of	35516,35517
cyst, excision of	35512,35513
Barton's fracture of radius, treatment of	47369,47372,47375
Basal cell carcinoma, removal of	31255-31295
Bat ear or similar deformity, correction of	45659
Bicornuate uterus, plastic reconstruction for	35680
Bile duct, common, radical resection	30461,30463,30464
duct fistula, repair of, after surgery	30470
duct, common, repair of	30472
duct, endoscopic stenting of	30491
Biliary atresia, paediatric, portoenterostomy for	43978
bypass	30460,30466,30467
dilatation, endoscopic	30494
drainage tube exchange, imaging guided	30451
manometry	30493
stricture, repair of	30469
Biopsy, aggressive bone/deep tissue tumour	50200
bone marrow	30081,30084,30087
breast	30360,30363
cervix, cone	35617,35618
cervix, punch	35608
conjunctiva	42676
drill, lymph gland, deep tissue/organ	30078
endometrial, for suspected malignancy	35620
endometrium	*
laparoscopic	30391
liver	30409,30411
lung, percutaneous needle	38412
lymph gland, muscle, other deep tissue/organ	30074,30075
lymph node of neck	31420
myocardial, by cardiac catherterisation	38275
needle aspiration	*
percutaneous aspiration, deep organ	30094
pleura	30090
prostate	37212,37215,37218
punch, of synovial membrane	30087
rectum, full thickness	32096
renal (closed)	36561
scalene node	30096
skin or mucous membrane	30071
thyroid	*
vertebra, needle	30093
Bladder, aspiration of, by needle	37041
biopsy of, with cystoscopy	36836
catheterisation of	36800
cystostomy or cystotomy	37008
diverticulum of, excision or obliteration	37020
ectopic, 'turning-in' operation	37842
enlargement of, using intestine	37047
excision of	37000,37014
exstrophy closure	37050
exstrophy of, repair of	37842
neck reconstruction, prostatectomy	37210,37211
neck resection, endoscopic	36854
repair of rupture	37004
stress incontinence, Stamey or similar	37043
stress incontinence, sling procedure	37042
stress incontinence, suprapubic procedure	37044
transection, with re-anastomosis to trigone	37053
tumour/s, diathermy/resection	36839,36845
tumour/s, laser destruction with cystoscopy	36839
washout test of	11921
Blepharospasm, injection of botulinus toxin	42827
Block, nerve, regional or field	(see nerve)
Blood, administration of	13703,13706
arterial, collection for pathology	13839,13842
collection of, for transfusion	13709
collection of, in infants, for pathology	13312
dye - dilution indicator test	11715
peripheral, invitro processing, cryopreservation	13760
pressure monitoring, indwelling catheter	11600,11601
pressure monitoring, indwelling catheter (ICU only)	13876
retrograde admin for cardioplegia	38588
sampling, fetal	16606
transfusion	13703,13706
transfusion, fetal	16609-16615
transfusion, paediatric/neonatal	13306,13309
volume estimation, nuclear	12500
Bone, cysts, injection into or aspiration of	47900
densitometry	12306-12321
excision of, with melanoma	31340

*** Payable on attendance basis**

Service	Item
flap, infected, craniectomy for	39906
graft to femur	48200,48203
graft to humerus	48212,48215
graft to other bones	48239
graft to phalanx or metacarpal	46402,46405
graft to radius and ulna	48221
graft to radius or ulna	48218,48224,48227
graft to scaphoid	48230,48233,48236
graft to spine	48642-48651
graft to tibia	48206,48209
graft, harvesting of	47726,47729,47732
graft, with internal fixation	48242
lesion/s, removal, diaphyseal aclasia	50426
marrow, administration of	13706
marrow, aspiration biopsy of	30087
marrow, harvesting of for transplantation	13700
marrow, in vitro processing/cryopreservation	13760
tumour, benign, resection of	50230
tumour, innocent, excision of	30241
tumour, malignant, operations for	50200-50239
Botulinum toxin injection into vocal cords	41869
Botulinus toxin injection for blepharospasm	42827
toxin injection for strabismus	42830
Boutonniere deformity, reconstruction of	46444,46447
Bowel, colectomy, total	32009-32021
hemicolectomy	32000,32003,32006
ileostomy closure/reservoir	32060-32069
large, resection of	32000,32003
large, subtotal colectomy	32004,32005
perineal proctectomy	32047
rectosigmoidectomy (Hartmann's op)	32030
rectum and anus, resection	32039-32046
rectum, resection of	32024-32028
resection for enterocolitis stricture, neonatal	43834
resection for jejunal atresia, neonatal	43810
restoration following Hartmann's op	32029,32033
ruptured, repair or removal of	30375
small, intubation	30487,30488
small, resection of	30565,30566
small, strictureplasty	30564
Brachial plexus, exploration of	39333
vessel, ligation/exploration, other	34106
Brachycephaly, cranial vault reconstruction for	45785
Brachytherapy planning	15536
For prostate cancer	15338,15513,15539,37220
Brain stem evoked response audiometry	11300
stem tumour, craniotomy for removal	39709
Branchial cyst, removal of	30286
fistula, removal of	30289
Breast, biopsy, fine needle, imaging guided	30360
abnormality detected by mammography	30343
benign lesion	30339,30340
central ducts, excision for benign condition	30367
core biopsy of solid tumour or tissue	30363
cyst, aspiration of	*
exploration/drainage, operating theatre	30364
lesion, pre-op localisation, imaging guided	30361
malignant tumour	30344,30347
mammaplasty	45524,45527,45528
manipulation tissue surrounding prosthesis	*
mastectomy	(see mastectomy)
microdochotomy	30366
nipple, accessory, excision of	30372
prosthesis operations	45548-45554
pstosis, correction of (unilateral)	45556,45557
ptosis, correction of (bilateral)	45558
reconstruction	45530-45542
silicone prosthesis, removal of	45555
tissue, accessory, excision of	30369
tumour site, re-excision	30348
Broad ligament cyst/tumour, excision/removal	35712-35717
Brodie's abscess, operation for	43515
Bronchial tree, intrathoracic operation on, other	38456
Bronchoscopy, as an independent procedure	41889
with biopsy or other procedure	41892
with dilatation of tracheal stricture	41904
with transbronchial lung biopsy	41898
Bronchospirometry	11500
Bronchus, dilatation of stricture and stent insertion	41905
operations on	41889,41892,41895
removal of foreign body in	41895
Broviac catheter, insertion of, for chemotherapy	34527,34528
catheter, removal of	34530
Bubonocele operation	30612,30614
Bunion, excision of	47933
Burch colposuspension	37044
Burns, dressing of (not involving grafting)	30003-30014
excision of under GA (not involving grafting)	30017,30020
free grafting	45406-45494
scars, excision of	45519
Burr-hole craniotomy, intracranial haemorrhage	39600
placement of intracranial electrodes	40709
single, preparatory to ventricular puncture	39012
Bursa, incision of	*
large, excision of	30110,30111
semimembranosus, excision of	30114
small, excision of	30106,30107
Burst abdomen, repair of	30403
Bypass, extracranial to intracranial	39818
graft, infected, of extremities, excision of	34175
graft, infected, of neck, excision of	34157
graft, infected, of trunk, excision of	34169
grafting for aneurysm	33050,33055
grafting, arterial, for occlusive arterial disease	32700-32763
grafting, cross leg, saphenous to iliac or femoral vein	34806

C

C-13 or C-14 urea breath test	12533
Caecostomy, involving laparotomy	30375
closure of	30562
Caesarean section	16520,16522

*** Payable on attendance basis**

Service	Item
Calcaneal spur, of foot, excision of	49818
Calcanean bursa, excision of	30110,30111
Calcaneum fracture, treatment of	47606-47618
Calculus, biliary, extraction of	30454-30458
biliary/renal tract, extraction of	30450
bladder, removal of	36863
kidney, removal of	36540,36543
renal, extraction of	36627-36648
staghorn, nephrolithotomy and/or pyelolithotomy	36543
sublingual/salivary gland duct, removal of	30265,30266
ureter, removal of	36549
ureteric, endoscopic removal/manipulation	36857
Caldwell-Luc operation	41710
Calf, decompression fasciotomy of	47975,47978,47981
Caloric test of labyrinth(s)	11333,11336
Cancer of skin/mucous membrane, removal	30196-30205
Cannulae, membrane oxygenation	38627
bypass	38627
ventricular assist	38627
Cannulation, arterial, for infusion chemotherapy	34524
central vein	13318,13815
central vein, subcutaneous tunnel	34527
coronary sinus, for admin of blood or crystalloid	38588
for cardiopulmonary bypass	38600,38603
for retrograde cerebral perfusion	38577
intra-abdominal vessel, for chemotherapy	34521
peripheral arterial	35317-35321
peripheral venous	35317,35319,35320
pulmonary artery	13818
umbilical artery	13303
umbilical/scalp vein in neonate	13300
Canthoplasty	42590
Capsule, posterior, needling of	42737
Capsulectomy	42719,42722,42731
of finger joints	46336
Capsulotomy, laser	42788,42789
other than laser	42734
Carbolisation of eye	*
Carbon dioxide laser resurfacing, face or neck	45025,45026
dioxide output, estimation of	11503
labelled urea breath test	12533
Carbuncle, incision and drainage, with GA	30223
Carcinoma	(see tumour)
Cardiac by-pass, whole body perfusion	22060
catheterisation	38200-38218
catheterisation - for myocardial biopsy	38275
deep hypothermic circulatory arrest	22075
electrophysiological studies	38209,38212,38213
operation (intrathoracic), other	38456
pacemaker, insertion/replacement	38281
rhythm, restoration, electrical stimulation	13400
surgery, for congenital heart disease	38700-38766
surgery, re-operation via median sternotomy	38640
tumour, excision of	38670-38680
Cardiopexy, antireflux operation	30530
Cardioplegia, retrograde administration of	22070
Cardiopulmonary bypass, cannulation for	38600,38603
support procedures	13815-13857
Cardiotocography, antenatal (restriction)	16514
Cardioversion	13400
Care planning	720-728
Carotid artery, aneurysm, graft replacement	33100
artery, internal, transection/resection	32703
body tumour, resection of	34148,34151,34154
cavernous fistula, obliteration of	39815
vessels, examination of	11618,11621,11624
Carpal bone, replacement arthroplasty	46324,46325
ligament, transverse, division of	39331
resection arthroplasty	46325
scaphoid, fracture, treatment of	47354,47357
tunnel release	39331
Carpometacarpal joint, arthrodesis of	46303
joint, dislocation, treatment of	47030,47033
joint, synovectomy of	46342
Carpus dislocation, treatment of	47030,47033
fracture, treatment of	47348,47351
operation on, acute osteomyelitis	43503,46462
operation on, chronic osteomyelitis	43512,46462
osteectomy/osteotomy of	48406,48409
Cartilage, tarsal, excision of	42578
excision of, with melanoma	31340
Caruncle, urethral, cauterisation of	35523
urethral, excision of	35526,35527
Case conferencing	740-773
Cataract, juvenile, removal of	42716
surgery	42702
Catheter, peritoneal insertion and fixation	13109
epidural, insertion of	39140
tenckhoff peritoneal dialysis, removal of	13110
Catheterisation, bladder, independent procedure	36800
blood pressure monitoring	11600,11601,13876
cardiac	38200-38218
central vein	13318,13319,13815
central vein, subcutaneous tunnel	34527,34528
eustachian tube	41755
frontal sinus	41740
intracranial, for pressure monitoring	13830
peripheral arterial	35317-35321
peripheral venous	35317,35319,35320
peritoneal, for dialysis	13109,13110
pulmonary artery	13818
right heart balloon	13818
umbilical artery	13303
umbilical or scalp vein in a neonate	13300
ureteric, with cystoscopy	36824
Caudal infusion/injection	(see Intrathecal)
Cauterisation, angioma (restriction applies)	45027
cervix	35608
perforation of tympanum	41641
septum/turbinates/pharynx	41674
tarsus, for ectropian/entropian	42581
urethra or urethral caruncle	35523

*** Payable on attendance basis**

Service	Item
Cautery, conjunctiva, including treatment of pannus	42677
nasal, for arrest of haemorrhage	41677
Cavernous sinus, tumour or vascular lesion, excision	39660
Cavopulmonary shunt, creation of	38733,38736
Cellulitis, incision with drainage, under GA	30223
Central cannulation for cardiopulmonary bypass	38600
nervous system evoked responses	11024, 11027
vein catheterisation	13318,13319,13815
vein catheterisation, via subcutaneous tunnel	34527,34528
Cerebello-pontine angle tumour	41575-41579
- retromastoid removal of	41575-41579
- translabyrinthine removal	41575-41579
- transmastoid removal	41575-41579
Cerebral palsy, hips or knees, application of cast under GA	50390
perfusion, retrograde, cannulation for	38577
tumour, craniotomy for removal	39712
ventricle, puncture of	39006
Cerebrospinal fluid drain, lumbar, insertion of	40018
fluid reservoir, insertion of	39018
Cervical decompression of spinal cord	40331-40335
discectomy (anterior), without fusion	40333
oesophagectomy	30294
oesophagostomy, closure or plastic repair of	30293
re-exploration for hyperparathyroidism	30317
rib, removal of	34139
sympathectomy	35003,35006
Cervix, amputation or repair of	35617,35618
cauterisation of, other than by chemical means	35608
colposcopic examination of	35614
colposcopy with biopsy and diathermy	35646
cone biopsy of	35617,35618
diathermy of	35608,35646
electrocoagulation diathermy	35644,35645
ionisation of	35608
large loop excision	35647,35648
laser therapy (restriction applies)	35539,35542,35545
punch biopsy	35608
purse string ligation	16511
removal of polyp from	35611
removal of purse string ligature	16512
repair of extensive laceration/s	16571
repair of, not otherwise covered	35617,35618
residual stump, removal of, abdominal approach	35612
residual stump, removal of, vaginal approach	35613
Chalazion, extirpation of	42575
Chemical peel, full face	45019,45020
Chemotherapy	13915-13936
device for drug delivery, loading of	13939,13942,13945
device, insertion, central vein catheterisation	34527,34528
device, removal of	34530
infusion, cannulation for	34521,34524
Chest, or limb, decompression escharotomy	45054
Chloasma, full face chemical peel	45019,45020
Choanal atresia, repair/correction	45645,45646
Cholangiogram, percutaneous transhepatic	30440
Cholangiography, operative	30439
Cholangiopancreatography	30484
Cholecystectomy	30443-30449
Cholecystoduodenostomy	30460,31472
Cholecystoenterostomy	30460,31472
Cholecystostomy	30375
Choledochal cyst, resection of	43972,43975
Choledochoduodenostomy	30460,30461
Choledochoenterostomy	30460,30461
Choledochogastrostomy	30461
Choledochojejunostomy	30460,30461
Choledochoscopy	30442,30452
Choledochotomy	30454,30455,30457
Chondro-cutaneous or chondro-mucosal graft	45656
Chondroplasty of knee	49503,49506
Chordee, correction of	37417
Chorionic villus sampling	16603
Chymopapain (Discase), intradiscal injection of	40336
Cicatricial flexion/extension contracture, joint, correction	50112
Ciliary body and/or iris, excision of tumour	42767
Circulatory support device, management of	13851,13854
support procedures	38600-38624
Circumcision	30653-30660
arrest of post-operative haemorrhage	30663
- with GA	
- 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
Clival tumour, removal of	39653-39658
Cloaca, persistent, correction of	43969
Cloacal exstrophy, neonatal, operation for	43882
Club hand, radial, centralisation/radialisation	50399
Coccyx, excision of	30672
Cochlear implant, insertion with mastoidectomy	41617
tests	11318,11321
Cochleotomy, or repair of round window	41614
Coeliac artery, decompression of	34142
Colectomy, subtotal, of large intestine	32004,32005
total, for Hirschsprung's, paediatric	43996
total, with excision rectum/anastomosis	32051,32054,32057
total, with excision rectum/ileostomy	32015,32018,32021
total, with ileo-rectal anastomosis	32012
total, with ileostomy	32009
Colles' fracture of radius, treatment of	47369,47372,47375
Colonic atresia, neonatal, laparotomy for	43816

*** Payable on attendance basis**

Service	Item
lavage, total, intra-operative	32186
reservoir, construction of	32029
Colonoscopy, fibreoptic	32084-32093
Colorectal strictures, endoscopic dilatation of	32094
Colostomy, closure of	30562
entero-	30515
lavage of	*
refashioning of	30563
with laparotomy	30375
with laparotomy, neonatal anorectal malformation	43822
Colotomy, with laparotomy	30375
Colour discrimination test, Farnsworth Munsell	*
Colpoperineorrhaphy	35576,35580
Colpopexy	35590
Colpoplasty	35584
Colposcopy, using Hinselmann-type instrument	35614
with other procedures	35644-35647
Colpotomy	35572
Composite graft to nose, ear or eyelid	45656
Computerised perimetry	11221-11225
Condylectomy	45611,48406,48424
of mandible	45611
Cone biopsy of cervix	35617,35618
Confinement	16515-16525
Congenital absence of vagina, reconstruction for	35565
atresia, auditory canal reconstruction	45662
heart disease, operations for	38700-38766
Conjunctiva, cautery of	42677
biopsy of	42676
cryotherapy to	42680
removal of tumour from	(see tumour,other)
Conjunctival cysts, removal of	42683
graft over cornea	42638
lacerations not involving sclera	30032
peritomy	42632
Conjunctivorhinostomy	42629
Consultation	(see attendances)
Contact lenses, attendances	10801-10816
Contour reconstruction, insertion of foreign implant	45051
restoration of face, autologous bone/cartilage graft	45647
Contraceptive device, intra-uterine, introduction of	35503
device, intra-uterine, removal under GA	35506
Contracted socket, reconstruction	42527
Contracture, cicatricial flexion/extension of joint, correction	50112
Dupuytren's, subcutaneous fasciotomy for	46366
flexor/extensor, digits of hand, correction of	46492
Cordotomy, laminectomy for	39124
percutaneous	39121
Cornea, conjunctival graft over	42638
epithelial debridement for corneal ulcer/erosion	42650
epithelial debridement for keratoplasty	42651
removal of imbedded foreign body	42644
removal of superficial foreign body	30061
transplantation of	42653,42656,42659
Corneal blood vessels, laser coagulation of	42797
incisions, non penetrating	42674
keratoplasty, epithelial debridement for	42651
perforations, sealing of	42635
scars, excision of	42647
suture, running, manipulation of	42667
sutures, removal of	42668
ulcer, epithelial debridement of cornea for	42650
ulcer, ionisation of	*
Coronary artery bypass operations	38497,38500,38503
artery bypass vein graft, dissection	38637
endarterectomy, open operation	38505
Corpus callosum, anterior section of, for epilepsy	40700
Corticectomy, for epilepsy	40703
Corticolysis of lens material	42791,42792
Costo-transverse joint, injection into	39013
Counterpulsation, intra-aortic balloon, management	13845,13848
Cranial nerve, intracranial decompression of	39112
shunt diversion, insertion of	40003
shunt, revision or removal of	40009
vault reconstruction	45785
Craniectomy and removal of haematoma	39603
for osteomyelitis/removal infected bone	39906
Craniocervical junction lesion, transoral approach for	40315
Craniopharyngioma, craniotomy for removal of	39712
Cranioplasty and repair of fractured skull	39615
reconstructive	40600
Craniostenosis, operations for	40115,40118
Craniotomy and tumour removal	39709,39712
burr-hole for intracranial haemorrhage	39600
for arachnoidal cyst	39718
for hydromyelia (with laminectomy)	40342
for reopening post-op for haemorrhage/swelling	39721
Cricopharyngeal myotomy	41776
Cricothyrostomy	41884
Cruciate ligaments, reconstruction/repair	49536,49539,49542
Cryocautery of skin lesions	30189,30192,30195
Cryoneurotomy of peripheral nerves	39323
Cryosurgery to haemorrhoids with rubber band ligation	32135
Cryotherapy for detached retina	42773
for trichiasis	42587
hepatic, destruction of liver tumours	30419
of retina, with vitrectomy	42728
to nose, for haemorrhage	41680
to retina, independent procedure	42818
Crystalloid, retrograde admin for cardioplegia	38588
Curettage, for evacuation of gravid uterus	35643
uterus (D and C)	35639,35640
Cutaneous neoplastic lesions, treatment of	30195
nerve, nerve graft to	39318
nerve, repair of	39300,39303
ureterostomy, closure of	36621
vesical fistula, operation for	37023
vesicostomy, establishment of	37026
Cyclodestructive procedures for treatment of glaucoma	42770,42771

*** Payable on attendance basis**

Service	Item
Cyst, arachnoidal, craniotomy for	39718
Baker's, excision of	30114
Bartholin's, cautery destruction of	35516,35517
Bartholin's, excision of	35512,35513
Bartholin's, marsupialisation of	35516,35517
bone, injection into or aspiration of	47900
brain, operations for	39703
branchial, removal of	30286
breast, aspiration of	*
broad ligament, excision of	35712-35717
bronchgenic, thoracotomy and excision	43912
choledochal, resection of	43972,43975
enterogenous, thoracotomy and excision	43912
epididymal, removal of	37601
fimbrial, excision of	35712-35717
hydatid, liver, treatment of	30434-30438
hydatid, lungs, enucleation of	38424
intracranial, needling and drainage of	39703
kidney, removal from	36558
liver, laparoscopic marsupialisation	30416,30417
mucous, of mouth, removal	30282,30283
other, removal of	31200-31240
ovarian, aspiration of	35518
ovarian, excision of, with laparotomy	35712-35717
pancreatic, anastomosis	30586,30587
parovarian, excision of, with laparotomy	35712-35717
pharyngeal, removal of	41813
pilonidal, excision of	30675,30676
renal, excision of	36558
skin/subcutaneous/mucous membrane, removal of	31200-31240
tarsal, extirpation of	42575
thyroglossal, removal of	30313,30314
vaginal, excision of	35557
vallecular, removal of	41813
Cystadenomatoid malformation, neonatal, thoracotomy	43861
Cystocele, repair of	35576,35580
Cystometrography	11903
with other procedures	11912,11915,11918
Cystoscopy, with	36836
- biopsy of bladder	
- controlled hydrodilatation of bladder	36827
- diathermy or resection of bladder tumour/s	36839,36845
- endoscopic incision/resection	36825,36854
- injection into bladder wall	36851
- insertion of ureteric stent, or brush biopsy	36821
- insertion of urethral prosthesis	36811
- laser destruction of bladder tumours	36839
- lavage of blood clots from bladder	36842
- removal of foreign body	36833
- resection of ureterocele	36848
- ureteric catheterisation	36818,36824
- ureteric meatotomy	36830
- urethroscopy with/without urethral dilatation	36812
- without litholapaxy	36863
- without urethroscopy	36815
Cystostomy, suprapubic	37008
suprapubic, change of tube	*
Cystotomy, suprapubic	37008,37011
Cytotoxic agent, instillation into body cavity	13948

D

D and C	35639,35640
Dacryocystectomy	42596
Dacryocystorhinostomy	42623,42626
Dark Adaptometry	11211
Debridement of contaminated wound	30023
of tissue, ischaemic limb	35100,35103
Debulking operation, gynaecological malignancy	35720
Decompression fasciotomy, calf/forearm	47975,47978,47981
fasciotomy, hand	47981
of Arnold-Chiari malformation	40106
of facial nerve, mastoid portion	41569
of intracranial tumour	39706
operation for priapism	37393
subtemporal	40015
Deep organ, percutaneous aspiration biopsy	30094
tissue or organ, biopsy of	30074,30075,30078
Defibrillator generator, insertion/replacement	38524
insertion of patches for	38521
Delorme procedure	32111
Dermabrasion	45021,45024
Dermo-fat or fascia graft	45018
Dermoid, excision of	(see tumour,other)
nasal, excision of	41729
orbital, excision of	42574
periorbital, excision of	42573
Detached retina, diathermy/cryotherapy	42773
retina, removal of silicone band	42812
retina, resection/buckling/revision	42776
Dialysis, peritoneal	13112
peritoneal, supervision in hospital	13100,13103
Diaphragm, plication of for eventration	43915
Diaphragmatic hernia, neonatal, repair of	43837,43840
hernia, repair of	30600,30601
hernia, simple closure of	30387
Diaphyseal aclasia, removal of lesion/s from bone	50426
Diastematomyelia, tethered cord, release of	40112
Diathermy of bladder tumours	36839,36845
cervix	35608,35646
detached retina	42773
electrocoagulation, of cervix	35644,35645
palmar or plantar wart	30186
perforation of tympanum	41641
pharynx	41674
rectal polyps with sigmoidoscopy	32078
salivary gland duct	30262
septum	41674
starburst vessels, head or neck	30213,30214
telangiectases, head or neck	30213,30214
turbinates	41674

*** Payable on attendance basis**

Service	Item
urethra	37318
Diffusing capacity	11503
Digit, amputation of	46464-46480
distal, excision of ganglion/mucous cyst	46495
extra, amputation of	46464
flexor/extensor contracture, correction of	46492
or ray, transposition/transfer, vascular pedicle	46507
synovectomy of tendon/s	46348-46360
transposition/transfer, vascular pedicle	46507
Digital nail, toe, removal of	47904,47906
nerve, nerve graft to	39318
nerve, repair of	39300,39303
temperature, measurement of	11615
Direct flap repair	45209-45224
Disarticulation, of limb	(see amputation)
Disc, intervertebral, laminectomy for removal	40300
intervertebral, microsurgical discectomy of	40301
lesion, recurrent, laminectomy for	40303
Discectomy, cervical (anterior), without fusion	40333
microsurgical, of intervertebral disc/s	40301
percutaneous lumbar	48636
Disimpaction of faeces under GA	32153
Dislocations, treatment of	(see body part)
Dissection, lymph nodes of neck	31423-31438
Diverticulum, bladder, excision/obliteration	37020
Meckel's, removal of	30375
urethral, excision of	37372
Dohlman's operation	41773
Domiciliary Medication Management Review	900
Donald-Fothergill operation	35584
Donor haemapheresis	13755
Doppler recordings, carotid vessels	11618,11621,11624
recordings, peripheral vessels	11603-11612
Double vagina, excision of septum	35566
Drez lesion, operation for	39124
Drill biopsy of lymph gland/deep tissue/organ	30078
Drug delivery device, loading of	13939,13942,13945
Duct, salivary gland, diathermy/dilatation	30262
salivary gland, major, transposition of	41910
salivary gland, marsupialisation	30265,30266
salivary gland, meatotomy	30265,30266
salivary gland, removal of calculus	30265,30266
Ducts submandibular, removal of	30255
Duodenal atresia, duodeno-duodenostomy/jejunostomy	43807
intubation	30487,30488
stenosis, duodeno-duodenostomy/jejunostomy	43807
ulcer, perforated, laparotomy and suture	30375
Duodenoduodenostomy for duodenal atresia/stenosis	43807
Duodenojejunostomy for duodenal atresia/stenosis	43807
Duodenoscopy	30473,30476,30478
Dupuytren's contracture, operations for	46366-46393
Dysthyroid eye disease, decompression of orbit	42545

E

E.C.G.	11700-11713
E.C.T.	14224
E.E.G.	11000, 11003, 11006
E.M.G.	11012,11021,11833
E.N.G.	11339
ESWL	36546
Ear, composite graft to	45656
drum perforation, excision of rim	41644
external, complex total reconstruction of	45660,45661
full thickness laceration, repair of	30052
full thickness wedge excision of	45665
lop, bat or similar deformity, correction of	45659
middle, clearance of	41635,41638
middle, exploration of	41629
middle, insertion of tube for drainage of	41632
middle, operation for abscess or inflammation of	41626
removal of foreign body from	41500,41503
syringe of	*
toilet, using operating microscope	41647
ventilating tube, removal	*
Eclampsia, treatment of	16509
Ectopic bladder, 'turning-in' operation	37842
pregnancy, removal of	35676,35677,35678
pregnancy, ultrasound guided needling and injection	35674
Ectropion, correction of	45626
tarsal cauterisation for	42581
Elbow, arthrodesis of	49106
arthroscopic surgery of	49121
arthroscopy of, diagnostic	49118
arthrotomy of	49100
dislocation, treatment of	47018,47021
flexorplasty/tendon transfer to restore function	50405
ligamentous stabilisation of	49103
radial head, replacement of	49112
total replacement of	49115
total synovectomy of	49109
Electrical stimulation, maximal perineal	*
stimulation, restoration cardiac rhythm	13400
Electrocardiography	11700-11713
Electrocochleography	11303,11304
Electroconvulsive therapy	14224
Electrocorticography	11009
Electrode(s), epidural, insertion by laminectomy	39139
epidural, percutaneous insertion of	39130
epidural, percutaneous, management of	39131
graciloplasty, insertion of	32206
intracranial placement	40709,40712
myocardial, permanent, insertion, thoracotomy	38470
pacemaker, permanent, insertion, sub-xyphoid	38473
transvenous, insertion of	38256,38284
Electrodiagnosis, neuromuscular	11012-11021
Electroencephalography (E.E.G)	11000, 11003, 11006
Electrolysis epilation, for trichiasis	42587
Electromyography (E.M.G.)	11012,11021,11833
Electroneurography of facial nerve	11015
Electronystagmography (E.N.G.)	11339
Electrooculography	11205

*** Payable on attendance basis**

Service	Item
Electrophysiological studies, cardiac	38209,38212,38213
Electroretinography	11206,11209
Embolectomy	33803,33806
Embolus, removal from artery of neck	33800
Emergency, after hours	1,2,97, 98
Emergency, after hours (11pm to 7am)	601, 602, 697, 698
Emphysema, lobar, neonatal, thoracotomy & lung resection	43861
Empyema, intercostal drainage of	38409,38410
radical operation for	38415
Enbloc resection of tumour	50212-50227
Encephalocoele, excision and closure of	40109
Endarterectomy	33500-33542
coronary, open operation	38505
to prepare bypass site for anastomosis	33554
Endobronchial tumour, endoscopic laser resection	41901
Endocarditis, operative management of	38493
Endocrine tumour, exploration of	30578,30580,30581
Endolymphatic sac, transmastoid decompression	41590
Endometrial biopsy for suspected malignancy	35620
Endometriosis, laparoscopic ablation	35638
Laparoscopic resection of	35641
Endometrium, ablation of, endoscopic	35622
biopsy of	*
biopsy of for suspected malignancy	35620
biopsy of with hysteroscopy	35630
endoscopic examination and ablation by microwave	35616
Endoscopic biliary dilatation	30494
cholangio-pancreatography	30484
dilatation of colorectal strictures	32094
examination of intestinal conduit/reservoir	36860
examination of small bowel	30569,32095
gastrostomy, percutaneous	30481,30482
incision/resection, external sphincter/bladder neck	36854
laser ablation of prostate	37207,37208
laser resection of endobronchial tumours	41901
laser therapy of gastrointestinal tract	30479
manipulation/extraction of ureteric calculus	36857
prostatectomy	37203,37206
resection of pharyngeal pouch	41773
sphincterotomy	30485
stenting of bile duct	30491
Endoscopy with balloon dilatation gastric stricture	30475
Enterocele, repair of	35590,35593
Enterocolitis, acute neonatal necrotising, laparotomy	43828,43831
necrotising stricture, bowel resection	43834
Enterocolostomy	30515
Enterocutaneous fistula, radical repair of	30382
Enteroenterostomy	30515
Enterostomy, closure of	30562
with laparotomy	30375
Enterotomy, intra-operative, for endoscopy	30568
Entropion, correction of	45626
repair of	42866
Enucleation of eye	42506,42509
hydatid cysts of lung	38424
Epicondylitis, open operation for	47903
Epicutaneous patch testing	12012-12021
Epididymal cyst, excision of	37601
Epididymectomy	37613
Epidural blood patch	18233
catheter, insertion of	39140
electrode, insertion	39130,39139
electrode, management, adjustment etc.	39131
implant, removal of	39136
infusion/injection	(see Group T7)
stimulator, revision of	39133
Epigastric hernia, repair of	30616-30621
Epilation electrolysis, for trichiasis	42587
Epilepsy, operations for	40700-40712
Epiphyseal arrest	48500-48509
plate, prevention of closure	48512
Epiphysiodesis, femur/fibula/tibia	48500,48503,48506
staple arrest of hemi-epiphysis	48509
Epiphysiolysis, to prevent closure of plate	48512
Epispadias, repair of	37836,37839,37842
Epistaxis, treatment of	41656,41677,41680
Epithelial debridement for corneal ulcer/erosion	42650
debridement/eliminating band keratyoplasty	42651
Ergometry, with electrocardiography	11712
Erythrocyte radioactive uptake survival time	12503
screening test, volume Cr51	12500
Escharotomy, decompression, limb or chest	
Ethmoidal artery, transorbital ligation of	41725
sinuses, operation on	41737,41749
Ethmoidectomy, fronto-nasal	41731
fronto-radical	41734
transantral, with radical antrostomy	41713
Eustachian tube, catheterisation of	41755
obliteration of	41564
Evacuation of retained products of conception	16564
Eventration, plication of diaphragm for	43915
Evisceration of globe of eye	42512,42515
Evoked response audiometry, brain stem	11300
responses, central nervous system	11024, 11027
Exenteration of orbit of eye	42536
Exomphalos, neonatal, operations for	43870,43873
Exostoses in external auditory meatus, removal	41518
Exostosis, excision of	47933,47936
Exstrophy, cloacal, neonatal, operation for	43882
of bladder, closure	37050
of bladder, repair of	37842
Extensor tendon of hand or wrist, repair of	46420,46423
tendon of hand, tenolysis of	46450
tendon, synovectomy of	46339
External auditory canal, reconstruction	41524,45662
auditory meatus, removal of exostoses	41518
cephalic version	16501
ear, complex total reconstruction of	45660,45661
fixation, orthopaedic, removal	47948,47951
stent, application	34824-34833

*** Payable on attendance basis**

Service	Item
External cephalic version	16501
Extra digit, amputation of	46464
Extracardiac conduit, insertion/replacement	38757,38760
Extracorporeal shock wave lithotripsy	36546
Extracranial to intracranial bypass	39818,39821
Extradural tumour or abscess, laminectomy for	40309
Eye, capsulotomy, laser	42788,42789
carbolisation of	*
coagulation, laser, of corneal/scleral blood vessels	42797
conjunctiva, cautery of	42677
conjunctival graft	42638
corticolysis, laser, of lens material	42791,42792
dermoid, excision of	42573,42574
division of suture, laser	42794
enucleation of	42506,42509,42510
fibrinolysis	42791,42792
foreign body in cornea or sclera, removal of	42644
foreign body in, removal of	42560-42569
foreign body in, superficial, removal of	30061
globe of, evisceration of	42512
investigation of ocular surface dysplasia	11235
iridotomy, laser	42785,42786
iris tumour, laser photocoagulation	42806
orbit, insert/remove implant	42518
paracentesis	42734
phototherapeutic keratectomy, laser	42810
pinguecula, surgical excision	42689
trabeculoplasty, laser	42782
vitreolysis, laser, of lens material	42791
Eyeball, repair of perforating wound	42551,42554,42557
Eyebrow, elevation of	42872
Eyelashes, ingrowing, operation for	45626
Eyelid closure in facial nerve paralysis, implant insertion	42869
composite graft to	45656
ectropion or entropion, correction of	45626
full thickness laceration, repair of	30052
full thickness wedge excision of	45665
grafting for symblepharon	45629
ptosis, correction of	45623
reconstruction of, whole thickness	45614,45671,45674
reduction of	45617,45620
removal of cyst from	42575
tarsorrhaphy	42584
upper recession of	42863

F

Face, repair of complex fractures	45753,45754
chemical peel	45019,45020
Facet joint denervation by percutaneous neurotomy	39118
Facial, nerve, decompression of	41569
nerve palsy, excision of tissue for	45581
nerve paralysis, plastic operation for	45575,45578
scar, revision of (restriction applies)	45506,45512
Facio-hypoglossal/accessory nerve, anastomosis of	39503
Fallopian tubes, catheterisation, with hysteroscopy	35633
tubes, Rubin test for patency	35706
tubes, hydrotubation of	35703,35709
tubes, implantation of, into uterus	35694,35697
tubes, microsurgical anastomosis	35700
tubes, sterilisation	35687,35688
tubes, sterilisation with Caesarean section	35691
Falloposcopy, unilateral/bilateral	35710
Family group psychotherapy	342,344,346
group therapy	170, 171,172
Farnsworth Munsell colour discrimination test	*
Fascia, deep, repair of, for herniated muscle	30238
graft	45018
Fasciectomy, for Dupuytren's Contracture	46369-46393
Fasciotomy, forearm or calf	47975,47978,47981
interosseous muscle space of hand	47981
muscle	30226
plantar, radical	49854
subcutaneous, Dupuytren's contracture	46366
Femoral hernia, repair of	30609,30612,30614
vein puncture in infants, blood collection	13312
vessel, ligation/exploration, other	34103
Femoro-femoral crossover bypass grafting	32718
graft, infected, excision of	34172
Femur, bone graft to	48200,48203
congenital deficiency, treatment of	50411,50414
drill decompression of head/neck or both	47982
epiphyseodesis	48500,48506
fracture, treatment of	47516-47537,49336
operation on, for osteomyelitis	43506,43515
osteectomy/osteotomy	48424,48427
Fenestration cavity, venous graft to	41605
operation	41602
Fibreoptic bronchoscopy	41898
colonoscopy	32084-32093
Fibrinolysis	42791,42792
Fibroma, removal of	(see tumour,other)
Fibula, congenital deficiency, transfer fibula to tibia	50423
epiphyseodesis	48503,48506
fracture, treatment of	47576
operation on, for osteomyelitis	43503,43512
osteectomy/osteotomy	48406,48409
Field block	(see nerve)
Filtering and allied operations for glaucoma	42746
Fimbrial cyst, removal of	35712-35717
Finger, amputation of	46465-46483
digital nail, removal of	46513,46516
dislocation, treatment of	47036,47039
flexor tendon sheath, open operation	46522
fracture, treatment of	47300-47333
ingrowing nail, resection of	46528,46531
mallet, fixation/repair	46438,46441
percutaneous tenotomy of	46456
trigger, correction of	46363
Fissure in ano, operation for	32150
Fistula, alimentary, repair of	35596
anal, excision/repair	32159-32166

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Service	Item
antrobuccol, operation for	41722
aorto-duodenal, repair of	34160,34163,34166
arteriovenous, dissection, ligation	34112,34115,34118
arteriovenous, dissection, repair	34121-34130
arteriovenous, ligation cervical vessel/s	39812
branchial, removal of	30289
carotid-cavernous, obliteration of	39815
cutaneous, salivary gland, repair of	30269
enterocutaneous, radical resection	30382
genito-urinary, repair	35596
in ano, subcutaneous, excision of	32156
oro-antral, plastic closure of	41722
parotid gland, repair of	30269
sacrococcygeal, excision of	30675,30676
thyroglossal, radical removal of	30314
tracheo-oesophageal, division and repair	43900
urethral, closure of	37833
urethro-rectal	37336
urethro-vaginal	37333
vesical, cutaneous, operation for	37023
vesico-intestinal, closure of	37038
vesico-vaginal, closure of	37029
wound, review under GA, independent	32168
Fixation, external, removal of	47948,47951
internal, of spine	48678-48690
Flap, Abbe	45701,45704
direct, indirect or local, revision of	45239
free tissue transfer, revision of	45496-45499
indirect	45227-45236
myocutaneous, delay of	45015
myocutaneous, for breast reconstruction	45530
neurovascular island	45563,46504
pharyngeal, for velo-pharyngeal incompetence	45716
repair, direct	45209-45224
repair, local, single stage	45200,45203,45206
repair, muscle, single stage	45000-45012
Flexor tendon, hand, repair of	46426-46435
tendon pulley, reconstruction	46411
tendon sheath, finger or thumb, open operation	46522
tendon, hand, tenolysis of	46453
tendon, hand/wrist, synovectomy of	46339
tendon, wrist, repair of	46426,46429
tendon/s, digit, synovectomy of	46348-46360
Flexorplasty to restore elbow function	50405
Flow volume loops	11512
Fluid balance, supervision of	*
Foetal blood sampling	
fluid filled cavity, drainage of	
intraperitoneal blood transfusion	
intravascular blood transfusion	
Foeto-amniotic shunt, insertion of	16627
Foot, amputation or disarticulation of	44359,44361,44364
and ankle, tibialis tendon transfer	50339,50342
arthrodesis of	49815,49845
calcaneal spur, excision of	49818
claw or hammer toe, correction of	49848,49851
hallux valgus or hallux rigidus, correction of	49821-49842
metatarso-phalangeal joint, replacement of	49857
metatarso-phalangeal joint, synovectomy of	49860,49863
neurectomy for plantar digital neuritis	49866
paronychia of, pulp space infection, incision	47912
radical plantar fasciotomy or fasciectomy of	49854
tendon of, repair of	49800,49803
tendon or ligament transplantation of	49812
tenotomy of	49806,49809
tibialis tendon transfer	50339,50342
For anaesthesia	20100-25205
Foramen Magnum, tumour or vascular lesion, excision	39662
Forearm, amputation or disarticulation of	44328
decompression fasciotomy of	47975,47978,47981
fracture, treatment of	47378-47393
radial aplasia/dysplasia, centralisation/radialisation	50399
Foreign body, antrum, removal of	41716
bladder, cystoscopic removal of	36833
bronchus, removal of	41895
cornea or sclera, imbedded, removal of	42644
cornea or sclera, superficial, removal of	30061
ear, removal of	41500,41503
implant, contour reconstruction, insertion	45051
intra-ocular, removal of	42560-42569
joint, removal of	(see arthrotomy)
maxillary sinus, removal of	41716
muscle/deep tissue, removal of	30067,30068
nose, removal of	41659
oesophagus, removal of	41825
subcutaneous, removal of	30064
superficial, removal of	30061
tendon, removal of	30067,30068
trachea, removal of	41886
urethra, removal of	37318
Fractures, treatment of	(see body part)
Free grafts	45400-45494
split skin, to burns	45460-45494
transfer of tissue	45563-45565
transfer of tissue, anastomosis artery/vein	45502
Frenulum, mandibular or maxillary, repair	30281
Frontal sinus, catheterisation of	41740
sinus, intranasal operation on	41737
sinus, radical obliteration of	41746
sinus, trephine of	41743
Fronto-ethmoidectomy, radical	41734
Fronto-nasal ethmoidectomy	41731
Fronto-orbital advancement	45782,45785
Full thickness grafts, free	45451
thickness wedge excision of lip, eyelid or ear	45665
Fundi, optic, examination of	11212
Fundoplasty/fundoplication, antireflux operation	30527,30529,30530
antireflux operation by	31464,31466
Funnel chest, elevation of	38457,38458
Furuncle, incision with drainage of	30219,30223
Fusion, spinal, cervical/thoracic/lumbar	48660-48675

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Service	Item
spinal, posterior interbody	48654,48657
vertebral body, diseases of	48640
G	
Gallbladder, drainage of	30375
excision of	30443-30449
Galvanocautery of skin lesions	30192
Gamete intra-fallopian transfer	13200-13221
Ganglion, excision of	30106,30107
hand, excision of	46494,46495,46498
wrist joint, excision of	46500-46503
Gangliotomy, radiofrequency trigeminal	39109
Gangrenous tissue, debridement of	35100,35103
Gartner duct cyst, removal of	35557
Gastrectomy, partial	30518
sub-total, radical, for carcinoma	30523
total	30521,30524,30526
Gastric by-pass for obesity	30512
band, in association with implanted resevoir	14215,31441
cooling (by lavage with ice-cold water)	*
hypothermia	13500,13503
lavage in the treatment of ingested poison	14200
reconstruction with oesophagectomy	30535
reduction for obesity	30511
stricture, endoscopy with balloon dilatation	30475
tumour, removal of	30520
ulcer, perforated, laparotomy with suture	30375
Gastro-camera investigation	30473
Gastro-oesophageal balloon intubation	13506
reflux, clinical assessment of	11810
reflux, operations for	43951,43954,43957
Gastroduodenal stricture, balloon dilatation	30475
Gastroduodenostomy	30515
reconstruction of	30517
Gastroenterostomy	30515
Gastrointestinal blood loss estimation	12506
protein loss	12509
tract, dilatation of stricture of upper	
Gastroschisis, operations for	43864,43867
Gastroscopy	30473,30476,30478
insertion of nasogastric/nasoenteral tube	31456,31458
Gastrostomy button, non-endoscopic insertion/replacement	30483
percutaneous endoscopic	30481,30482
percutaneous tube, jejunal extension	31460
with laparotomy	30375
Genioplasty	45761
Genital prolapse, operations for	35576,35580,35584
Gilliam's operation	35683,35684
Gland, adrenal, excision of	36500
Bartholin's, marsupialisation of	35516,35517
lacrimal, excision of palpebral lobe	42593
lymph, biopsy of	30074,30075
lymph, drill biopsy of	30078
lymph, pelvic, excision of	35551
lymph, pelvic, excision of, with hysterectomy	35664
parotid, superficial lobectomy/tumour removal	30253
parotid, total extirpation of	30247,30250
salivary, duct, dilatation or diathermy of	30262
salivary, duct, marsupialisation	30265,30266
salivary, duct, meatotomy	30265,30266
salivary, duct, removal of calculus	30265,30266
salivary, operations on	30262-30269
sublingual, extirpation of	30259
submandibular, extirpation of	30256
Glaucoma, filtering and allied operations for	42746,42749
Molteno valve, insertion of	42752
Molteno valve, removal of	42755
iridectomy and sclerectomy for	42746
iridectomy or iridotomy	42764
provocative tests for	11200
tonography for, one or both eyes	11203
Glenoid fossa, reconstruction of	45788
Glioma, craniotomy for removal of	39709
Globe of eye, evisceration of	42512,42515
Glomus tumour, transmastoid removal of	41623
tumour, transtympanic, removal of	41620
Glossectomy, with partial pharyngectomy	41785
Gonadal dysgenesis, vaginoplasty for	37851
Goniotomy	42758
Graciloplasty procedures	32200-32210
Grafenberg's (or Graf) ring, introduction of	35503
ring, removal under GA	35506
Graft, axillo-femoral, infected, excision of	34172
bone	(see bone)
bypass, for occlusive arterial disease	32700-32763
bypass, for treatment of aneurysm	(see aneurysm)
composite (chondro-cutaneous/mucosal)	45656
conjunctival over cornea	42638
corneal	42653,42656,42659
dermis, dermo-fat or fascia	45018
femoro-femoral, infected, excision of	34172
free fascia for facial nerve paralysis	45575,45578
free, split 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

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Service	Item
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	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
Care planning	720-730
Case conferencing (other than Specialist or Cons Physician)	734-779
Case conferencing by Consultant Physician	801-815
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

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Service	Item
umbilical, epigastric, or linea alba, repair of	30616-30621
ventral or incisional, repair of	30403,30405
ventral, following closure exomphalos, repair of	43939
Herniated muscle, fascia, deep, repair of	30238
Hiatus hernia, antireflux operations for	30527,30529,30530
hernia, repair of	30601
para-oesophageal, repair of	31468
Hickman catheter, insertion of, for chemotherapy	34527,34528
catheter, removal of	34530
Hindquarter, amputation or disarticulation of	44373
Hinselmann colposcope, examination uterine cervix	35614
Hip, amputation or disarticulation at	44370
arthrectomy	49309,49312
arthrodesis	49306
arthroplasty	49309-49346
arthroplasty, revision	49346
arthroscopy	49360,49363,49366
arthrotomy	49303
congenital dislocation, open reduction	50351
contracture of, medial/anterior release	50375-50384
dislocation, acetabulum fracture, treatment	47495,47498
dislocation, congenital, treatment of	50349,50352,50350
dislocation, treatment of	47048,47051
iliopsoas tendon transfer to greater trochanter	50387
prosthesis, operation on	49315
replacement procedures	49318-49345
spica, application of	47540
spica, initial application, congenital dislocation	50353
transfer of abdominal musculature to greater trochanter	50387
transfer of adductors to ischium	50387
Hirschsprung's disease, colostomy/enterostomy for	30375
disease, neonatal, laparotomy for	43819
disease, paediatric, operations for	43990-43999
Hormone implantation, by cannula	14206
implantation, direct, incision and suture	14203
Humerus, bone graft to	48212,48215
fracture, treatment of	47411-47459
operation for osteomyelitis	43506,43515
osteectomy/osteotomy	48412,48415
Hummelsheim type muscle transplant, squint	42848
Hydatid cyst, liver, total excision of	30437,30438
cyst, liver, removal of contents of	30434,30436
cyst, lungs, enucleation of	38424
Hydradenitis, excision for	31245
Hydrocele, infantile, repair of	30612,30614
removal of	30631
tapping of	30628
Hydrocephalus, operations for	40000-40009
Hydrocortisone, injections into keloid with GA	30210
Hydrodilatation of bladder with cystoscopy	36827
Hydromyelia, operations for	40339,40342
Hydrotubation of Fallopian tubes	35703,35709
Hymenectomy	35509
Hyperbaric oxygen therapy	13020,13025,13030
Hyperemesis gravidarum, treatment of	16505
Hyperextension deformity of toe, release, lengthening	50345
Hyperhidrosis, axillary, excision for	30180,30183
Hyperparathyroidism, operations for	30315-30320
Hypertelorism, correction, intra/sub-cranial	45767,45770
Hypertension, portal, treatment of	30602-30606
Hyperthermia treatment using Tronado unit	*
Hypnotherapy	*
Hypodermic injections	*
Hypospadias, examination under GA	37815
granuloplasty, meatal advancement	37818
meatotomy and hemi-circumcision	37354
penis erection test with examination	37815
repair of	37821-37833
urethral fistula repair	37833
Hypothenar spaces of hand, drainage of	46519
Hypothermia, gastric	13500,13503
deep hypothermic circulatory arrest	22075
total body	22065
Hysterectomy	35653-35673
laparoscopically assisted	35750-35756
with ovarian transposition, malignancy	35729
Hysteroscopic resection of myoma or uterine septum	35623
Hysteroscopy	35626-35636
Hysterotomy	35649

I

Ileal atresia, neonatal, laparotomy for	43816
Ileo-femoral by-pass grafting	32712,32718
endarterectomy	33521
Ileorectal anastomosis	32012
Ileostomy	32009-32021
closure of, with rectal resection	32060,32063,32066
closure of, without resection of bowel	30562
refashioning of	30563
reservoir, continent type, creation of	32069
trimming	*
with proctocolectomy	32015
with total colectomy	32009
Iliac endarterectomy	33518
vein, thrombectomy	33810,33811
vessel, ligation or exploration not otherwise covered	34103
Iliopsoas tendon transfer to greater trochanter	50387
Immunisation against infectious disease	*
Implant, cochlear, insertion of	41617
epidural, for pain management, removal of	39136
foreign, insertion for contour reconstruction	45051
insertion or removal from eye socket	42518
Implantation, fallopian tubes into uterus	35694,35697
hormone or living tissue	14203,14206
Implanted, pacemaker testing	11718,11721
device for delivery of therapeutic agents	14221
pump or reservoir, loading of	14218
reservoir associated with adjustable gastric band	14215
Impotence, injection for investigation/treatment	37415
Incidental appendicectomy	30574
Incisional hernia, repair of	30403
Incomplete confinement	16518

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Service	Item
Incontinence, anal, Parks' intersphincteric procedure	32126
bladder stress, suprapubic operation	37044
male urinary, injection for treatment of	37339
stress, sling operation for	35599
Indirect flap	45227-45239
Induction, management, second trimester labour	16525
Indwelling oesophageal tube, gastrostomy for fixation	30375
Infantile hydrocele, repair of	30612,30614
Infection, acute intercurrent, complicating pregnancy	16508
Inferior vena cava, thrombectomy	33810,33811
vena caval filter, insertion of	35330
Infiltration, alcohol, etc, around nerve or in muscle	*
of local anaesthetic	(see explan notes)
Inflammation of middle ear, operation for	41626
Infusion chemotherapy	13915-13936
chemotherapy, cannulation for	34521,34524
device, automated, spinal, insertion of	39126,39128
intra-arterial, sympatholytic agent	14209
Ingrowing eyelashes, operation for	45626
nail of finger or thumb, resection of	46528,46531
nail of toe, resection of	47915,47916
Inguinal abscess, incision of	30223
hernia, repair of	30609,30612,30614
hernia, repair, age less than 3 months	44108,44111,44114
Injection, alcohol, etc, around nerve or in muscle	*
alcohol, cortisone, phenol into trigeminal nerve	39100
alcohol, retrobulbar	42824
botulinus toxin	42827
hormones, for habitual miscarriage	16504
immunoglobulin	*
into angioma (restriction applies)	45027
into joint/synovial cavity	50124,50125
into prostate	37218
into spinal joints or nerves	39013
intramuscular	*
intravenous	*
local anaesthetic	(see explan notes)
sclerosant fluid into pilonidal sinus	30679
Injections, multiple, for skin lesions	30207
varicose veins	*
Inlay graft, using a mould	45445
Innocent bone tumour, excision of	30241
Innominate artery, endarterectomy of	33506
Inoculation against infectious disease	*
Insufflation Fallopian tubes, for patency (Rubin test)	35706
Intensive care management/procedures	13815-13888
Intercostal drain, insertion of	38409,38410
Internal auditory meatus, exploration of	41599
drainage of empyema, without rib resection	38409,38410
Interosseous muscle space of hand, fasciotomy of	47981
Interphalangeal joint, arthrodesis of	46300
joint, arthrotomy of	46327,46330
joint, dislocation, treatment of	47036,47039
joint, hemiarthroplasty	46309-46321
joint, interposition arthroplasty of	46306
joint, joint capsule release of	46381
joint, ligamentous repair	46333
joint, synovectomy/capsulectomy/debridement	46336
joint, total replacement arthroplasty of	46309-46321
joint, volar plate arthroplasty	46307
Interscapulothoracic amputation or disarticulation	44334
Interventional endovascular procedures	35300-35330
Intervertebral disc/s, laminectomy for removal of	40300
disc/s, microsurgical discectomy of	40301
Intestinal conduit or reservoir, endoscopic examination	36860
duct, patent vitello, excision of	43945
malrotation, neonatal, laparotomy for	43801,43804
obstruction, surgical relief of	30387
plication, Noble type, with enterolysis	30375
remnant, abdominal wall vitello, excision of	43942
resection, large	32000,32003
resection, small	30565,30566
sling procedure prior to radiotherapy	32183
urinary conduit, revision	36609
urinary reservoir, continent, formation	36606
Intra-abdominal artery/vein, cannulation, chemotherapy	34521
Intra-anal abscess, drainage of	32174,32175
Intra-aortic balloon, counterpulsation, management	13845,13848
balloon pump, insertion of	38606,38609
balloon pump, removal of	38612,38613
Intra-arterial cannulisation for blood collection	13842
infusion chemotherapy	13927-13936
infusion, of sympatholytic agent	14209
Intra-atrial baffle, insertion of	38745
Intra-epithelial neoplasia, laser therapy for	35539,35542,35545
Intra-ocular excision of dermoid of eye	42574
foreign body, removal of	42560-42569
procedures, resuturing of wound after	42857
Intra-operative ultrasound, biliary tract	30439
staging of intra-abdominal tumours	30441
Intra-oral tumour, radical excision of	30275
Intra-orbital abscess, drainage of	42572
Intra-uterine contraceptive device, introduction of	35503
contraceptive device, removal of under GA	35506
growth retardation, attendance for	16508
Intracerebral tumour, craniotomy and removal of	39709
Intracranial abscess, excision of	39903
aneurysm, clipping or reinforcement of sac	39800
aneurysm, ligation of cervical vessel/s	39812
arteriovenous malformation, excision of	39803
cyst, drainage of via burr-hole	39703
electrode placement	40709,40712
haemorrhage, burr-hole craniotomy for	39600,39603
infection, drainage of via burr-hole	39900
neurectomy, for trigeminal neuralgia	39106
pressure monitoring device, insertion of	39015
pressure monitoring, catheter/subarachnoid bolt	13830
stereotactic procedures	40800,40803
tumour, biopsy and/or decompression	39706
tumour, burr-hole biopsy for	39703,39706
tumour, craniotomy and removal of	39709,39712
Intradiscal injection of chymopapain	40336

*** Payable on attendance basis**

Service	Item
Intradural lesion, laminectomy for, not otherwise covered	40312
Intrahepatic bypass	30466,30467
Intramedullary tumour, laminectomy and radical excision	40318
Intramuscular injections	*
Intranasal operation on antrum/removal offoreign body	41716
operation on frontal sinus or ethmoid sinuses	41737
operation on sphenoidal sinus	41752
Intrascleral ball or cartilage, insertion of	42515
Intrathecal infusion device, revision of	39133
infusion/injection	(see Group T7)
steroid injection	18232
Intrathoracic operation on heart, lungs, etc, other	38456
vessels, anastomosis/repair	38727,38730
Intravascular injections	*
pressure monitoring	11600,11601,13876
Intravenous infusion chemotherapy	13915-13924
injections	*
perfusion of a sympatholytic agent	14209
regional anaesthesia of limb	18213
Intraventricular baffle, insertion of	38754
Intubation, small bowel	30487,30488
Intussusception, laparotomy and reduction of	30375
management fluid/gas reduction for	14212
paediatric, operations for	43933,43936
Invitro fertilisation	13200-13221
processing of bone marrow	13760
Ionisation, cervix	35608
corneal ulcer	*
zinc, of nostrils, in the treatment of hay fever	*
Iontophoresis, collection of specimen of sweat by	12200
Iridectomy	42764
and sclerectomy, for glaucoma (Lagrange's op)	42746
following intraocular procedures	42857
Iridencleisis	42746
Iridocyclectomy	42767
Iridotomy	42764
laser	42785,42786
Iris and ciliary body, excision of tumour of	42767
excision of tumour of	42764
tumour, laser photocoagulation of	42806
Iron kinetic test	12503
Ischaemic limb, debridement of deep tissue	35100
limb, debridement of superficial tissue	35103
ventricular septal rupture, repair of	38509
Ischio-rectal abscess, drainage of	32174,32175
abscess, incision with drainage	30223

J

Jacket, plaster, application of, to spine	47708
Jaw, dislocation, treatment of	47000
operation on, for acute osteomyelitis	43503
operation on, for chronic osteomyelitis	43512
reconstruction operation	45596-45611
Jejunal atresia, bowel resection and anastomosis	43810
extension, percutaneous gastrostomy tube	31460
Jejunostomy, operative feeding	31462
Joint, application of external fixator, not for fracture	50130
arthrodesis of	50109
arthroplasty of, not otherwise covered	50127
arthroscopy of	50100
arthrotomy of	50103
aspiration of (restriction applies)	50124,50125
cicatricial flexion contracture of, correction	50112
deformity, correction of	50300
dislocation, treatment of	47024-47045
finger/hand, debridement of	46336
greater trochanter, transplantation of	50121
injection into	50124,50125
manipulation of	50115
sacro-iliac, arthrodesis	49300
sacro-iliac, disruption of	47513
stabilisation, repair capsule/ligament	50106
subtalar, arthrodesis of	50118
synovectomy of, not otherwise covered	50104
Juvenile cataract, removal of	42716

K

Keloid, excision of	(see tumour,other)
extensive, multiple injections of hydrocortisone	30210
Keratectomy, partial, for corneal scars	42647
phototherapeutic	42810
Keratocanthoma, removal of	31255-31295
Keratoplasty	42653,42656,42659
refractive	42671
Keratosis, obturans, surgical removal	41509
treatment of	*
Kidney, dialysis, in hospital	13100,13103
donor, continuous perfusion of	22055
exploration of	36537
ruptured, exposure and exploration of	36576
solitary, pyeloplasty by open exposure	36567
transplant	36503,36506,36509
Kirschner wire, insertion of	47921
Klockoff's test, assessment of cochlear function changes	11321
Knee, amputation at or below	44367
arthrodesis of	49512,49545
arthroplasty of	49518-49534
arthroscopy of	49557-49566
arthrotomy of	49500
collateral or cruciate ligament repair	49503,49506
congenital deformity, post-op manipulation, plaster	50348
contracture of, posterior release	50363-50372
cruciate ligament reconstruction	49536,49539,49542
dislocation, treatment of	47054
fracture, treatment of	47588,47591
hamstring tendon transfer	50357,50360
hemiarthroplasty of	49517
ligament or tendon transfer	49503,49506
meniscectomy of	49503,49506
mobilisation, for post-traumatic stiffness	49569
nerve block for control of post op pain	18210,18211

*** Payable on attendance basis**

Service	Item
orthopaedic treatment of	49503,49506
patello-femoral stabilisation	49503,49506,49564
patello-femoral stabilisation, revision of	49548
prosthesis, removal of	49515
reconstruction/repair	49536,49539
rectus femoris tendon transfer	50357
replacement procedures	49518-49534
revision of orthopaedic procedures	49551,49554
synovectomy of	49509
Kyphosis, spinal fusion for	48606,48609,48613
L	
Labial adhesions, separation of	*
Labioplasty, where medically indicated	35533
Labour, second trimester, management of	16525
Labyrinth, destruction of	41572
Labyrinthotomy	41572
Labyrinths, caloric test of	11333,11336
Laceration, ear/eyelid/nose/lip, full thickness, repair	30052
repair and suturing of	30026-30049
Lacrimal canalicular system, establishment patency	42599,42602
canaliculus, immediate repair of	42605
drainage by insertion of glass tube	42608
gland, excision of palpebral lobe	42593
passages, obstruction, probing for	42610-42615
sac, excision of	42596
Lagrange's operation (iridectomy and sclerectomy)	42746
Laminectomy and insertion of epidural implant	39139
followed by posterior fusion	40324,40327
for cordotomy or myelotomy	39124
for extradural tumour or abscess	40309
for hydromelia	40342
for intradural lesion	40312
for recurrent disc lesion and/or spinal stenosis	40303
for removal of intervertebral disc/s	40300
for spinal stenosis	40303,40306
with bone graft and posterior fusion	48654,48657
with excision of arteriovenous malformation	40318
with excision of intra-medullary tumour	40318
Laparascopic division of adhesions	31450,31452
splenectomy	31470
Laparoscopy and hysteroscopy under GA	35636
complicated operative	35638,35641
diagnostic	30390
division of adhesions	30393
involving procedures via laparoscope	35637,35638
laparoscopically assisted hysterectomy	35750-35756
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 or erbium, of rhinophyma	45652
excision/ablation, carbon dioxide or erbium, 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
removal of cancer of skin/mucous membrane	30196
removal of palmar/plantar warts	30187
resurfacing, carbon dioxide, face or neck	45025,45026
therapy for intraepithelial neoplasia	35539,35542,35545
therapy for malignancy of gastrointestinal tract	30479
trabeculoplasty	42782,42783

*** Payable on attendance basis**

Service	Item
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	22055,34533
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
Little's Area, cautery of	41674
Liver abscess, open abdominal drainage of	30431,30433
biopsy	30409,30411,30412
cyst/s, laparoscopic marsupialisation	30416,30417
hydatid cyst, removal of contents of	30434,30436
hydatid cyst, total excision of	30437,30438
lobectomy of, for trauma	30428,30430
lobectomy of, other than for trauma	30418,30421
repair of laceration/s, for trauma	30422,30425
ruptured, repair	30375
segmental resection of	30414,30415,30427
tumours, destruction of by cryotherapy	30419
Living tissue, implantation of	14203,14206
Lobar emphysema, neonatal, thoracotomy & lung resection	43861
Lobectomy, liver, for trauma	30428,30430
liver, other than for trauma	30418,30421
lung	38438,38441
partial, for epilepsy	40703
superficial, of parotid gland	30253
Local anaesthetic, injection of	(see explan notes)
flap repair	45200,45203,45206
flap revision	45239
infiltration, nerve/muscle, with alcohol etc.	*
Loose bodies in joint	(see arthrotomy)
Lop ear or similar deformity, correction of	45659
Lord's procedure, massive dilatation of anus	32153
Lumbar cerebrospinal fluid drain, insertion of	40018
decompression of spinal cord	40351
discectomy, percutaneous	48636
puncture	39000
shunt diversion, insertion of	40006
shunt, revision or removal of	40009
sympathectomy	35000,35009
Lunate bone, osteectomy or osteotomy of	48406
Lung compliance, estimation of	11503
hydatid cysts, enucleation of	38424
intrathoracic operation, not otherwise covered	38456
needle biopsy of	38412
resection, congenital cystadenomatoid malformation	43861
resection, congenital lobar emphysema	43861
volumes	11503

*** Payable on attendance basis**

Service	Item
wedge resection of	38440
Lymph glands, axilla, excision of	30332,30336,30335
glands, biopsy of	30074,30075,30078
glands, groin, excision of	30329,30330
glands, pelvic, radical excision of	35551
node biopsies, retroperitoneal	35723
node dissection, retroperitoneal	37607,37610
node of neck, biopsy of	31420
nodes of axilla, excision of	30335,30336
nodes of neck, dissection of	31423-31438
Lymphadenectomy, atypical mycobacterial infection	44130
granulomatous disease	44130
pelvic	35551,36502
Lymphangiectasis, limbs, major excision	45048
Lymphangioma, excision of	45030-45036
Lymphoedema, major excision of	45048
M	
Macrocheilia, operation for	45675
Macrodactyly, surgical reduction of enlarged elements	46510
Macroglossia, operation for	45675
Macrostomia, operation for	45676
Macules, electrosurgical destruction or chemotherapy of	*
Magnetic removal of intraocular foreign body	42560,42566
Malignant lesion, removal of	31300-31335
Malignant upper aerodigestive tract tumour	31400,31403,31406
excision of	
Mallet finger, closed pin fixation of	46438
finger, open repair of text test	46441
finger, with intra-articular fracture, open reduction	46442
Mammaplasty, augmentation	45524,45527,45528
reduction	45520,45522
Mammary prosthesis, removal of	45548,45551,45552
prosthesis, replacement of	45552,45554
Manchester operation for genital prolapse	35584
Mandible, condylectomy	45611
dislocations, treatment of	47000
hemi-mandibular reconstruction with bone graft	45608
operation on, for acute osteomyelitis	43503
operation on, for chronic osteomyelitis	43512
or maxilla, fractures, treatment of	47753-47789
osteectomy or osteotomy of	45720-45752
resection of	45599,45602,45605
segmental resection of, for tumours	45605
Mandibular, frenulum, repair of, under GA	30281
Manipulation of fibrous tissue surrounding breast prosthesis	*
of joints	50115
of spine	48600,48603
of ureteric calculus, endoscopic	36857
without anaesthesia	*
Manometric oesophageal motility test	11800
Manometry, biliary	30493
Marshall-Marchetti operation for urethropexy	35599,37044
Marsupialisation of Bartholin's cyst or gland	35516,35517
salivary gland	30265,30266
Mastectomy, total	30351,30352
subcutaneous	30354,30355
Mastitis, granulomatous, exploration and drainage	30364
Mastoid cavity, obliteration of	41548,41564
portion, decompression of facial nerve	41569
Mastoidectomy, cortical	41545
intact wall technique, with myringoplasty	41551,41554
radical or modified radical	41557-41564
revision of, with myringoplasty	41566
with insertion of cochlear implant	41617
with transmastoid removal of glomus tumour	41623
Maxilla, operation on, for acute osteomyelitis	43503
operation on, for chronic osteomyelitis	43512
or mandible, fractures, treatment of	47753-47789
osteectomy or osteotomy	45720-45752
resection of, segmental, for tumour/cyst	45605
resection of, sub-total	45602
resection of, total	45596,45597
Maxillary antrum, lavage of	41704
antrum, proof puncture and lavage of	41698,41701
artery, transantral ligation of	41707
frenulum, repair of	30281
sinus, drainage of, through tooth socket	41719
sinus, operations on	41710-41722
Meatoplasty, with correction of auditory canal stenosis	41521
with removal of cartilage and/or bone	41512,41515
Meatotomy and hemi-circumcision, hypospadias	37354
ureteric, with cystoscopy	30265,30266,36830
urethral	37321
Meatus, external auditory, removal of exostoses in	41518
external auditory, removal of keratosis obturans	41509
internal auditory, exploration of	41599
pinhole urinary, dilatation of	37300
Meckel's diverticulum, removal of	30375
Meconium ileus, laparotomy for	43813,43816
Medial palpebral ligament, ruptured, repair of	42854
Median bar, endoscopic resection of	36854
sternotomy for post-operative bleeding	38656
Mediastinum, cervical exploration of	38448
exploration of, for hyperparathyroidism	30318,30320
intrathoracic operation on, not otherwise covered	38456
Meibomian cyst, extirpation of	42575
Melanoma, removal of	31300-31335
Melasma, full face chemical peel	45019,45020
Meloplasty, for correction of facial asymmetry	45587,45588
Membranes, retained, evacuation of	16564
Meningeal haemorrhage, operations for	39600,39603
Meningocele, excision and closure of	40100
Meniscectomy, knee	49503,49506
temporo-mandibular	45755
Mesenteric artery, inferior, operation on	32736
vessels, by-pass grafting to	32730,32733
Meso caval shunt for portal hypertension	30603
Metacarpal bones, amputation of	44325
bones, bone grafting, pseudarthrosis	46402,46405
bones, fracture, treatment of	47336-47345

*** Payable on attendance basis**

Service	Item
bones, operation for osteomyelitis	46462
bones, osteotomy/osteectomy	46396,46399
Metacarpophalangeal joint, arthrodesis	46300
joint, arthroplasty	46306-46321
joint, arthrotomy	46327,46330
joint, dislocation, treatment of	47042,47045
joint, hemiarthroplasty	46309-46321
joint, ligamentous repair of	46333
joint, volar plate arthroplasty	46307
Metacarpus, operation on, for chronic osteomyelitis	43512
Metastatic carcinoma, craniotomy for removal of	39709
Metatarsal bones, osteotomy or osteectomy of	48400,48403
fracture, treatment of	47633-47657
Metatarso-phalangeal joint, synovectomy of	49860,49863
joint, total replacement of	49857
Metatarsus, amputation or disarticulation of	44358
operation on, for acute osteomyelitis	43500
Micro-arterial graft	45503
Microdochotomy of breast, benign or malignant condition	30366
Microlaryngoscopy	41855
- with arytenoidectomy	41867
- with division of laryngeal web	41868
- with removal of juvenile papillomata	41858
- with removal of papillomata by laser surgery	41861
- with removal of tumour	41864
Microsomia, construction of condyle and ramus	45791
Microvascular anastomosis using microsurgical techniques	45502
repair using microsurgical techniques	45500
Microvenous graft	45503
Middle ear, clearance of	41635,41638
ear, exploration of	41629
ear, insertion of tube for drainage of	41632
ear, operation for abscess or inflammation of	41626
palmar spaces of hand, drainage of	46519
Midtarsal amputation of foot	44364
Miles' operation	32039
Minitracheostomy insertion	41884
Minnesota tube, insertion of	13506
Miscarriage, habitual, treatment of	16504
incomplete, curettage for	35639,35640
threatened, ligation of cervix	16511
threatened, treatment of	16505
Mitral annulus, reconstruction after decalcification	38485
valve, open valvotomy of	38487
Mitrofanoff continent valve, formation of	37045
Moh's procedure	31000,31001,31002
Mole, desiccation by diathermy	*
retained, evacuation of	16564
Molluscum contagiosum, removal in operating theatre	30189
Morbid obesity, operations for	30511,30512,30514
Moschowitz operation	35590
Motility test, manometric, of oesophagus	11800
Mouth, premalignant growth in, removal of	(see tumour,other)
Mucous membrane, biopsy of	30071
membrane, cancer, treatment	30196-30205
membrane, graft	42641
membrane, repair of recent wound	30026-30049
Multiple delivery, administration of anaesthetic	
Multiple, injections for varicose veins	32500,32501
pregnancy, interventional techniques	16633,16636
Muscle, activity sampling (electromyography)	11012, 11015,11018
biopsy of	30074,30075
distal, devascularisation of	32200
excision of	30226,30229
excision of, with melanoma	31340
extra-ocular, ruptured, repair of	42854
flap repair	45000,45009,45012
flap, delay of	45015
local infiltration in	*
removal of foreign body from	30067,30068
ruptured, repair of	30232,30235
transfer for facial nerve paralysis	45578
transplant (Hummelsheim type), for squint	42848
Myelomeningocele, excision and closure of	40103
Myelotomy, laminectomy for	39124
Myocardial electrode, permanent, insertion, thoracotomy	38470
biopsy, by cardiac catherterisation	38275
Myocutaneous flap, delay of	45015
flap repair	45003,45006
Myoma, hysteroscopic resection	35623
Myomectomy, hypertrophic obstructive cardiomyopathy	38650
uterine, abdominal	35649
uterine, laparoscopic	35638
Myotomy, cricopharyngeal	41770,41776
hypertrophic obstructive cardiomyopathy	38650
ocular muscles	42833,42839,42851
oesophagogastric (Heller's operation)	30532,30533
Myringoplasty	41527,41530
- and mastoidectomy	41551,41560
- and ossicular chain reconstruction	41542
- and revision of mastoidectomy	41566
- with mastoidectomy and ossicular chain recon	41554,41563
Myringotomy	41626

N

Service	Item
Naevus, excision of	31250
Nail bed, exploration and repair of deformity	46489
bed, reconstruction of laceration	46486
digital, of finger or thumb, removal of	46513,46516
digital, of toe, removal of	47904,47906
ingrowing, of finger or thumb, resection	46528,46531
ingrowing, of toe, excision/resection	47915,47916,47918
ingrown, of toe, operation under GA, paediatric	44136
plate injury/deformity, radical excision	46534
plate or rod, removal of	47930
Narcotherapy	*
Nasal adhesions, division of	41683
bones, fracture, treatment of	47735,47738,47741
cavity and/or post nasal space, examination of	41653

*** Payable on attendance basis**

Service	Item
cavity, packing for arrest of haemorrhage	41677
haemorrhage, arrest of	41656,41677
haemorrhage, cryotherapy in the treatment of	41680
polyp or polypi, removal of	41662,41665,41668
septum button, insertion of	41907
septum, reconstruction of	41672
septum, septoplasty or submucous resection	41671
space, post, direct examination of	41761
turbinates, cryotherapy	41695
Nasendoscopy	41764
Naso-lacrimal tube, replacement of	42610-42615
Nasopharyngeal angiofibroma, transpalatal removal	41767
Nasopharynx, fibreoptic examination of	41764
Neck, deep-seated haemangioma, excision of	45036
excision of infected by-pass graft	34157
scar, revision of (restriction applies)	45506,45512
Necrosectomy, pancreatic	30577
Necrotic material, debridement of	35100,35103
Needle biopsy, aspiration	*
biopsy of prostate	37218
biopsy of vertebra	30093
Needling of cataract	42734
Neonatal alimentary obstruction, laparotomy for	43825
surgery	43801-43822
Neoplasia, intraepithelial, laser therapy	35539,35542,35545
Neoplastic lesions, cutaneous, treatment of	30195
Nephrectomy	36516-36529
radical, for nephroblastoma, paediatric	43984
Nephro-ureterectomy, complete, with bladder repair	36531
for tumour	36532
for tumour, complicated	36533
Nephroblastoma, operations for	43981,43984
Nephrolithotomy	36540,36543
Nephroscopy	36627-36648
Nephrostomy	36552
drainage tube, exchange of, imaging guided	36649
percutaneous, using interventional imaging	36624
Nerve block, regional or field	18206-18298
conduction studies	11012, 11015,11018
cranial, intracranial decompression	39112
cutaneous, nerve graft to	39318
cutaneous, repair of	39300,39303
exploration of	39330
facio-hypoglossal or facio-accessory, anastomosis of	39503
graft to nerve trunk	39315
intracranial, for trigeminal neuralgia	39106
local infiltration around, with alcohol etc	*
peripheral, removal of tumour from	39324,39327
section, retrolabyrinthine, vestibular/cochlear	41596
section, translabyrinthine, vestibular	41593
transposition of	39321
trigeminal, primary branch, injection with alcohol etc	39100
trunk, internal (interfasicular), neurolysis of	39312
trunk, microsurgical repair	39306,39309
trunk, nerve graft to	39315
vestibular, section of, via posterior fossa	39500
Neurectomy, foot, for plantar digital neuritis	49866
intracranial, for trigeminal neuralgia	39106
peripheral nerve	39324,39327
transantral vidian, with antrostomy	41713
Neuroblastoma, operations for	43981,43987,43984
Neuroendocrine tumour, retroperitoneal, removal of	30321,30323
Neuroendoscopy	40903
Neurolysis, by open operation	39330
of nerve trunk	39312
Neuroma, acoustic, removal of	41575-41579
Neuromuscular electrodiagnosis	11012-11021
Neurostimulator receiver, spinal, subcutaneous placement	39134
Neurotomy, of peripheral nerves	39327
percutaneous, for facet joint denervation	39118
percutaneous, of spinal nerves	39115
Neurovascular island flap, for pulp innervation	46504
island flap, with vascular pedicle	45563
Nipple, accessory, excision of	30372
inverted, surgical eversion of	30370
reconstruction of	45545,45546
Noble type intestinal plication with enterolysis	30375
Node, lymph, biopsy of	30074,30075
scalene, biopsy	30096
Nodes, lymph, pelvic, excision of	35551
Nodule, treatment, electrosurgical destruction/cryosurgery	*
Non-gravid uterus, suction curettage of	35639,35640
Nose, cauterisation or packing, for haemorrhage	41677
composite graft to	45656
cryotherapy to, for haemorrhage	41680
dermoid of, congenital, excision of	41729
foreign body in, removal of, other than simple	41659
fracture, treatment of	47735,47738,47741
full thickness repair of laceration (restriction)	30052
operations, other	41659-41695
plastic operations	45632-45653
O	
Obesity, morbid, surgical reversal of gastric procedure	30514
Ocular muscle, torn, repair of	42854
surface dysplasia, investigation	11235
Oculoplethysmography, carotid vessels	11618,11621,11624
Odontoid screw fixation	40316
Oesophageal atresia, neonatal, operations for	43843-43858
atresia/corrosive stricture, replacement for	43903
motility test, manometric	11800
perforation, repair of, by thoracotomy	30560
prosthesis, insertion of	30490
stricture, endoscopic dilatation of	41819
transection for portal hypertension	30606
tube, indwelling, gastrostomy for fixation	30375
Oesophagectomy	30535-30557
cervical	30294
Oesophagogastric myotomy	30532,30533
Oesophagoscopy	30473-30478

*** Payable on attendance basis**

Service	Item
with dilatation of stricture	41819
with rigid oesophagoscope	41816,41822,41825
Oesophagostomy, cervical	30293,30294
cervical, neonatal oesophageal atresia	43858
closure or plastic repair of	30293
Oesophagus, resection of stricture, paediatric	43906
balloon dilatation of	41832
dilatation of	41819-41831
intrathoracic operation on, not otherwise covered	38456
local excision for tumour	30559
removal of foreign body in	41825
Olecranon, excision of bursa of	30110,30111
fracture, treatment of	47396,47399,47402
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
Oxycephaly, cranial vault reconstruction for	45785
Oxygen consumption, estimation of	11503
therapy, hyperbaric	13020,13025,13030

*** Payable on attendance basis**

Service	Item
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
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	49503,49506,49564
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	45230
- delay of	
- formation of	45227
- preparation of site and attachment to site	45233
- spreading of pedicle	45236
Pelvi-ureteric junction, plastic procedures to	36564
cystoscopy of	36825
Pelvic abscess, drainage via rectum or vagina	30223
abscess, laparotomy for drainage of	30394
bone, operation on, for osteomyelitis	43509,43518
bone, osteectomy or osteotomy of	48424,48427
floor 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	37417,37418
frenuloplasty	37435
injection for impotence	37415
lengthening by translocation of corpora	37423
paraphimosis, reduction of under GA	30666
partial amputation of	37402
repair of avulsion	37411
repair of laceration of cavernous tissue, or fracture	37408
surgery for penile drainage causing impotence	37420
Peptic ulcer, bleeding, control of	30505-30509
ulcer, perforated, suture of	30375
Per anal release, rectal stricture	32114
Perchlorate discharge study	12521
Percutaneous aspiration biopsy of deep organ	30094
cordotomy	39121

*** Payable on attendance basis**

Service	Item
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	22055
of limb or organ	22055
retrograde, cerebral (if performed)	22075
retrograde, intravenous, sympatholytic agent	14209
whole body	22060
Perianal abscess, drainage of	32174,32175
abscess, incision with drainage	30223
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	*
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
Placement of catheters and injection of opaque material	

*** Payable on attendance basis**

Service	Item
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
vessel, ligation or exploration, other	34103
Porta hepatitis, radical resection for carcinoma	30461
Portacath, laparatomy with insertion of	30400
Portal hypertension, operations for	30602-30606
Porto caval shunt for portal hypertension	30602
Portoenterostomy for biliary atresia	43978
Posterior chamber, removal of silicone oil	42815
sclerotomy	42734
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
- laparotomy for control of	30385
- tonsils/adenoids, arrest, under GA	41796,41797
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	16508
- acute intercurrent infection	
- diabetes or anaemia	16502
- intrauterine growth retardation	16508
- threatened premature labour	16502,16508
multiple, attendance other than routine antenatal	16502
Premalignant skin lesions, treatment of	30192
Premature labour, attendances not routine antenatal	16502,16508
Preoperative examination for anaesthesia	17603
Prepuce, breakdown of adhesions of	*
operations on	30653-30666
Presacral and sacrococcygeal tumour, excision of	32036
sympathectomy	35012
Pressure monitoring, intracranial	13830
monitoring, intravascular	11600,11601,13876
Priapism, decompression of	37393
shunt operation for	37396
Primary repair of cutaneous nerve	39300
repair of extensor tendon of hand or wrist	46420
repair of flexor tendon of hand or wrist	46426,46432
repair of nerve trunk	39306
restoration of alimentary continuity	41843
Proctectomy, perineal	32047
Proctocolectomy with ileostomy	32015,32018,32021
Proctoscopy	*
Products of conception, retained, evacuation of	16564
Professional attendances	(see attendance)
Profilometry, urethral pressure	11906,11909
Progesterone implant	14203,14206
Prolapse, genital, operations for	35576,35580,35584
ovaries, operation for	30387
rectum, abdominal rectopexy	32117
rectum, perineal repair of	32120
rectum, reduction of	*
rectum, rubber band ligation of	32135
rectum, sclerotherapy for	32132
urethra, excision of	37369
urethra, operation for	35587
Prolonged professional attendance, lifesaving	160-164
Proof puncture of maxillary antrum	41698,41701
Prostate, biopsy of	37212-37219
endoscopic laser ablation	37207,37208
total excision of	37209,37210,37211
Prostatectomy, endoscopic	37203,37206
open	37200
radical	37210,37211
Prostatic abscess, endoscopic drainage of	37221
abscess, open drainage of	37212
coil, insertion of	37223
Prosthesis, breast, manipulation fibrous tissue surrounding	*
breast, removal and/or replacement	45548-45555
knee, removal of	49515
oesophageal, insertion of	30490
shoulder, removal of	48927

*** Payable on attendance basis**

Service	Item
Provocative test for glaucoma	11200
Pseudarthrosis, bone grafting of metatarsal for	46402,46405
bone grafting of phalanx for	46402,46405
Psychiatry, by consultant psychiatrists	(see attendances)
Psychotherapy, by consultant psychiatrists	(see attendances)
Pterygium, removal of	42686
Ptosis of eyelid, correction of	45623
breast, correction of (unilateral)	45543
Public health physicians - attendances	410-417
Pudendal and spinal nerve motor latency, measurement	11833
Pulmonary artery, banding of	38715,38718
artery catheterisation	13818
artery pressure monitoring, open heart	11627
-under 12 years of age	
decortication with thoracotomy	38421
Pulp space infection of foot, incision for	47912
space infection of hand, incision for	46525
Pulse generator, subcutaneous placement	39134
Pump or resevoir, loading of	14218
implanted, associated with adjustable gastric band	31441
Punch biopsy of synovial membrane	30087
Punctum, occlusion of	42620,42621,42622
snip operation	42617
Purse string ligation, cervix	16511
string ligature of cervix, removal	16512
Puva therapy	14050,14053
Pyelography retrograde, preparation for	36824
Pyelolithotomy	36540,36543
Pyeloplasty, by open exposure	36564,36567,36570
Pyeloscopy, retrograde, of one collecting system	36652,36654,36656
Pyelostomy, open	36552
Pyloromyotomy for pyloric stenosis	43930
Pyloroplasty	30375
reconstruction of	30517
Pylorus, dilation of, with vagotomy	30502
Pyogenic granulation, cauterisation of	*
Pyonephrosis, drainage of	36537

Q

Quadriceps, patella, reconstruction, congenital dislocation	50420
Quadricepsplasty, for knee mobilisation	49569
Quinsy, incision of	41807

R

Radial vessel, ligation or exploration, other	34106
Radiation dosimetry	15518-15536
field setting	15500-15515
oncology treatment	15203-15214
proctitis, anorectal application of formalin	32212
Radioactive B12 absorption test	12512,12515
Radioisotope, therapeutic dose, administration of	16003-16012
Radiosurgery, stereotactic	15600
Radiotherapy, deep or orthovoltage	15100-15115
planning	15500-15536
radioactive sources, sealed	15303-15357
radioactive sources, unsealed	16003-16012
superficial	15000-15012
Radioulnar joint, dislocation, treatment of	47024,47027
joint, distal, reconstruction/stabilisation	46345
joint, distal, synovectomy	46342
Radius, bone graft to	48218-48227
fracture, treatment of	47360-47408
operation on, for acute osteomyelitis	43503
operation on, for chronic osteomyelitis	43512
osteectomy or osteotomy of	48406,48409
Ranula, removal of	30282,30283
Rectal biopsy, full thickness	32096
fistula, closure of	37038,37336
polyp, removal of with sigmoidoscopy	32078,32081
prolapse, Delorme procedure for	32111
prolapse, abdominal rectopexy of	32117
prolapse, paediatric, injection under GA	44105
prolapse, perineal recto-sigmoidectomy for	32112
prolapse, perineal repair of	32120
prolapse, reduction of	*
prolapse, rubber band ligation of	32135
prolapse, sclerotherapy for	32132
stricture, dilatation of	32115
stricture, per anal release of	32114
tumour, excision of	32099,32102,32108
Rectocele, perineal repair of	32131
vaginal repair of	35576,35580
Rectopexy, abdominal, of rectal prolapse	32117
Rectosigmoidectomy (Hartmann's operation)	32030
perineal, for rectal prolapse	32112
Rectosphincteric reflex, measurement of	11830
Rectovaginal fistula, repair of	35596
Rectum and anus, abdomino-perineal resection of	32039-32046
anterior resection of	32024-32028
examination under GA, paediatric	44102
perineal resection of	32047
suction biopsy of	30071
Recurrent hernia, repair of	30403
Reduction mammaplasty (unilateral)	45520
with surgical repositioning of nipple	45520
without surgical repositioning of nipple	45522
Reduction ureteroplasty	36618
Refitting of contact lenses	10816
Reflux, gastro-oesophageal, correction	43951,43954,43957
vesico-ureteric, correction	36588
Refractive keratoplasty	42671
Regional nerve block	(see nerve)
Regitine phentolamine test for phaeochromocytoma	*
Renal artery, aberrant, operation for	36537
biopsy (closed)	36561
cyst, excision of	36558
dialysis in hospital	13100,13103
function test	12524,12527
pelvis, brush biopsy of, with cystoscopy	36821
transplant	36503,36506,36509

*** Payable on attendance basis**

Service	Item
Resevoir, implanted associated with gastric band	14215,31441
or pump, loading of	14218
Respiratory function, estimation of	11503-11512
Resuturing of wound following intraocular procedures	42857
Retina, cryotherapy of	42728,42818
detached, diathermy or cryotherapy for	42773
detached, removal of encircling silicone band	42812
detached, resection or buckling operation for	42776
detached, revision operation for	42779
light coagulation for	42782,42783
photocoagulation of	42809
pre-detachment of, cryotherapy for	42818
Retinal photography	11215,11218
Retrobulbar abscess, operation for	42572
injection of alcohol	42824
transillumination	42821
Retrolabyrinthine vestibular nerve section	41596
Retroperitoneal abscess, drainage of	30402
lymph node biopsies	35723
lymph node dissection	37607,37610
neuroendocrine tumour, removal of	30321,30323
tumour, removal of	30321,30323
Retropharyngeal abscess, incision with drainage	30223
Retropubic prostatectomy	37200
Retroversion, operation for	35683,35684
Rhinophyma, carbon dioxide laser ablation/excision	45652
shaving of	45653
Rhinoplasty procedures	45632-45644
secondary revision of	45650
Rhinotomy, lateral, with removal of tumour	41728
Rhizolysis, spinal	40330
Rib, cervical, removal of	34139
first, resection of portion	34136
fracture, treatment of	47471
operation for acute osteomyelitis	43503
operation for chronic osteomyelitis	43512
osteectomy or osteotomy of	48406,48409
resection, with radical operation for empyema	38415
Ring fixator, adjustment of	50309
Rod, plate or nail, removal of	47930
Rodent ulcer, operation for	(see ulcer,other)
Rosen incision, myringoplasty	41527
Rotator cuff of shoulder, repair of	48906,48909
Round window repair or cochleotomy	41614
Roux-en-Y biliary bypass	30460,30466,30467
Rovsing's operation	36537
Rubin test for patency of Fallopian tubes	35706
Ruptured medial palpebral ligament, repair of	42854
membranes, threatened premature labour	16508
muscle, repair of	30232,30235
thoracic aorta, operative management of	38572
urethra, repair of	37306,37309
viscus, major repair or removal of	30375

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Service	Item
Sacral sinus, excision of	30675,30676
sympathectomy	35012
Sacro-iliac joint, arthrodesis of	49300
joint disruption, treatment of	47513
Sacrococcygeal and presacral tumour, excision of	32036
teratoma, neonatal, excision of	43876,43879
Salivary gland, major, transposition of duct	41910
gland, operations on	30262-30269
Salpingectomy, laparoscopic	35638
with laparotomy, not with hysterectomy	35712-35717
with vaginal hysterectomy	35673
Salpingo-oophorectomy not with hysterectomy	35712-35717
Salpingolysis	35694,35697
Salpingostomy	35694,35697
laparoscopic	35638
Saphenous vein anastomosis	34809
Scalene node biopsy	30096
Scalenotomy	34133
Scalp vein catheterisation in a neonate	13300
Scaphoid, bone graft to	48230,48233,48236
Scapula, fracture, treatment of	47468
(other than acromion), osteectomy/osteotomy	48406,48409
operation for chronic osteomyelitis	43512
Scar, abrasive therapy to	45021,45024
face or neck, revision of (restriction applies)	45506,45512
other than face or neck, revision of (restriction)	45515,45518
other, removal of	31200-31240
Scars, corneal, removal of, by partial keratectomy	42647
Schilling test	12512,12515
Sclera, removal of imbedded foreign body	42644
removal of superficial foreign body	30061
transplantation of	42662,42665
Scleral blood vessels, laser coagulations of	42797
graft to lid	42860
Sclerectomy and iridectomy for glaucoma	42746
Sclerosant fluid, injection of into pilonidal sinus	30679
injection of starburst vessels, head/neck	30213,30214
injection of telangiectases, head/neck	30213,30214
Scoliosis, anterior correction of (Dwyer procedure)	48621,48624
application of halo	47714
congenital, vertebral resection and fusion for	48632
re-exploration for	48615
requiring anterior decompression of spinal cord	48630
revision of failed surgery	48618
spinal fusion for	48606-48613
spinal fusion for, with segmental instrumentation	48627
spinal fusion with use of Harrington rod	48681
Screw, pin or wire, buried, removal of	47924,47927
Scrotal contents, exploration of	37604
Scrotum, excision of abscess of	30223
partial excision of	37438
Sebaceous cyst, removal of	(see cyst,other)
Second trimester labour, management of	16525
Secondary, repair of extensor tendon of hand or wrist	46423
repair of flexor tendon of hand or wrist	46429

*** Payable on attendance basis**

Service	Item
Segmentectomy	38438
Selective coronary angiography, preparation	38215,38218
Semen, collection of	13290,13292
Semimembranosus bursa, excision of	30114
Seminal vesicle/ampulla of vas, total excision of	37209
Sengstaken-Blakemore tube, insertion of	13506
Septal defect, atrial, closure of	38742
defect, ventricular, closure of	38751
perforation, closure of	41671
Septectomy, cardiac	38739,38748
Septoplasty of nasal septum	41671
Septostomy, or balloon valvuloplasty	38270
Septum button, nasal, insertion of	41907
nasal, cauterisation/diathermy	41674
nasal, reconstruction of	41672
nasal, septoplasty or submucous resection	41671
vaginal, excision of, for correction of double vagina	35566
Sequestrectomy	43512-43524
Seroma, breast, exploration, drainage, operating theatre	30364
Sesamoid bone, osteotomy or osteectomy of	48400
Seton, readjustment of, in anal fistula	32166
Shirodkar suture	16511
Shoulder, amputation or disarticulation at	44331
arthrectomy or arthrodesis	48939,48942
arthroscopic surgery	48948-48960
arthroscopy	48945
arthrotomy	48912
dislocation, treatment of	47009,47012,47015
hemi-arthroplasty of	48915
nerve block for post op pain	18212
open reduction for congenital dislocation	50408
orthopaedic treatment of	48900,48903
prosthesis, removal of	48927
removal of calcium deposit from cuff	48900
rotator cuff, repair of	48906,48909
spica, application of	47540
stabilisation, for multidirection instability	48933
synovectomy of	48936
total replacement of	48918,48921,48924
Shunt, aorto-pulmonary or cavo-pulmonary	38733,38736
arteriovenous, external, insertion/removal	34500,34506
cranial or cisternal, insertion of	40003
cranial or cisternal, revision or removal of	40009
lumbar, insertion of	40006
lumbar, revision or removal of	40009
Sigmoidoscopic examination	32072,32075
- with diathermy or resection of polyp/s	32078,32081
Sigmoidoscopy, fibreoptic, flexible	32084,32087
Silicone band, encircling, removal from detached retina	42812
breast prosthesis, removal of	45555
Sinoscopy	41764
Sinus, diathermy of	*
ethmoidal, external operation on	41749
excision of	30099,30102,30103
frontal, catheterisation of	41740
frontal, radical obliteration of	41746
frontal, trephine of	41743
injection of sclerosant fluid under anaesthesia	30679
intranasal operation on	41737
maxillary, drainage of, through tooth socket	41719
pilonidal, excision of	30675,30676
pre-auricular, excision of	30104
sphenoidal, intranasal operation on	41752
urogenital, vaginal reconstruction for	35565
Skin, biopsy of	30071
cancer, treatment of	30196-30205
full face chemical peel	45019,45020
graft to orbit	42524
grafts	(see graft)
lesions, multiple injections for	30207
lesions, treatment of	30192,30195
malignant lesion, removal of	31300-31335
repair of recent wound of	30026-30049
sensitivity testing for allergens	12000,12003
subcutaneous tissue, extensive excision	31245
tags, anal, excision of	32142,32145
Skull base surgery for tumour removal	39640-39662
base tumour, removal, infra-temporal	41581
calipers, insertion of	47705
fracture, attendance for treatment of	47703
fractured, operations for	39606-39615
osteomyelitis, acute, operation for	43503
osteomyelitis, chronic, operation for	43521
osteomyelitis, craniectomy for	39906
treatment of fracture, not requiring operation	47703
tumour, excision of	39700
Sleep apnoea, overnight investigation for	12203,12207
Overnight paediatric investigation	12210, 12213, 12215, 12217
Sling operation for stress incontinence	35599
procedure, intestinal, prior to radiotherapy	32183
Slough, debridement of	35100,35103
Small bone, exostosis, excision of	47933
bowel intubation	30487,30488
bowel strictureplasty	30564
bowel, endoscopic examination of	32095
intestine, resection of	30565,30566
Smith's fracture of radius, treatment of	47369,47372,47375
Smith-Petersen nail, removal of	47924,47927
Socket, eye, contracted, reconstruction of	42527
Specialist attendance	(see attendance)
Specimen of sweat, collection of, by iontophoresis	12200
Speech discrimination tests	11321
Spermatic cord, exploration of, inguinal approach	30644
Spermatocele, excision of	37601
Sphenoidal sinus, intranasal operation on	41752
Sphincter, anal, direct repair of	32129
anal, stretching of	32153
bladder, endoscopic incision/resection	36854
muscle and pelvic floor abnormalities, diagnosis of	11833
of Oddi, transduodenal operation on	30458
urethral, reconstruction	37375

*** Payable on attendance basis**

Service	Item
urinary, artificial, insertion	37381,37384,37387
urinary, artificial, revision or removal	37390
Sphincterotomy, anal, independent procedure	43999
endoscopic	30485,36854
Spinal and pudendal nerve motor latency, measurement	11833
catheter and subcutaneous reservoir, insertion of	39127
catheter, insertion of for infusion device	39125,39128
cord, cervical decompression	40331-40335
fusion to cervical, thoracic or lumbar regions	48660-48675
fusion, application of halo for scoliosis	47714
fusion, posterior	40321,40324,40327
fusion, posterior interbody, with laminectomy	48654,48657
nerves, injection into	39013
nerves, percutaneous neurotomy	39115
neurostimulator receiver, subcutaneous placement	39134
rhizolysis	40330
shunt for hydrocephalus	40006
stenosis, laminectomy for	40303,40306
thoracic decompression	40345,40348
thoraco-lumbar/high lumbar decompression	40351
using segmental instrumentation	48613
Spine, application of plaster jacket to	47708
bone graft to	48642-48651
fracture, treatment of	47681-47702
internal fixation of	48678-48690
manipulation of	48600,48603
operation on, for acute osteomyelitis	43509
operation on, for chronic osteomyelitis	43518
Spirometry	11506,11509
Spleen, ruptured, repair or removal of	30375
Splenectomy	30597,30599
laparoscopic	31470
Spleno renal shunt, selective, for portal hypertension	30605
Splenorrhaphy	30596
Split skin free grafts, granulating areas	45400,45403
skin free grafts to one defect	45439-45448
Sports physcians, attendances by medical practitioners who are sports phsyicians	444-449
Squamous cell carcinoma, removal of	31255-31295
Squint, muscle transplant (Hummelsheim type)	42848
operation for	42833-42842
readjustment of adjustable sutures	42845
recurrent, operation for	42851
Staging laparotomy for gynaecological malignancy	35726
Stapedectomy	41608
Stapes mobilisation	41611
Staple arrest of hemi-epiphysis	48509
Starburst vessels, head/neck, diathermy or injection	30213,30214
Stenosing tendovaginitis, hand/wrist, open operation	46363
Stenosis, arteriovenous fistula/access device, correction of	34518
auditory canal, correction of	41521
spinal, laminectomy for	40303,40306
tracheal, dilatation of, with bronchoscopy	41904
venous, operations for	34812,34815
Stent, external, application restore valve competency	34824-34833
insertion, transluminal	35306,35309,35310
ureteric, passage through nephrostomy tube	36604
Stereotactic procedures	40800,40801,40803
radiosurgery	
Sterilisation (female)	35687,35688
in conjunction with Caesarean section	35691
Sternal wire/s, removal of	38460
Sternocleidomastoid muscle, bipolar release, torticollis	50402
Sternotomy for removal of thymus or mediastinal tumour	38446
involving division of adhesions	38643,38647
median, for post-operative bleeding	38656
wound, debridement of	38462,38464
Sternum and mediastinum, reoperation for infection	38468,38469
biopsy of	30081,30087,30084
fracture, treatment of	47466,47467
operation for acute osteomyelitis	43503
operation for chronic osteomyelitis	43512
reoperation for dehiscence or infection	38466
Stomach lavage	*
lavage in the treatment of ingested poison	14200
Stone/s, biliary/renal tract, extraction of	(see calculus)
removal of, by urethroscopy	36540,36543
Strabismus, injection of botulinus toxin for	42830
operation for	42833,42839
Stress incontinence, abdomino-vaginal operation	35602,35605
incontinence, Marshall-Marchetti, urethropexy	35599,37044
incontinence, sling operation	35599
incontinence, treatment by maximal perineal stimulation	*
incontinence, vaginal procdeure for	35600
Stricture, anal, anoplasty for	32123
oesophagus, dilatation of	41819
rectal, dilatation of	32115
rectum, plastic operation to	30387
tracheal, dilatation of, with bronchoscopy	41904
urethral, dilatation of	37303
Strictureplasty, small bowel	30564
Strontium 89, administration of	16015
Stump, amputation, reamputation of	44376
amputation, trimming of	*
cervix-residual, removal of, abdominal approach	35612
cervix-residual, removal of, vaginal approach	35613
Styloid process of temporal bone, removal of	30244
Sub-valvular structures, heart, reconstruction, re-implant	38490
Subclavian artery, endarterectomy	33506
to femoral bypass grafting	32715
vessel, ligation/exploration, other	34103
Subcutaneous fasciotomy, Dupuytren's contracture	46366
fistula in ano, excision of	32156
foreign body, removal not otherwise covered	30064
reservoir and spinal catheter, insertion of	39127
tenotomy	47960
tissue, repair of recent wound of	30026-30049
Subdural haemorrhage, tap for	39009

*** Payable on attendance basis**

Service	Item
Sublingual gland, duct, removal of calculus	30265,30266
gland, extirpation of	30259
gland, meatotomy or marsupialisation	30265,30266
Submandibular abscess, incision of	30223
ducts, relocation of	30255
gland, extirpation of	30256
Submaxillary gland, repair of cutaneous fistula	30269
Submucous resection of nasal septum	41671
resection of turbinates	41692
Subperiosteal abscess	43500-43524
Subphrenic abscess, laparotomy for drainage of	30394
Subtalar arthrodesis	50118
Subtemporal decompression	40015
Subungual haematoma, incision of	30219
Suction biopsy of rectum	30071
curettage of uterus	35639,35640,35643
Supraglottic laryngectomy with tracheostomy	41840
Suprapubic cystostomy or cystotomy	37008
cystostomy tube, change of	*
prostatectomy	37200
stab cystotomy	37011
Surgical reduction of enlarged elements, macrodactyly	46510
wounds, resuturing of (not burst abdomen)	*
Suspension of uterus	35683,35684
of vaginal vault, abdominal approach	35590
Suture, laser division of, eye, following trabeculoplasty	42794
shirodkar	16511
traumatic wounds	30026-30049
Sutures, adjustable, readjustment of, for squint	42845
dressing and removal of, requiring GA	30055
Swann-Ganz catheterisation	13818
Sweat, collection of specimen of, by iontophoresis	12200
gland bearing area, excision of	30180,30183
Sycosis barbae/nuchae, excision of	31245
Symblepharon, grafting for	45629
Syme's amputation of foot	44361
Sympathectomy, chemical	(see nerve blocks)
surgical	35000-35012
Symphysis pubis, fracture, treatment of	47474-47489
Syndactyly, repair	(see flap repair)
Synechiae, division of	42761
Synovectomy, of ankle	50312
of elbow	49109
of finger joints	46336
of hand tendons	46336,46342
of joint, not otherwise covered	50104
of metatarso-phalangeal joint	49860,49863
of shoulder	48936
of tendons of digit	46348-46360
total, of knee	49509
total, of wrist	49224
Synovial cavity, aspiration of	50124,50125
membrane, punch biopsy of	30087

T

Service	Item
Talipes equinovarus, cast/manipulation/splint	49878
equinovarus, procedures for	50315-50330
Talus fracture, treatment of	47606-47618
vertical, congenital, reconstruction	50336
Tarsal cartilage, excision of	42578
cauterisation of, for ectropion or entropion	42581
coalition, excision of	50333
cyst, extirpation of	42575
Tarsometatarsal joint, fracture, treatment of	47621,47624
joint, Lisfranc's amputation of	44364
Tarsorrhaphy	42584
Tarsus, dislocation, treatment of	47063,47066
fracture, treatment of	47627,47630
operation on, for acute osteomyelitis	43503
operation on, for chronic osteomyelitis	43512
osteectomy or osteotomy of	48406,48409
Tear duct, probing of	42610-42615
third degree, repair of	16573
Teflon injection, into vocal cord	41870
injection, peri-urethral	37339
Telangiectases, head/neck, diathermy or injection of	30213,30214
Temperature, digital, measurement of	11615
Temporal artery, biopsy of	34109
bone, reconstruction of	45788
bone, removal of styloid process of	30244
bone, resection for removal of tumour	41584,41587
Temporo-mandibular joint, arthroplasty	45758
meniscectomy	45755
Temporosphenoidal electroencephalography	11006
Tendon	49718-49727
- Achilles, repair of	49718-49727
- artificial prosthesis, insertion of for grafting	46414
- foot, adductor hallucis, transfer of	49827,49830
- foot, repair of	49800-49812
- foreign body in, removal	30067,30068
- hand/digit, synovectomy of	46336-46360
- hand/wrist, repair of	46420-46435
- lengthening of	47957,47960,47963
- major, of ankle, repair of	49718-49727
- or ligament transfer	47966
- prosthesis, artificial, insertion for grafting	46414
- reconstruction of, by tendon graft	46408
- repair of	47954,49718
- sheath, open operation for tenovaginitis	46363,47972
- tenotomy	47960,47963
- transfer of, to restore elbow function	50405
- transfer of, to restore hand function	46417
- transplantation of	47966
Tenolysis, hand	46450,46453
Tenoplasty	47963
Tenosynovectomy	47969
Tenosynovitis, open operation, tendon sheath hand/wrist	46363
Tenotomy	47960,47963,49806,49809
percutaneous, of finger	46456
Tenovaginitis, open operation for	46363,47972

*** Payable on attendance basis**

Service	Item
Tensillon test	*
Teratoma, mediastinal, thoracotomy and excision	43912
sacrococcygeal, neonatal, excision of	43876,43879
Testicular implant	45051
Testis, exploration of	37604
impalpable, exploration of groin	37812
undescended, orchidopexy for	37803,37806,37809
Testopexy	37803
Tethered cord, release of	40112
Thenar spaces of hand, drainage of	46519
Therapeutic haemapheresis	13750
Therapeutic venesection	13757
Thigh, amputation through	44367
hamstring tendon transfer	50357,50360
rectus femoris tendon transfer	50357
Third degree tear, repair of	16573
ventriculostomy	40012
Thompson arthroplasty of hip	49315
Thoracic aneurysm, replacement by graft	33103
aorta, operative management of rupture/dissection	38572
aorta, repair or replacement procedures	38550-38571
cavity, aspiration of	38400,38403
decompression of spinal cord	40345,40348
outlet compression, removal operation	34139
sympathectomy	35003,35006
Thoraco-lumbar decompression of spinal cord	40351
Thoracoplasty	38427,38430
Thoracoscopy	38436
Thoracotomy	38418,38421,38424
and excision of cyst/teratoma	43912
for congenital cystadenomatoid malformation	43861
for congenital lobar emphysema	43861
for oesophageal atresia, neonatal	43852
for removal of thymus or mediastinal tumour	38446
involving division of adhesions	38643,38647
or median sternotomy for post-operative bleeding	38656
Threatened abortion, treatment of	16505
miscarriage, purse string ligation of cervix	16511
miscarriage, treatment of	16505
premature labour, treatment of	16502,16508
Three snip operation	42617
Thrombectomy of arteriovenous access device	34515
of artery or vein	33803,33806,33812
Thrombosis, peri-anal, incision of	32147
reoperation on extremity for	33848
Thrombus, removal of	33803,33806,33812
Thumb, digital nail, removal of	46513,46516
flexor tendon sheath, open operation	46522
fractures, treatment of	47300-47333
ingrowing nail, resection	46528,46531
nodule, removal of	(see tumour,other)
Thymectomy	38456
Thymoma, malignant, removal from mediastinum	38456
Thymus, removal of by thoracotomy or sternotomy	38446
Thyroglossal cyst and/or fistula, removal of	30313,30314
Thyroid uptake	12518
Thyroidectomy	30296-30310
Tibia, bone graft to	48206,48209
congenital deficiency, treatment of	50417,50423
congenital pseudarthritis, resection, fixation	50354
epiphyseodesis	48503,48506
fracture, treatment of	47543-47573
operation on, for acute osteomyelitis	43503
operation on, for chronic osteomyelitis	43512
osteectomy or osteotomy of	48418,48421
Tibial vessel, ligation/exploration not otherwise covered	34106
Tic douloureux, injection for	39100
Tilt table testing for investigation of syncope	11724
Tissue expansion for breast reconstruction	45539,45542,45566
expansion, intra-operative	45572
free transfer of	45563
living, implantation of	14203,14206
subcutaneous, repair of recent wound of	30026-30049
Toe, amputation or disarticulation of	44338-44358
dislocation, treatment of	47069,47072
fracture, simple, treatment of	*
fractures, treatment by reduction	47663-47678
hammer or claw, correction of	49848,49851
hyperextension deformity, release, lengthening	50345
phalanx of, operation for acute osteomyelitis	43500
Toenail, ingrowing, excision or resection for	47915,47916,47918
ingrown, operation with GA, paediatric	44136
removal of	47904,47906
Tongue, partial or complete excision of	30272,41779,41785,41782
tie, repair of	30278,30281
Tonography, one or both eyes	11203
Tonsils, lingual, removal of	41804
or tonsils and adenoids	41796,41797
- arrest of haemorrhage, requiring GA	
- removal of, twelve years or over	41792,41793
- removal of, under twelve years	41788,41789
Topectomy, for epilepsy	40703
Torkildsen's operation	40000
Torticollis, bipolar release sternocleidomastoid muscle	50402
operation for	44133
Trabeculectomy for glaucoma	42746,42783
Trabeculoplasty, laser, of eye	42782
Trachea, dilatation of stricture and stent insertion	41905
removal of foreign body from	41886
Tracheal excision, repair, with cardiopulmonary bypass	38455
excision, repair, without cardiopulmonary bypass	38453
stricture, dilatation of with bronchoscopy	41904
Trachelorrhaphy	35617,35618
Tracheo-oesophageal fistula, division and repair	43900
formation of, including enoscopic procedures	41885
Tracheomalacia, aortopexy for	43909
Tracheoplasty or laryngoplasty with tracheostomy	41879
Tracheostomy	
by open exposure of the trachea	41881
closure of	30102,30103

*** Payable on attendance basis**

Service	Item
using Minitrach or similar device	41884
with laryngoplasty or tracheoplasty	41879
with supraglottic laryngectomy	41840
with vertical hemi-laryngectomy	41837
Transantral ethmoidectomy with radical antrostomy	41713
ligation of maxillary artery	41707
vidian neurectomy	41713
Transfusion	13703,13706
collection of blood for	13709
paediatric/neonatal	13306,13309
Transillumination, retrobulbar	42821
Translabyrinthine vestibular nerve section	41593
Transluminal balloon angioplasty	35300-35305
stent insertion	35306,35309,35310
Transmastoid decompression of endolymphatic sac	41590
removal of glomus tumour	41623
Transmetacarpal amputation of hand	44325
Transmetatarsal amputation of foot	44364
Transorbital ligation of ethmoidal arteries	41725
Transplantation, cornea	42653,42656,42659
ligament or tendon	47966
ureter	36585-36603
Transposition of digit	46507
of nerve	39321
Transthoracic drainage of pericardium	38450
Transtympanic removal of glomus tumour	41620
Transurethral injection for urinary incontinence	37339
Transvenous electrode/s, permanent, insertion of	38278,38284
pacemaking electrode, temporary, insertion of	38256
Treacher Collins Syndrome, peri-orbital correction of	45773
Trephine of frontal sinus	41743
Trichiasis, treatment of	42587
Trichoepitheliomas, face/neck, removal by laser excision	30190
Trigeminal gangliotomy, radiofrequency/balloon/glycerol	39109
nerve, injection with alcohol, cortisone etc	39100
neuralgia, intracranial neurectomy	39106
Trigger finger, correction of	46363
Tube, indwelling oesophageal, gastrostomy for fixation	30375
insertion of, for drainage of middle ear	41632
Tubed pedicle or indirect flap	45230
- delay of	
- formation of	45227
- preparation of site and attachment to site	45233
- spreading of pedicle	45236
Tuboplasty	35694,35697
Tumour, adrenal gland, excision of	30324
bladder, diathermy/resection with cystoscopy	36839,36845
bladder, laser destruction with cystoscopy	36839
bone, benign, requiring allograft, resection of	50230
bone, innocent, excision of	30241
bone, malignant, operations for	50200-50239
broad ligament, removal of	35712-35717
cardiac, excision of	38670-38680
carotid body, resection of	34148,34151,34154
cerebello-pontine angle, removal of	41575-41579
endocrine, exploration of	30578,30580,30581
extradural, laminectomy for	40309
face/neck, laser excision	30190
gastric, removal of	30520
glomus, removal of	41620,41623
gynaecological, radical or debulking operation	35720
intra-oral, radical excision of	30275
intra-temporal fossa, removal of	41578
intracerebral, craniotomy and removal of	39709
intracranial, biopsy/decompression, osteoplastic flap	39706
intracranial, burr-hole biopsy or drainage	39703
intracranial, craniotomy and removal of	39709,39712
intramedullary, laminectomy for	40318
involving ciliary body an/or iris, excision of	42767
iris, excision of	42764
larynx, removal of	41852
limbic, removal of	42692
malignant upper aerodigestive tract	31400,31403,31406
malignant, bone, operations for	50200-50239
malignant, skin, removal of	31300-31335
mandible, segmental resection for	45605
mediastinal, removal by thoracotomy or sternotomy	38446
microlaryngoscopy with removal of	41864
neuroendocrine, removal of	30321,30323
other, removal of (restriction applies)	31200-31240
ovarian, radical or debulking operation for	35720
parapharyngeal, excision of, cervical approach	31409,31412
parathyroid, removal of	30306
parotid gland, removal of	30253
parotid, excision of	30251
peripheral nerve, removal from	39324,39327
pituitary, hypophysectomy or removal of	39715
rectal, excision of	32099,32102,32108
removal of, by laminectomy	40309,40318
removal of, by lateral rhinotomy	41728
removal of, by temporal bone resection	41584,41587
removal of, by urethrectomy	37330
sacrococcygeal and presacral, excision of	32036
skin, malignant, removal of	31300-31335
skin, micrographic serial excision	31000,31001,31002
skull base, removal of	39640-39662
skull, excision of	39700
spinal, laminectomy for	40318
thyroid, removal of	30310
vagina, simple, removal of	35557
vocal cord, removal from	41852
Turbinates, cauterisation or diathermy of	41674
dislocation, treatment of	41686
submucous resection of	41692
Turbinectomy	41689
Turricephaly, cranial vault reconstruction for	45785
Tympani, paracentesis of	41626
Tympanic membrane, micro-inspection of	41650
membrane, micro-inspection with ear toilet	41647
Tympanum, perforation, cauterisation or diathermy	41641

*** Payable on attendance basis**

Service	Item

U

UVB therapy	14050,14053
Ulcer, corneal, epithelial debridement for	42650
corneal, ionisation of	*
duodenal, perforated, suture of	30375
gastric, perforated, suture of	30375
other, removal of	31200-31240
peptic, bleeding, control of	30505-30509
peptic, perforated, suture of	30375
Ulna, bone graft to	48218-48227
fracture, treatment of	47360-47408
operation on, for acute osteomyelitis	43503
operation on, for chronic osteomyelitis	43512
osteectomy or osteotomy of	48406,48409
Ulnar vessel, ligation/exploration not otherwise covered	34106
Ultrasonic localisation of placenta, Doppler technique	*
Ultrasound, intraoperative, biliary tract	30439
staging of intra-abdominal tumours	30441
Umbilical artery catheterisation	13303
granuloma, excision under GA	43948
hernia, repair of	30616-30621
vein catheterisation in a neonate	13300
Undescended testis, orchidopexy for	37803,37806,37809
Unstable lie, attendances other than routine antenatal	16502
Upright tilt table testing for syncope	11724
Urachus, patent, excision of	37800
Urea breath test	12533
Ureter, brush biopsy of, with cystoscopy	36821
divided, repair of	36573
exploration of	36612
retrocaval, correction of, by open exposure	36564,36567
transplantation of	36597
- into another ureter	
- into bladder	36588,36591
- into intestine	36594
- into isolated intestinal segment	36600,36603
- into skin	36585
Ureterectomy	36579
Ureteric calculus, endoscopic extraction/manipulation	36857
catheterisation with cystoscopy	36818,36824
dilatation	36821
meatotomy	36830
reflux, correction of	36588
stent, insertion of	36821
stent, removal/replacement of	36825
stent, through nephrostomy tube	36604
Ureterolithotomy	36549
complicated by previous surgery	37444
Ureterolysis	36615
Ureteroplasty	36618
Ureteroscopy	36803,36806,36809
Ureterostomy, cutaneous, closure of	36621
revision of	36609
Urethra, cauterisation of	35523
diathermy of	37318
diverticulum, excision of	37372
endoscopic examination with cystoscopy	36812
laser therapy, intraepithelial neoplasia	35539,35542,35545
prolapsed, excision of	35587,37369
ruptured, repair of	37306,37309
Urethral abscess, drainage of	30223
caruncle, cauterisation of	35523
caruncle, excision of	35526,35527
dilatation with cystoscopy	36812
diverticulum, excision of	37372
fistula, closure of	37333,37336,37833
pressure profilometry	11906,11909
prosthesis, with cystoscopy	36811
reconstruction, hypospadias/epispadias	37815,37827,37830
sounds, passage of, as an independent procedure	37300
sphincter, reconstruction of	37375
stricture, dilatation of	37303
stricture, optical urethrotomy for	37327
stricture, plastic repair of	37342-37351
tumour, removal of by urethrectomy	37330
valves, destruction of	37854
warts, cystoscopy for the treatment of	36815
Urethral sling, division or removal of	37340,37341
Urethrectomy	37330
Urethrocele, operation for	35587
Urethropexy (Marshall-Marchetti operation)	35599,37044
Urethroplasty	37342-37351
Urethroscopy, as an independent procedure	37315
with biopsy/diathermy/foreign body/stone	37318
with cystoscopy	36812
with cystoscopy and injection for incontinence	37339
with laser destruction of stone	37318
Urethrostomy	37324
Urethrotomy, external or internal	37324
optical, for urethral stricture	37327
Urinary conduit or reservoir, endoscopic examination	36860
conduit, revision of	36609
infection, bladder washout test	11921
reservoir, formation of	36606
sphincter, artificial	37381,37384
- insertion of cuff	
- insertion of pressure regulating balloon, pump	37387
- revision or removal of	37390
Urine flow study	11900
Urogenital sinus, vaginal reconstruction for	35565
Uterine adenomyoma, excision of	35649
adhesiolysis, with hysteroscopy	35633
adhesions, laparoscopic division	35638
adnexae, removal, with abdominal hysterectomy	35653
lavage, (saline flushing)	*
myomectomy	35649
septum, hysteroscopic resection	35623
tubes, insufflation of, for patency (Rubin test)	35706
Utero-sacral ligaments, laparoscopic division	35638
Uterus, acute inversion, vaginal correction	16570
bicornuate, plastic reconstruction for	35680

*** Payable on attendance basis**

Service	Item
curettage of	35639,35640
debulking prior to vaginal hysterectomy	35658
gravid, evacuation of contents	35643
implantation of Fallopian tubes into	35694,35697
suspension or fixation of	35683,35684
Uvula, excision of	41810
Uvulectomy and partial palatectomy	41787
Uvulopalatopharyngoplasty	41786
Uvulotomy	41810
V	
Vagina, artificial formation of	35565
dilatation of, as an independent procedure	35554
laser therapy, intraepithelial neoplasia	35539,35542,35545
partial or complete removal of	35560
removal of simple tumour of	35557
Vaginal correction of acute inversion of uterus	16570
fistula, repair or closure of	35596,37029,37333
hysterectomy	35657,35673
orifice, plastic repair to enlarge	35569
procedure for stress incontinence	35600
reconstruction, congenital absence/gynatresia	35565
repair, anterior and/or posterior	35576,35580
repair, with sacrospinous colpopexy	35567
septum, excision for correction of double vagina	35566
vault, suspension of, abdominal approach	35590
warts, removal under GA or nerve block	35507,35508
Vaginectomy, radical, for malignancy	35561,35562,35564
Vaginoplasty for congenital adrenal hyperplasia	37851
Vagotomy	30496-30503
Vallecular cysts, removal of	41813
Valve annuloplasty, heart	38475,38477,38478
leaflet/s, aortic, decalcification of	38483
mitral, open valvotomy of	38487
repair, heart	38480,38481
replacement, heart	38488,38489
Valvotomy for pulmonary stenosis	38456
open, of mitral valve	38487
Valvuloplasty, balloon or septostomy	38270
Varicocele, surgical correction of	30634,30635
Varicose veins, injection of sclerosing fluid	*
veins, multiple injections	32500,32501
veins, operations for	32500-32517
Vas deferens, operations on	37616-37623
Vasectomy	37622,37623
Vasoepididymostomy (unilateral)	37616,37619
Vasotomy	37622,37623
Vasovasotomy	37616,37619
Vein, anastomosis, microsurgical	45502
bypass for venous stenosis or occlusion	34812
cannulation of, in a neonate	13300
central, catheterisation	13318,13319,13815
central, catheterisation, subcutaneous tunnel	34527,34528
femoral bypass, saphenous vein anastomosis	34809
graft for priapism	37396
great, ligation or exploration not otherwise covered	34103
harvesting, leg/arm, for bypass, not same limb	32760
harvesting, leg/arm, for patch graft, not same incision	33551
intra-abdominal, cannulation, infusion chemotherapy	34521
ligation or exploration not otherwise covered	34106
major, repair of wound of	33815-33839
patch grafting to	33545,33548
saphenous, cross leg by-pass graft	34806
scalp, catheterisation of	13300
stenosis, patch angioplasty for	34815
thrombectomy of	33810,33811,33812
transplant to restore valvular function	34821
umbilical, catheterisation of	13300
varicose, injection of sclerosing fluid	*
varicose, multiple injections	32500,32501
varicose, operations for	(see varicose)
Veins, major, access as part of re-operation	35202
Velopharyngeal incompetence, flap or pharyngoplasty	45716
Vena cava, inferior, operations on	34800,34803
caval filter, insertion of	35330
Venepuncture for sending blood to Approved Pathologist	*
Venesection	*
therapeutic	13757
Venography, operative	35200
Venous anastomosis, not otherwise covered	32766,32769
catheterisation, peripheral	35317,35319,35320
graft to fenestration cavity	41605
stenosis or occlusion, vein bypass for	34812
valve, plication or repair to restore competency	34818
Ventilation, mechanical, intensive care	13857,13879,13882
Ventral hernia following closure exomphalos, repair of	43939
hernia, repair of	30403
Ventricular aneurysm, plication of	38506
aneurysm, resection	38507,38508
assist device, insertion of	38615,38618
assist device, removal of, independent	38621,38624
augmentation	38766
chamber, operation for arrhythmia	38518
myomectomy	38763
puncture	39006
reservoir or external drain, insertion of	39015
septal defect, closure of	38751
septal rupture, ischaemic, repair of	38509
septectomy	38748
Ventriculo-cisternostomy	40000
Ventriculostomy, third	40012
Vermilionectomy	45668,45669
Version, external cephalic	16501
Vertebra, needle biopsy of	30093
Vertebral bodies, fracture, treatment of	47681-47702
bodies, total or sub-total, excision of	48639
diseases of, excision & spinal fusion for	48640
resection and fusion for congenital scoliosis	48632
vessels, examination of	11618,11621,11624
Vesical fistula, cutaneous, operation for	37023
Vesico-intestinal fistula, closure of	37038

*** Payable on attendance basis**

Service	Item
Vesicostomy, cutaneous, establishment of	37026
Vesicovaginal fistula, closure of	37029
Vestibular nerve section, retrolabyrinthine	41596
nerve section, translabyrinthine	41593
nerve section, via posterior fossa	39500
Vidian neurectomy, transantral, with antrostomy	41713
Villus, chorionic, sampling	16603
Viscera, abdominal, operation involving laparotomy	30387
pelvic, operation involving laparotomy	30387
Viscus, ruptured, repair or removal of	30375
Vitamin products, injection of	*
Vitello intestinal duct, patent, excision of	43945
intestinal remnant, abdominal wall, excision of	43942
Vitrectomy	42719,42722,42725
Vitreolysis of lens material	42791,42792
Vocal cord, biopsy of	41849
cord, botulinum toxin injection into	41869
cord, removal of nodule or tumour	41852
cord, teflon injection into	41870
Volvulus, reduction of, with laparotomy	30375
Vulva, biopsy of, with colposcopy	35615
laser therapy for intraepithelial neoplasia	35539,35542,35545
wide local excision of suspected malignancy	35536
Vulval warts, removal under GA or nerve block	35507,35508
Vulvectomy, hemi	35536
radical for malignancy	35548
Vulvoplasty, where medically indicated	35533

W

Warts, anal, removal under GA or nerve block	32177,32180
palmar or plantar, removal of	30186,30187
penile or urethral, cystoscopy for treatment of	36815
removal in operating theatre	30189
vulval/vaginal, removal, GA or nerve block	35507,35508
Webbed fingers/toes, repair (see osteotomy and/or flap repair)	
Wedge excision for axillary hyperhidrosis	30180
excision of lip, eyelid or ear, full thickness	45665
Wertheim's operation	35664
Whipple's operation (pancreatico-duodenectomy)	30584
Whole body count	12530
Wire, orthopaedic, insertion of	47921
pin or screw, buried, removal of	47924,47927
Wolfe graft	45451
Wound, debridement under GA or major block	30023
dressing of, requiring GA	30055
recent, repair of by sticking plaster	*
resuturing following intraocular procedures	42857
surgical, resuturing of (not burst abdomen)	*
traumatic, suture of	30026-30049
Wrist, arthrodesis of	49200,49203
arthroplasty of	49209
arthroscopic surgery	49221,49224,49227
arthroscopy of	49218
arthrotomy of	49212
fracture, treatment of	47369,47372,47375
osteoplasty	49224
proximal carpectomy	49206
reconstruction of	49215
tendon sheath, open operation	46363
tendon, repair of	46420-46435
Wry neck, operation for	44133

X

Xanthelasma, treatment of	(see tumour,other)
Xenon arc photo-coagulation	42782,42783

Z

Z-plasty, in association with Dupuytren's Contracture	46384
Zinc ionisation of nostrils in the treatment of hay fever	*
Zygo-apophyseal joint, injection into	39013
Zygoma, osteotomy or osteectomy of	45720-45752
Zygomatic arch, reconstruction of	45788
bone, fracture, treatment of	47762-47771

*** Payable on attendance basis**

Service	Item
A	
Abscess	
- deep, percutaneous drainage	52058
- drainage tube, exchange of	52059
- incision with drainage, requiring admission	52055
- large, incision with drainage, requiring admission	52057
Alveolar ridge augmentation	52624, 52626
- cleft grafting of	52337
Antrobuccal fistula operation	53015
Antrostomy, radical	53006
Antrum	
- drainage of, through tooth socket	53012
- intranasal operation, or removal of foreign body	53009
- maxillary, proof puncture and lavage of	53000, 53003
- maxillary, removal of foreign body from	53009
Arch bars, to maxilla or mandible, removal of	52106
Artery, facial, mandibular or lingual, ligation of	52141
- maxillary, ligation of	52138
Arthrocentesis, with irrigation of temporomandibular joint	53225
Antroscopy of temporomandibular joint	53215, 53218
Aspiration biopsy, one or more jaw cysts	52021
Assistance at operation	51800, 51803
Attendance	51700, 51703
Axillary sinus, excision of	52033
B	
Basal cell carcinoma	
- complicated , removal	52051, 52054
- uncomplicated, removal	52036-52048
Biopsy, aspiration of jaw cysts	52021
- lymph gland, muscle or other deep tissue or organ	52027
- skin or mucous membrane	52024
Bone	
- cyst, injection into or aspiration of	52064
- graft, harvesting of, via separate incision	52318,52319
- graft, to other bones	52130
- graft, with internal fixation	52131
- growth stimulator	52095
- tumour, malignant, operations for	52180-52186
C	
Calculus, removal of, salivary gland duct	52075
Caldwell-Luc's operation	53006
Carbuncle, incision with drainage, in operating theatre	52057
Cauterisation, septum/turbinates/pharynx	53060
Cellutitus, incision with drainage, in operating theatre	52057
- incision with drainage, not requiring GA	52055
Cleft lip, operations for	52440-52458
Cleft palate, primary repair	52333
- palate, secondary repair, closure of fistula	52336
- palate, secondary repair, lengthening procedure	52339
Composite graft to nose, ear or eyelid	52482
Condylectomy/condylotomy	53224
Contour reconstruction, insertion of foreign implants	52321
Cricothyrostomy	52133
Cutaneous nerve, nerve graft to	52832
- repair of	52828, 52830
Cyst, jaw, aspiration biopsy of	52021
- mandible or maxilla, segmental resection of	52114
- not otherwise covered, removal of	52036-52048
D	
Deep tissue or organ, biopsy of	52027
Dermis, dermofat or fascia graft	52424
Dermoid, excision	52036-52045
Diathermy, salivary gland duct	52072
Dilatation, salivary gland duct	52072
Dislocation, mandible, treatment of	53200-53203
Duct, salivary gland, diathermy or dilatation of	52072
- salivary gland, removal of calculus from	52075
- sublingual gland, removal of calculus from	52075
E	
Endo-biopsy	52024,52027
Endoscopic, laser therapy of upper aerodigestive tract	52035
Exostosis, mandibular or palatal, excision of	52600
External fixation, orthopaedic, removal	52097,52098
F	
Face, contour reconstruction	52379
Facial artery or vein, ligation of	52141

Service	Item
Fibroma, removal of	52036-52045
Fistula, antrobuccal, operation for	53015
- oro-antral, plastic closure of	53015
Flap repair, direct	52324,52327
- repair, single stage local	52300-52306
Foreign body, antrum, removal of	53009
- body, deep, removal, interventional imaging	52144
- body, maxillary sinus, removal of	53009
- body, muscle/other deep tissue, removal of	52018
- body, subcutaneous, removal, other	52015
- body, superficial removal, other	52012
- body, tendon, removal of	52018,52144
- implants for contour reconstruction, insertion of	52321
Fracture, mandible or maxilla, treatment of	53400-53439
- zygomatic bone, treatment of	53411-53414
Free grafts, full thickness	52315
- grafts, mucosa/split skin/connective tissue	52309,52312
Frenulum, mandibular or maxillary, repair of	52084
Furuncle, incision with drainage, in operating theatre	52057
G	
Genioplasty	52378
Gland, lumph, biopsy of	52027
- salivary, dilatation or diathermy of duct	52072
- salivary, incision of	52057
- salivary, meatotomy or marsupialisation	52075
- salivary, removal of calculus from duct	52075
- salivary, transposition of duct	52147
- sublingual, extirpation of	52069
- submandibular, extirpation of	52066
- submaxillary, extirpation of	52066
- submaxillary, incision of	25057,52147
Glenoid fossa, zygomatic arch, temporal bone, reconstruction	53209
Grafts, compsite (chondrocutaneous/mucosal)	52480
- free, full thickness	52315
- mucosa or split skin	52309,52312
H	
Haematoma, aspiration of	52056
- incision with drainage, not requiring GA	52055
- large, incision with drainage, in operating theatre	52057
Haemorrhage, post-nasal and/or post-operative, control of	52135
Hemifacial microsomia, construction condyle and ramus	53212
Hyperplasia, papillary, of palate, removal of	52609-52615
Hypertrophied tissue, removal of	52036-52045
I	
Innocent bone tumour, excision of	52063
Intranasal operation on antrum/removal foreign body	53009
Intra-oral tumour, radical excision of	52160
J	
Jaw, aspiration biopsy of cyst/s	52021
- dislocation, treatment of	53200,53203
- fracture, treatment of	53400-53439
- operation on, for osteomyelitis	52090
- plastic and reconstructive operation on	52342-52375
K	
Keloid, excision of	52036-52045
Kirschner wire, insertion of	52096
L	
Lacerations	
- ear/eyelid/nose/lip, full thickness, repair of	52010
- repair and suturing of	52000-52009
Lavage and proof puncture of maxillary antrum	53000,53003
Le Fort osteotomies	52380,52382
Lingual artery or vein, ligation of	52141
Lip, full thickness wedge excision of	52108
Lipectomy, wedge excision	51904,51906
Lipoma, removal of	52036-52045
Local flap repair, single stage	52300-52306
Lymph gland, muscle or other deep tissue or organ biopsy of	52027
Lymph node, biopsy of	52025
Lymphoid patches, removal of	52036-52045
M	
Macrocheilia, operation for	52482
Macrostomia, operation for	52484
Mandible, dislocation, treatment of	53200,53203
- fixation by intermaxillary wiring	52420
- hemi-mandiblectomy of	52120
- hemi-mandibular reconstruction with bone graft	52122
- operation on, for osteomyelitis	52090
- or maxilla, fractures, treatment of	53400-53439

Service	Item
- osteectomy of osteotomy of	53400-53439
- removal of one or more plates	52342-52375
- removal of buried wire, pin or screw	52099, 52102
- segmental resection of, for tumours or cysts	52114
- sub-total resection of	52117
- total resection of	52123
Mandibular artery or vein, ligation of	52141
- exostosis, excision of	52600
- frenulum, repair of	52084
Maxilla, operation on, for osteomyelitis	52090
- or mandible, fractures, treatment of	53400-53439
- osteectomy or osteotomy of	52342-52375
- removal of buried wire, pin or screw	52099, 52102
- removal of one or more plates	52105
- sub-total resection of	52117
- total resection of	52126, 52129
Maxillary antrum, lavage of	53004
- proof puncture and lavage of	53000, 53003
- artery, ligation of	52138
- frenumlum, repair of	52084
- sinus, drainage of, through tooth socket	53012
- sinus, operations on	53006, 53009
- sinus, sinus lift procedure	53019
- tuberosity, reduction of	52606
Melanoma, excision of	52036-52048
Micro-arterial graft	52434
Microvascular anastomosis using microsurgical techniques	52430
- repair using microsurgical techniques	52424
Mouth, lowering of floor of (Obwegeser or similar)	52621
Mucous membrane, biopsy of	52024
- membrane, repair of recent wound of	52000-52009
Muscle, biopsy of	52027
- excision of	52060
- or other deep tissue, removal of foreign body	52018
- ruptured, repair of	52061, 52062
Mylohyloid ridge, reduction of	52603
N	
Naevus, excision of	52036-52045
Nasal bones, treatment of fracture/s	53458-53460
Nasal cavity and/or post nasal space examination of	53056
- cavity, packing for arrest of haemorrhage	53062
- haemorrhage, arrest of	53058
- haemorrhage, cryotherapy to	53064
- space, post, direct examination of	53052
Nasal septum, reconstruction	53017
Nasal septum, septoplasty	53016
Nasendoscopy	53054
Nerve, clock, regional or field	53700-53704
- peripheral, neurectomy/neurotomy/tumour	52806, 52809
- transposition of	52818
- trigeminal, cryosurgery of	52824
- trunk, graft to	52821
- trunk, neurolysis of	52803
- trunk, repair of	52812-52815
Neurolysis by open operation	52800
- of nerve trunk	52803
Neurectomy, peripheral nerve	52806, 52809
Node, lymph, biopsy of	52027
O	
Orbital cavity, bone or cartilage graft to, wall or floor	53455
- cavity, reconstruction of wall or flor	53453
Oro-antral fistula, plastic closure of	53015
Orthopaedic pin or wire, insertion of	52096
- pin or wire, removal of	52099, 52102
- plates, removal of	52105
Osseointegration procedure	52627-52636
Osteectomy of mandible or maxilla	52342-52375
Osteomyelitis, operation on mandible or maxilla	52090
- operation on skull	52092
- operation on combination of adjoining bones	52094
Osteotomies, mid-facial	52380, 52382
Osteotomy of mandible or maxilla	52342-52375
Palatal exostosis, excision of	52600
Palate, cleft, repair of	52333, 52336, 52339
- papillary hyperplasia removal of	52609,-52615
- plastic closure of defect of	52330
Papillary hyperplasia of the palate, removal of	52609-52615
Papilloma, removal or	52036-52045
Parotid duct, repair of	52148
Pharyngeal flap for velo-pharyngeal incompetence	52460
Pin, orthopaedic, insertion of	52096
- orthopaedic, removal of	52099, 52102
Plastic repair, free grafts	52309-52315
- repair, single stage, local flap	52300-52306
Plates, orthopaedic, removal of	52015, 52018
Post nasal space, examination under GA	53056
- direct examination of with/without biopsy	53052
Premalignant lesions, cryotherapy, diathermy or carbon dioxide laser	52034
Preauricular sinus operations	52030

Service	Item
Proof puncture of maxillary antrum	53000, 53003
R	
Radical antrostomy	53006
Ranula, removal of	52087
Reduction of dislocation of mandible	53200, 53203
Rodent ulcer, operation for	52036-52045
S	
Salivary gland duct, diathermy or dilatation of	52072
- gland duct, removal of calculus from	52075
- gland duct, transposition of	52147
- gland, incision of	52057
- gland, repair of cutaneous fistula of	52073
Scar, removal of, not otherwise covered	52036-52045
Sebaceous cyst, removal of	52036-52045
Segmental resection of mandible or maxilla for tumours	52114
Single stage local flap repair	52300-52306
Sinus, excision of	52030, 52033
- maxillary, drainage of, through tooth socket	53012
Skin biopsy of	52024
- repair of recent wound	52000-52009
- sensitivity testing	53600
Skull, operation on, for osteomyelitis	52092
Subcutaneous foreign body, removal, other	52015
- tissue, repair of recent wound	52000-52009
Sublingual gland duct, removal or calculus from	52075
- gland, extirpation of	52069
Submandibular abscess, incision of	52057
- ducts, relocation of	52158
- gland, extirpation of	52066
- gland, incision of	52057
Submaxillary gland, extirpation of	52066
- gland, incision of	52057
Superficial foreign body, removal of	52012
- wound repair of	52000, 52009
Suture of traumatic wounds	52000-52009
T	
Temporal bone glenoid fossa/zygomatic arch, reconstruction of	53209
Tempormandibular joint	
- arthrodesis	53239
- arthrotomy	53220
- arthroscopy of	53215, 53218
- joint, external fixation, application of	53242
- joint, irrigation of	53225
- joint, manipulation of	53206
- stabilisation of	53236
- synovectomy of	53226
- joint, open surgical exploration of	53221-53233
Tendon, foreign body in, removal of	52018
- or other deep tissue, foreign body in, removal of	52018
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Fibrinogen - degradation products	FDP	65120
Fitzgerald factor	FGF	65150
Flecainide	FLEC	66611
Fletcher factor	FF	65150
Fluorescent treponemal antibody - absorption test (FTA-ABS) - microbial antibody testing	FTA	69384
Fluoxetine	FLUX	66611
Foetal red blood cells - Kliehauer	KLEI	65162
Folate - red cell	RCF	66599
Follicle stimulating hormone (FSH)	FSH	66695
Frozen section diagnosis of biopsy material	FS	72855-56
Fructosamine	FRUC	66557
Full blood examination	FBE	65070
G		
Gamma glutamyl transpeptidase	GGT	66500

Gastric parietal cell - tissue antigens - antibodies	PCA	71119
Gastrin	GAST	66695
Gliadin IgA - tissue antigens - antibodies	GLIA	71119
Globulin	GLOB	66500
Glomerular basement membrane - tissue antigens - antibodies	GBA	71109
Glucagon	GLGO	66695
Glucagon stimulation test	GSTC	66689
Glucose	GLUC	66500
Glucose - tolerance test	GTT	66542
Glycosolated haemoglobin (Hb Alc)	GHB	66551
Gold AU		66672-73
Gonadotrophin	GRHS	66689
Group B streptococcus - CSF antigens	STB	69372
Group B streptococcus - microbial antigen testing	STB	69372
Group P9 - simple basic pathology tests		73801-11
Growth hormone	GH	66695
Growth hormone - stimulation by exercise or L-dopa	GHSE	66686
Growth hormone - suppression by dexamethasone or glucose	GHSG	66686
H		
Haematocrit	HCT	65070
Haemochromatosis	FEUP	66794
Haemoglobin	HB	65060
Haemoglobinopathy tests	HMGP	65081
Haemophilus influenzae - CSF antigens	HI	69372
Haemophilus influenzae - microbial antibody testing	HUS	69384
Haemophilus influenzae - microbial antigen testing	HI	69372
Haloperidol	HALO	66611
Haptoglobins	HGLB	66632
HDL cholesterol	HDLC	66536
Heart - tissue antigens - antibodies	AHE	71109
Heparin - test	HEPR	65144
Hepatitis - acute	HAVM	69414
Hepatitis - chronic viral	HBCS	69453
Hepatitis - chronic viral	HBCE	69456
Hepatitis A - immune status	HAVG	69417
Hepatitis A and B - immune status	HABI	69450
Hepatitis A, B or C - acute	HVU	69459
Hepatitis B - acute or resolving	HBAR	69420
Hepatitis B - chronic or carriage of Hep. B antigen	HBSA	69432
Hepatitis B - chronic or carriage of Hep. B antigen	HBSE	69435
Hepatitis B - immune status - post exposure	HBIC	69426
Hepatitis B - immune status - post vaccination	HBIS	69429
Hepatitis B - resolving	HBR	69423
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Hepatitis C - detection	RNAC	69444
Hepatitis C – genotype	GHCV	69443
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Hepatitis C - quantitation	THCV	69442
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Hepatitis serology - in pregnancy	HEPP	69405-11
Herpes simplex virus - direct detection from clinical material	HSV	69375
Herpes simplex virus - investigation by culture	HSVC	69375
Herpes simplex virus - microbial antibody testing	HPA	69384
Herpes simplex virus - microbial antigen testing	HSV	69375
Heterophil antibodies	IM	65114
HIAA (hydroxyindoleacetic acid)	HIAA	66779
Histamine	HIAM	66779
Histone - tissue antigens - antibodies	AHI	71109
Histopathology of biopsy material	HIST	72813-36
Histoplasma - microbial antibody testing	HIP	69384
HIV - antiretroviral therapy	TVLT	69381
HIV - cerebrospinal fluid	CVLT	69382
HIV - monitoring	MVLT	69378
HLA typing - HLA class 1	HLA1	71149

HLA typing - HLA class 2	HLA2	71151
HLA typing - HLA-B27	HLAB	71147
HMMA (hydroxy-3-methoxymandelic acid, previously known as VMA)	HMMA	66779
HMPG (hydroxy-methoxy phenylethylene glycol)	HMPG	66779
Homovanillic acid	HVA	66779
Hormomes - stimulation by exercise or L-dopa	GHSE	66686
Hormone receptor assay - breast	HRA	66662
Hormone receptor assay - ovary	HRO	66662
Hormones - 11 deoxycortisol	DCOR	66695
Hormones - adrenocorticotrophic hormone	ACTH	66695
Hormones - aldosterone	ALDS	66695
Hormones - androstenedione	ANDR	66695
Hormones - calcitonin	CALT	66695
Hormones - cortisol	CORT	66695
Hormones - C-Peptide	CPEP	66695
Hormones - cyclic AMP	CAMP	66695
Hormones - dehydroepiandrosterone sulphate (DHEAS)	DHEA	66695
Hormones - dihydrotestosterone	DHTS	66695
Hormones - follicle stimulating hormone	FSH	66695
Hormones - gastrin	GAST	66695
Hormones - glucagon	GLGO	66695
Hormones - gonadotrophin	GRHS	66689
Hormones - growth hormone	GH	66695
Hormones - growth hormone - stimulation by exercise or L-dopa	GHSE	66686
Hormones - growth hormone - suppression by dexamethasone or glucose	GHSG	66686
Hormones - hormone receptor assay - breast	HRA	66662
Hormones - hormone receptor assay - ovary	HRO	66662
Hormones - human chorionic gonadotrophin – quantitation	HCG	66650-53, 66740, 73529
Hormones - human chorionic gonadotrophin – detection for pregnancy diagnosis	HCGP	73527, 73529
Hormones - human placental lactogen	HPL	66746
Hormones - hydroxyprogesterone	OHP	66695
Hormones - insulin	INS	66695
Hormones - insulin, hypoglycaemia test	INHY	66689
Hormones - luteinizing hormone	LH	66695
Hormones - oestradiol	E2	66695
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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
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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

I

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
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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
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Islet cell - tissue antigens - antibodies	AIC	71109
Isoelectric focussing and electrophoresis – characterisation of cryoglobulins	RYO	71059
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J

Jo-1 - tissue antigens - antibodies	JO1	71119

K

Keratin - tissue antigens - antibodies	KERA	71119
Kleihauer test	KLEI	65162

L

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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
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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
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Lip - cytology on specimens from	SMCY	73043
Lipase	LIP	66500
Lipid studies (see test groups at para PQ.4)	FATS	66500
Lipoprotein subclasses - electrophoresis	LEPG	66539
Listeria - microbial antibody testing	LIS	69384
Lithium	LI	66611
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Liver/kidney microsomes - tissue antigens - antibodies	LKA	71119
Lupus anticoagulant	LUPA	65132-37, 65142
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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
M		
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Mammary serum antigen	MSA	66650
Manganese	MN	66669-70
Mantoux test	MANT	73811
Measles - microbial antibody testing	MEA	69384
Mercury	HG	66672-73
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Methaemalbumin detection (Schumm's test)	SCHM	65117
Metanephrines	MNEP	66779
Methadone	MTDN	66611
Methotrexate	MTTA	66611
Methsuximide	MSUX	66611
Methylphenobarbitone	MPBT	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-ABS)	FTA	69384
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		
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
O		
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
P		
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
Propranolol	PPNO	66611
Prostate specific antigen	PSA	66655-66659
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-l-antitrypsin	AAT	66635
Protein, quantitation of - beta-2-microglobulin	BMIC	66629
Protein, quantitation of - caeruloplasmin	CPLS	66632
Protein, quantitation of - C-l esterase inhibitor	CEI	66644
Protein, quantitation of - classes or presence and amount of paraprotein by electrophoresis	EPPI	71057-71058
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		
Q fever - microbial antibody testing	QFF	69384
Quinalbarbitone	QUIB	66611
Quinidine	QUIN	66611
Quinine	QNN	66611
R		
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
S		
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
SotalolSALL	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
T		
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	66500
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
U		
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
V		
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
WXYZ		
Warfarin	WFR	66611
Yersinia enterocolitica - microbial antibody testing	YER	69384
Zinc		

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, curettings or fragments - lesion	5
Bone, biopsy or curettings quantitation - metabolic disease	6
Bone, femoral head	4
Bone, resection, neoplasm - all sites and types	6
Bone marrow, biopsy	4
Bone - all specimens not otherwise specified	4
Brain neoplasm, resection - cerebello-pontine angle	4
Brain or meninges, biopsy - all lesions	5
Brain or meninges, not neoplasm - temporal lobe	6
Brain or meninges, resection - neoplasm (intracranial)	5
Brain or meninges, resection - not neoplasm	4
Branchial cleft, cyst	4
Breast, excision biopsy, guidewire localisation - non-palpable lesion	6
Breast, excision biopsy, or radical resection, malignant neoplasm or atypical proliferative disease - all specimen types	6
Breast, incision biopsy or needle biopsy, malignant neoplasm - all specimen types	4
Breast – microdochectomy	6
Breast tissue - all specimens not otherwise specified	4
Bronchus, biopsy	4
Carotid body - neoplasm	5
Cholesteatoma	3
Digits, amputation - not traumatic	4
Digits, amputation - traumatic	2
Ear, middle and inner - not cholesteatoma	4
Endocrine neoplasm - not otherwise specified	5
Extremity, amputation or disarticulation - neoplasm	6
Extremity, amputation - not otherwise specified	4
Eye, conjunctiva - biopsy or pterygium	3
Eye, cornea	4
Eye, enucleation or exenteration - all lesions	6
Eye - not otherwise specified	4
Fallopian tube, biopsy	4
Fallopian tube, ectopic pregnancy	4
Fallopian tube, sterilization	2
Fetus with dissection	6
Foreskin - new born	2
Foreskin - not new born	3
Gallbladder	3
Gallbladder and porta hepatis-radical resection	6
Ganglion cyst, all sites	3
Gum or oral mucosa, biopsy	4
Heart valve	4
Heart - not otherwise specified	5
Hernia sac	2
Hydrocele sac	2
Jaw, upper or lower, including bone, radical resection for neoplasm	6
Joint and periarticular tissue, without bone - all specimens	3
Joint tissue, including bone - all specimens	4
Kidney, biopsy including transplant	5

Kidney, nephrectomy transplant	5
Kidney, partial or total nephrectomy or nephroureterectomy - neoplasm	6
Kidney, partial or total nephrectomy - not neoplasm	4
Large bowel (including rectum), biopsy - all sites	4
Large bowel, colostomy - stoma	3
Large bowel (including rectum), biopsy, and confirmation or exclusion of Hirschsprung's Disease	5
Large bowel (including rectum), polyp	4
Large bowel, segmental resection - colon, not neoplasm	5
Large bowel (including rectum), segmental resection, neoplasm	6
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 or resection for trauma	4
Liver, total or subtotal hepatectomy - neoplasm	6
Liver - all specimens not otherwise specified	5
Lung, needle or transbronchial biopsy	4
Lung, resection - neoplasm	6
Lung, wedge biopsy	5
Lung segment, lobar or total resection	6
Lymph node, biopsy - all sites	4
Lymph node, biopsy – for lymphoma or lymphoproliferative disorder	5
Lymph nodes, regional resection - all sites	5
Mediastinum mass	5
Muscle, biopsy	6
Nasopharynx or oropharynx, biopsy	4
Nerve, biopsy neuropathy	5
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)	5
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, paranasal, biopsy	4
Sinus, paranasal, resection - neoplasm	6
Skin, biopsy - blistering skin diseases	4
Skin, biopsy - inflammatory dermatosis	4
Skin,eyelid, wedge resection	4
Skin, local resection - orientation	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 – resection, all specimens	5
Soft tissue, infiltrative lesion, extensive resections at least 5cm in maximal dimension	6
Soft tissue, lipoma and variants	3
Soft tissue, neoplasm, not lipoma - all specimens	5
Soft tissue - not otherwise specified	4
Spleen	5
Stomach, endoscopic biopsy or endoscopic polypectomy	4
Stomach, resection, neoplasm - all specimens	6
Stomach - 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	6
Uterus with or without adnexa, neoplasm, Wertheim's or pelvic clearance	6
Uterus and/or cervix - all specimens not otherwise specified	4
Vagina, biopsy	4
Vagina, radical resection	6
Vaginal mucosa, incidental	3
Vulva or labia, biopsy	4
Vulval, subtotal or total with or without nodes	6